



Zuno Health Top Up Insurance
Prospectus

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1. Features & Scope

- Sum insured amounts offered are a minimum of Rs 1,00,000 and a maximum of Rs 5,00,00,000
- For Proposer, the entry age into this policy is 18 years and there is no upper limitation. For child, the entry age is 91 days max upto 25 years.
- The policy shall ordinarily be renewable except on ground of fraud, mis-description, misrepresentation or non-co-operation by the Insured/ policyholder.
- The policy will be issued for periods, 1 year, 2 Years and 3 Years.
- The family floater policy includes self, spouse, dependent children, Dependent Parent(s), Parents(s)-in-law
- The Individual policy includes Self, Spouse, Dependent Children, Parent(s), Parent(s)-in-law, Son-in-law, daughter-in-law, Grandparents, Grand Child/Children, Brother In Law, Sister In Law, Siblings, Niece, and Nephew.

Plan	Top Up	Super Top Up
Sum Insured (in Lakhs)	1,2,3,4,5,6,7,8,9,10,15,20	1,2,3,4,5,6,7,8,9,10,15,20,25,50,75,100, 150, 250, 500
Deductible	As mentioned in Table 1 below	
In-Patient Hospitalization	Covered	Covered
Pre-Hospitalization	30 Days	60 Days
Post-Hospitalization	60 Days	90 Days
AYUSH	Covered	Covered
No Claim Bonus	5% per year at renewal Upto 50% of Sum insured.	
Day Care Treatment	Covered	Covered
Domiciliary Hospitalization	Covered	Covered

Optional Covers	Top Up	Super Top Up
Pre-existing Waiting Period Waiver/Reduction	Can Be reduced for Disclosed PED - Waiver Option- 1) 12 months 2)24 months 3) No Waiting period	
Base Policy Co-pay Support Note: This cover would be applicable in case the Customer has an active base health Insurance Policy with Us or any Health/ General Insurance Company at the time of inception or at the time of renewal of this product	1,000-50,000	1000-2,00,000
Base Policy Higher Room Rent Support Note: This cover would be applicable in case the Customer has an active base health Insurance Policy with Us or any Health/ General Insurance Company at the time of inception or at the time of renewal of this product	1,000-50,000	1000-2,00,000
New Born Cover	Any one Option has to be selected from below: 1)New Born Cover within Maternity (Maternity Sum insured deductible applicable--- Applicable if only maternity opted) 2) New Born Cover within Base SI from Day 1 (Base Policy deductible applicable)	
Vaccination cover	SI-1000 to 50000	
Double Sum Insured for Critical Illness	Optional Cover	
Assistance Service (Domestic & Worldwide as per plan opted)	1) Medical Referrals 2)Emergency Medical Evacuation 3) Medical Repatriation 4)Compassionate Visit 5)Medical Monitoring 6) Second Medical Opinion 7)Return of Mortal Remains	
Hospital Cash	Any one option from each of the below options have to be selected:	

	1) Sum Insured Options- a) 500/Day, b) 1000/day, c) 2000/day, d) 3000/day, e) 5000/day 2) Number of Days - 1 day to 10 days 3) Deductible - 0, 1, 2, 3, 4, 5 days	
Dental OPD Cover	Sum Insured- 1,000 to 50,000	
Restoration Benefit	Optional Cover	
Recharge Benefit	Optional Cover	
Worldwide Coverage (Extended Coverage)	Any one option needs to be selected from below: Yes No	
Maternity	Sum Insured - Rs.50000 Deductible - 5000-25,000	Sum Insured Options- 50000,75000,1,00,000,150000 Maximum Deductible will be 50% of the maternity Sum insured selected by the Customer within the range of 5000-50,000 But in case if the SI option is 150000, still the customer can select maximum deductible upto 50,000.
Organ Donor	Optional Cover - 10% of SI to 50% of SI	
Emergency Ambulance	Sum insured Options- 1) 1500/event, 2) 2000/event, 3) 2500/event, 4)3000/Event	
241 Optional Cover	Optional Cover Can be opted for by the Insured if one year policy term is opted	
Voluntary Co-pay	Any one option needs to be selected from below: 10% Co-pay, 20% Co-pay	

Discount Option	
Family Discount	A discount of 5% on total premium will be given if two or more family members are covered under the same policy under the individual policy option
Online Discount	A discount of 15% on total premium will be given. (Applicable only if taken from Zuno website)
Long Term Discount	Long Term Discount- A discount of 7.5% and 10% on total premium will be given if a policyholder chooses to pay upfront premium for 2 years and 3 years respectively
Renewal Discount	A discount of 5% will be given on each continuous renewal of policy irrespective of whether insured has made claim in past. (Not Applicable if customer has opted for 241 Optional Cover in his first renewal but in second and subsequent renewals, the insured will get this discount).
Loyalty Discount	A discount of 5% will be given to insured who is having any active policy with Zuno General Insurance Limited.
Edelweiss Customer Discount	A discount of 5% shall be given to any proposer who has a valid and existing Unique Customer Identification Number as issued by the Edelweiss Group. Edelweiss Customer discount shall only be given to the proposer when (a) the person is verified customer of the Edelweiss Group as defined on the date when the proposal is made and (b) it is sold through direct sales mode only and not through the intermediaries
Edelweiss Group Employee Discount	A 5% discount on the premium if he/she is an employee of Edelweiss Group.

Sum Insured and Deductible options

Sum insured (in lakhs)	Deductible (in lakhs)	Plans	
		Top Up	Super Top Up
1	0.5	Y	Y
2	0.5,1	Y	Y
3	0.5,1,1.5,2	Y	Y
4	0.5,1,1.5,2,2.5,3	Y	Y
5	0.5,1,1.5,2,2.5,3, 3.5,4,4.5,5	Y	Y
6	0.5,1,1.5,2,2.5,3, 3.5,4,4.5,5	Y	Y
7	0.5,1,1.5,2,2.5,3, 3.5,4,4.5,5	Y	Y
8	0.5,1,1.5,2,2.5,3, 3.5,4,4.5,5	Y	Y
9	0.5,1,1.5,2,2.5,3, 3.5,4,4.5,5,5.5,6,6.5,7,7.5,8	Y	Y
10	0.5,1,1.5,2,2.5,3, 3.5,4,4.5,5,5.5,6,6.5,7,7.5,8,8.5,9	Y	Y
15	1,2,3,4,5,7.5, 10	Y	Y
20	1,2,3,4,5,7.5, 10,15	Y	Y
25	1,2,3,4,5,7.5,10,15,20	X	Y
50	5,7.5,10,15,20,25,30,35,40,45	X	Y
75	7.5,10,20,30,40,50,60,70	X	Y
100	5,7.5,10,20,30,40,50,60,70,80,90	X	Y
150	7.5,10,20,30,40,50,60,70,80,90,100	X	Y

250	7.5,10,20,30,40,50,60,70,80,90,100	X	Y
500	7.5,10,20,30,40,50,60,70,80,90,100	X	Y

3. Requirements for procuring the policy

1. Completed Proposal Form

2. Additional documents if any after verifying the proposal form and after underwriting the proposal.

3. Pre-Policy Issuance Medical Check-Up - We will require You to undergo a pre-policy medical check-up, basis on age, Sum Insured, deductible, BMI and plan opted as provided in the grid below. Wherever any pre-existing disease or any other adverse medical history is declared, such proposal will be subject to medical underwriting. Medical tests will be facilitated by us and conducted at Zuno General Insurance Limited's/ Our Service Provider's empanelled network of diagnostic centres. We / Service Provider will contact you and fix up an appointment for the Medical Examination to be conducted at a time convenient to You. 50% of the cost of all such medical tests will be borne by us if proposal is accepted.

Pre policy Medical Check-up Grid:-

1. The Company reserves the rights to prescribe further tests based on the Medical Reports of the applicant/s.

2. The medical reports are valid for a period of 60 days from the date of Pre-Policy Check-up. Below are various grids for Pre-Policy medical examination.

1.1. Top Up plan

Sum Insured	Deductible	Above 60years	Category	Medicals
1 Lac to 20 Lac	Deductible 5 Lacs and below	Above 60 Years	TOP UP 2	MER + CBC, ESR + RUA + Lipid Profile + Sr Creatinine + HbA1c + ECG + Chest X ray+LFT
1 Lac to 20 Lac	Deductible Above 5 Lac	Above 65years	TOP UP 1	MER + CBC, ESR + RUA + Lipid Profile + Sr Creatinine + HbA1c + ECG + Chest X ray

Sum Insured	Deductible	Age	Category	Medicals
up to 10 Lacs	Any Amount	Above 60 years	TOP UP 1	MER + CBC, ESR + RUA + Lipid Profile + Sr Creatinine + HbA1c + ECG + Chest X ray
15 Lacs to 1 Crore	Deductible 5 Lacs and below	Above 55 years	TOP UP 2	MER + CBC, ESR + RUA + Lipid Profile + Sr Creatinine + HbA1c + ECG + Chest X Ray + LFT
15 Lacs to 1 Crore	Deductible above 5 lacs	Above 60 years	TOP UP 2	MER + CBC, ESR + RUA + Lipid Profile + Sr Creatinine + HbA1c + ECG + Chest X Ray + LFT
Above One Crore –to Five crore	Deductible 20 Lacs and above	Above 45 Years	TOP UP 3	MER + CBC, ESR + RUA + Lipid Profile + HbA1c + ECG + Chest X Ray + LFT +RFT+ Tumour Marker
Above One Crore –to Five crore	Deductible below 20 Lacs up to 10 Lacs	Above 45 Years	TOP UP 4	MER + CBC, ESR + RUA + Lipid Profile + HbA1c + ECG + Chest X Ray + LFT +RFT+ Tumour Marker + TMT
Above One Crore –to Five crore	Deductible below 10 Lacs	Up to 18 Years	TOP UP 7	MER
Above One Crore –to Five crore	Deductible below 10 Lacs	Above 18 Years	TOP UP 5	MER + CBC, ESR + RUA + Lipid Profile + HbA1c + ECG + Chest X Ray + LFT +RFT+ Tumour Marker + TMT+ USG Abdomen and Pelvis
Above One Crore –to Five cror	Deductible below 10 Lacs	up to 40 Years	TOP UP 6	MER + CBC, ESR + RUA + Lipid Profile + HbA1c + ECG + Chest X Ray + LFT +RFT+ Tumour Marker + TMT+ USG Abdomen and Pelvis+ PSA (in Males) + PAP smear in Females + Mamography

- MER- Medical Examination Report
- ECG- Electrocardiogram.
- Lipid Profile - (Sr Cholesterol, Sr Triglycerides, Sr. HDL, Sr LDL, Ratio of T. Chol & HDL, Sr VLDL).
- HbA1C –Glycosylated Haemoglobin.

- RFT-- Serum Creatinine, BUN (Blood urea nitrogen)
- LFT—SGOT, SGPT, GGT
- CBC-Complete Blood Count,
- RUA- Routine Urinalysis.
- ESR- Erythrocyte Sedimentation Rate
- Tumour Markers:
 - a) Carcinoembryonic Antigen (CEA)
 - b) Prostate-specific Antigen (PSA).

2. Wherever required we may ask for insured person's health related details & information and request for additional tests to be conducted based on the declarations on the proposal form and the results of any medical tests that we have received.

Benefit Illustration in respect of policies offered on Individual and Family floater basis (Plan Type Top-Up)										
Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall - sum insured {Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount (Rs.)	Sum insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater discount, if any	Premium after discount (Rs.)	Sum insured (Rs.)
65	15,020	5,00,000	15,020	5%	14,269	5,00,000	15,020	35%	9,763	5,00,000
60	6,308	5,00,000	6,308	5%	5,993	5,00,000	6,308	40%	3,785	
35	2,103	5,00,000	2,103	5%	1,998	5,00,000	2,103	50%	1,051	
30	2,103	5,00,000	2,103	5%	1,998	5,00,000	2,103	50%	1,051	
Total	25,534		25,534		24,257		25,534		15,651	
"Total Premium for all members of the family is INR 25,534, when each member is covered separately. Sum insured available for each individual is Rs. 5,00,000."			"Total Premium for all members of the family is INR 24,257, when they are covered under a single policy. Sum Insured available for each family member is Rs.5,00,000."				"Total Premium when opted on a floater basis is INR 15,651. Sum Insured of Rs. 5,00,000 is available for the entire family."			
Note: Premium rates specified in the above illustration shall be standard premium rates without considering any loading. Also, the premium rates shall be exclusive of taxes applicable										

Benefit Illustration in respect of policies offered on Individual and Family floater basis (Plan Type Top-Up)										
Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall - sum insured (Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount (Rs.)	Sum insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater discount, if any	Premium after discount (Rs.)	Sum insured (Rs.)
65	15,810	5,00,000	15,810	5%	15,020	5,00,000	15,810	35%	10,277	5,00,000
60	6,640	5,00,000	6,640	5%	6,308	5,00,000	6,640	40%	3,984	
35	2,213	5,00,000	2,213	5%	2,103	5,00,000	2,213	50%	1,107	
30	2,213	5,00,000	2,213	5%	2,103	5,00,000	2,213	50%	1,107	
Total	26,877		26,877		25,533		26,877		16,474	
"Total Premium for all members of the family is INR 26,877, when each member is covered separately. Sum insured available for each individual is Rs. 5,00,000."			"Total Premium for all members of the family is INR 25,533, when they are covered under a single policy. Sum Insured available for each family member is Rs.5,00,000."				"Total Premium when opted on a floater basis is INR 16,474. Sum Insured of Rs. 5,00,000 is available for the entire family."			
Note: Premium rates specified in the above illustration shall be standard premium rates without considering any loading. Also, the premium rates shall be exclusive of taxes applicable										

Section I – Top Up Deductible Base Plan

In consideration of the premium paid and subject to the terms and conditions as set out in the Schedule with all its Parts, the Company by this Policy agrees as under:

That if during the period stated in the Schedule, the insured person shall contract any disease or suffer from any illness or sustain bodily injury through accident and if such disease, illness or injury shall require the insured Person/s, upon the advice of a duly Qualified Physician/Medical Specialist / Medical Practitioner or of duly Qualified Surgeon to incur Hospitalization expenses for medical/surgical treatment at any Nursing Home / Hospital as an in-patient, the Company will pay to the Insured Person/s the amount of such expenses in excess of the deductible per hospitalization indicated in the schedule Here deductible shall be applicable for each and every Hospitalisation except claims made for Any One Illness

Coverage

1. In-Patient Hospitalization - If an Insured Person is diagnosed with an Illness or suffers an Injury contracted during the Policy Period which requires hospitalization in a hospital, on the advice of a medical practitioner then We will pay You, Reasonable and Customary Medical Expenses incurred as below:

- i. Room Rent;
- ii. Nursing charges for Hospitalization as an Inpatient excluding private nursing charges;
- iii. Medical Practitioners' fees, excluding any charges or fees for standby services;
- iv. Physiotherapy, investigation and diagnostics procedures directly related to the current admission;
- v. Medicines, drugs as prescribed by the treating Medical Practitioner;
- vi. Intravenous fluids, blood transfusion, injection administration charges and /or consumables;
- vii. Operation theatre charges;
- viii. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
- ix. Intensive Care Unit charges.

2. Pre-Hospitalization:

The Medical Expenses incurred during the Policy Period, for the period as specified in the Schedule to this Policy immediately before the Insured Person was hospitalised, provided that:

- i. Such Medical Expenses were incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and
- ii. There is a valid claim admissible under Section I. Coverages 1&7 (In-patient Hospitalization Expenses & Domiciliary Hospitalisation) of the Policy.

3. Post-Hospitalization:

The Medical Expenses incurred during the Policy Period, for the period as specified in the Schedule to this Policy, immediately after the Insured Person was discharged following Hospitalisation, provided that:

- i. Such Medical Expenses were incurred for the same condition for which the Insured Person's earlier Hospitalisation was required, and
- ii. There is a valid claim admissible under Section I. Coverages 1&7 (In-patient Hospitalization Expenses & Domiciliary Hospitalisation) of the Policy.

4. AYUSH

The Company will Indemnify the Policy Holder/Insured Person, the Reasonable and Customary Charges, up to the amount specified against this benefit, for Medical Expenses incurred on the Insured Person's Medically Necessary and Medically Advised Inpatient Hospitalization during the Policy Period, on treatment taken under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH) in AYUSH Hospital or AYUSH Day Care Centre.

5. No Claim Bonus

At the end of each Policy Year, the Company will enhance the Sum Insured, on a cumulative basis, as a No Claim Bonus for each completed and continuous Policy Year, provided that no Claim has been lodged or paid by the Company in the expiring Policy Year under any of the cover excluding Dental OPD Cover , vaccination cover subject to the conditions specified below:

1. If you renew your Policy with Us without any break in the Policy Period and there has been no claim in the preceding year, then We will increase the Limit of Indemnity by percentage of Sum Insured per annum 5% of basic sum insured as No claim Bonus. The maximum No claim Bonus increase in the Limit of Indemnity will be limited to 50% of basic Sum insured
2. In case no claim is made in a particular Policy Year, No Claims Bonus would be credited automatically to the subsequent Policy year, even in case of multi-year Policies (with policy term of 2 years and 3 years).
3. In case a claim is made during the Policy Year, the No Claims Bonus will reduce at the same rate at which it is allotted for every claim-free year, but in no case shall the Total Sum Insured be less than the Sum Insured.

This clause does not alter the Company's right to decline renewal or cancellation of the Policy for reasons as specified in Clause 10.4 (Disclosure to Information Norm under Standard Terms and Conditions).

6. Day Care Treatment

The Company will Indemnify the Policy Holder/Insured Person for Medical Expenses incurred on Day Care Treatment which involve a Surgical Procedure, through Cashless or Reimbursement Facility, maximum up to the Sum Insured, provided that the period of treatment of the Insured Person in the Hospital/Day Care Centre does not exceed 24 hours, which would otherwise require an In-patient admission but not in the outpatient department and such Day Care Treatment was prescribed in written, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

7. Domiciliary Hospitalization

The Company will Indemnify the Policy Holder/Insured Person, up to the Sum Insured, for the Medical Expenses incurred towards Domiciliary Hospitalization, i.e. coverage extended when Medically Necessary treatment is taken at home, subject to the conditions specified below:

1. The Medical Expenses are incurred during the Policy Year.
2. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
3. the patient takes treatment at home on account of non-availability of room in a hospital

Note

1. Expenses on Hospitalization for minimum period of 24 hours only are admissible. However, this time limit will not apply for the day care treatments / procedures, where treatment is taken in the Hospital / Nursing Home and the Insured is discharged on the same day.
2. Our maximum liability for a continuous period of Illness, including relapses within 45 days from the last date of discharge from the Hospital or nursing home where treatment has been taken, shall be limited to the amount mentioned in the Policy Schedule. Occurrence of the same Illness after a lapse of 45 days as stated above will be considered as fresh Illness for the purpose of this Policy.

Section II – Super Top Up Deductible

In consideration of the premium paid and subject to the terms and conditions as set out in the Schedule with all its Parts, the Company by this Policy agrees as under:

- i. If You are hospitalized on the advice of a Medical Practitioner because of an Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then We will pay You, Reasonable and Customary charges/Medical Expenses incurred, subject to One-time deductible as specified on the policy document. One-time deductible is a cost sharing requirement under this policy that provides that the company will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the company. The deductible is applicable per policy year basis in aggregate towards hospitalisation expenses (admissible under policy) incurred during the policy period by insured (individual policy) or insured family (in case of family floater).

1. In Patient Hospitalization

If an Insured Person is diagnosed with an Illness or suffers an Injury contracted during the Policy Period which requires hospitalization in a hospital, on the advice of a medical practitioner then We will pay You, Reasonable and Customary charges/Medical Expenses incurred as below

- i. Room Rent;
- ii. Nursing charges for Hospitalization as an Inpatient excluding private nursing charges;
- iii. Medical Practitioners' fees, excluding any charges or fees for standby services;
- iv. Physiotherapy, investigation and diagnostics procedures directly related to the current admission;
- v. Medicines, drugs as prescribed by the treating Medical Practitioner;
- vi. Intravenous fluids, blood transfusion, injection administration charges and /or consumables;
- vii. Operation theatre charges;
- viii. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
- ix. Intensive Care Unit charges.

2. Pre-hospitalization:-

The Medical Expenses incurred during the Policy Period, for the period as specified in the Schedule to this Policy immediately before the Insured Person was hospitalised, provided that:

- i. Such Medical Expenses were incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and
- ii. There is a valid claim admissible under Section II.1 Coverages 1 & 7 (In-patient Hospitalization Expenses & Domiciliary Hospitalisation) of the Policy.

3. Post-hospitalization:-

The Medical Expenses incurred during the Policy Period, for the period as specified in the Schedule to this Policy, immediately after the Insured Person was discharged following Hospitalisation, provided that:

- i. Such Medical Expenses were incurred for the same condition for which the Insured Person's earlier Hospitalisation was required, and
- ii. There is a valid claim admissible under Section II.1 Coverages 1&7 (In-patient Hospitalization Expenses & Domiciliary Hospitalisation) of the Policy.

4. Day Care Treatment

The Company will Indemnify the Policy Holder/Insured Person for Medical Expenses incurred on Day Care Treatment which involve a Surgical Procedure, through Cashless or Reimbursement Facility, maximum up to the Sum Insured, provided that the period of treatment of the Insured Person in the Hospital/Day Care Centre does not exceed 24 hours, which would otherwise require an In-patient admission but not in the outpatient department and such Day Care Treatment was prescribed in written, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

5. AYUSH

The Company will Indemnify the Policy Holder/Insured Person, the Reasonable and Customary Charges, up to the amount specified against this Benefit, for medical expenses incurred on the Insured Person's medically necessary and medically advised Inpatient Hospitalization during the Policy Period, on treatment taken under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH) in AYUSH Hospital or AYUSH Day Care Centre.

6. No Claim Bonus

At the end of each Policy Year, the Company will enhance the Sum Insured, on a cumulative basis, as a No Claim Bonus for each completed and continuous Policy Year, provided that no Claim has been lodged or paid by the Company in the expiring Policy Year under any of the cover excluding Dental OPD Cover, vaccination cover subject to the conditions specified below:

1. If you renew your Policy with Us without any break in the Policy Period and there has been no claim in the preceding year, then We will increase the Limit of Indemnity by percentage of Sum Insured per annum 5% of basic sum insured as No claim Bonus. The maximum No claim Bonus increase in the Limit of Indemnity will be limited to 50% of basic Sum insured
2. In case no claim is made in a particular Policy Year, No Claims Bonus would be credited automatically to the subsequent Policy year, even in case of multi-year Policies (with policy term of 2 years and 3 years).
3. In case a claim is made during the Policy Year, the No Claims Bonus will reduce at the same rate at which it is allotted for every claim-free year, but in no case shall the Total Sum Insured be less than the Sum Insured.

This clause does not alter the Company's right to decline renewal or cancellation of the Policy for reasons as specified in Clause 10.4 (Disclosure to Information Norm under Standard Terms and Conditions).

7. Domiciliary Hospitalization

The Company will Indemnify the Policy Holder/Insured Person, up to the Sum Insured, for the Medical Expenses incurred towards Domiciliary Hospitalization, i.e. coverage extended when Medically Necessary treatment is taken at home, subject to the conditions specified below:

1. The Medical Expenses are incurred during the Policy Year.
2. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
3. the patient takes treatment at home on account of non-availability of room in a hospital

Note

Expenses on Hospitalization for minimum period of 24 hours only are admissible. However this time limit will not apply for the day care treatments / procedures, where treatment is taken in the Hospital / Nursing Home and the Insured is discharged on the same day.

Section III Optional Benefits –

The benefits below are optional and stand to be effective only if shown in the Policy Schedule as being effective. Our maximum liability will be limited to the amount specified in the Policy Schedule.

1. Pre-existing Disease Waiting Period Waiver/ Reduction

On payment of additional premium pre-existing waiting period shall be reduced or waived.

This cover will be applicable only if specified in the policy Schedule.

Waiting period will be Reduced / waived only for the disclosed pre-existing diseases which has been accepted by Us at the inception of policy.

By opting this cover, Exclusion clause 4.I will be waived / altered

This cover will not be applicable for any permanent exclusions which are specified in the Policy Schedule.

2. Base Policy Co-pay Support

The company will indemnify the expenses towards deduction of co-payment (voluntary co-pay / mandatory co-payment in the base policy upto the amount specified in the policy schedule.

Conditions-

- Amount deducted only for the expenses towards co-payment in base policy will be payable.
- This cover cannot be opted if option Voluntary co-pay is selected in this policy, mentioned under Section IV.
- Amount claimed under this benefit will be payable basis on the terms, conditions & exclusions as per this policy.
- Deductible mentioned in Section I /II will not be applicable for this cover.
- Sub-limit / Co-payment on cover and or diseases will not be applicable.
- Any deduction in base policy will not be indemnified by Us if claimed and covered with any other insurance cover.
- This cover would be applicable in case the Customer has an active base health Insurance Policy with Us or any Health/ General Insurance Company at the time of inception or at the time of renewal of this product

Our maximum liability will be limited to the amount mentioned in the Policy Schedule, which is within the basic Sum Insured of the policy.

3. Base Policy Higher Room Rent Support

The company will indemnify the expenses towards deduction of excess room rent and Associate medical Expenses in the base policy upto the amount specified in the policy schedule.

Conditions-

- Amount deducted only for the expenses towards excess room rent and Associate Medical Expenses in base policy will be payable.
- Amount claimed under this benefit will be payable basis on the terms, conditions & exclusions as per this policy.
- Deductible mentioned in section I /II will not be applicable for this cover
- Any deduction in base policy will not be indemnified by Us if claimed and covered with any other insurance cover.

- This cover would be applicable in case the Customer has an active base health Insurance Policy with Us or any Health/ General Insurance Company at the time of inception or at the time of renewal of this product

Our maximum liability will be limited to the amount mentioned in the Policy Schedule, which is within the basic Sum Insured of the policy.

4. Newborn Care

New born babies of the policy holder/Insured shall be covered from day one i.e. from day of baby's birth or delivery and the maximum limit of liability under this cover as opted by insured / policy holder, allowed maximum up to two children.

Sum insured options are as below:

- 1) Baby covered from day one limited to maternity sum insured (Deductible for Maternity Sum insured will be applicable).
- 2) Baby covered from day one up to sum insured opted by members (Deductible mentioned in base cover section I/II will be applicable).

Coverage-

We will cover the baby's in-patient hospitalization for an Illness or Injury during the Policy Period which needs hospitalization in a hospital, on the advice of a medical practitioner.

Pre-Post hospitalization expenses for Your baby will be payable as per the basic cover under this Policy, upto maternity limit/full Sum Insured as opted by You.

Policy period / coverage for Newborn Care is for a period of 90 days i.e. from date of birth to 90 days of baby's age any time during the policy period. Our maximum liability will be limited to the amount mentioned in the Policy Schedule, which is within the basic Sum Insured of the policy.

III. Special conditions for this cover (Other than those of this Policy)

1. This cover can be opted only at first policy inception or at the renewal of the Policy.
2. You can't cancel this solely in between the policy year the Policy needs to be cancelled, except at the time of renewal of the Policy, but if the policy is within free look period, then the customer can cancel this cover without this policy being cancelled. If you cancel your Zuno Health Top Up Insurance Policy, this cover shall also stand cancelled along with it.
3. This optional cover should be available in your Policy on the date of loss.
4. This coverage will be rendered effective on and from your baby's date of birth, provided this cover has been opted for prior to the said date of birth of Your baby. First 30 days waiting period and pre-existing condition exclusion will not be applicable for the baby.
5. No matter what the waiting period of the maternity benefit in Your existing Policy, the baby will be covered from day one as per the Sum Insured option chosen.
6. This benefit is given for one's self and/or spouse, as mentioned in a family floater under this Policy.
7. This coverage shall cease to be in effect once the baby reaches 91 days of age. The Insured can apply for a fresh Policy for the baby, as per the underwriting guidelines of the Company.
8. The coverage under this option shall be applicable to only one child per policy year.
9. The coverage under this option shall be given to a baby of a legally married couple, up to a maximum of any two children.
10. No charges will be paid for umbilical cord occult blood preservation.
11. This cover can be opted only at the time of purchase/ renewal of this Policy and prior to birth of the baby subject to underwriting guidelines of the Company.
12. Pre-post benefit for this cover will be available as per this Policy.
13. All other terms & conditions, exclusions & deductibles stay as per this Policy.

5. Vaccination cover

We will cover vaccinations of new born baby Immunization expenses for the amount of Sum Insured mentioned in the policy schedule until the New Born Baby completes one year.

If the Policy ends before the New Born Baby has completed one year, then, We will only cover vaccinations until the baby completes one year, and only if We have accepted the baby as an Insured Person at the time of renewal.

Deductible mentioned in section I /II will not be applicable for this cover

Our maximum liability will be limited to the amount mentioned in the Policy Schedule, which is over and above the basic Sum Insured as opted and mentioned in policy schedule.

6. Double Sum Insured for Critical illness (CI)

By opting this cover the Company will indemnify the Policy Holder/Insured Person, through Cashless/Reimbursement facility, double the basic sum insured which is specified in the policy schedule for the payment under the basic covers of the policy (Section I/II) as opted. If the Double Sum Insured for Critical Illness option is not chosen, then the insured will be indemnified upto base SI as per the terms and conditions under section-I&II as opted by customer.

The conditions are as specified below:

1. The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period,
2. The basic sum insured – excluding No Claim Bonus will be reinstated in case of opted critical illness is triggered.
3. In case the additional Critical Illness Sum Insured is not utilized in a Policy Year, it shall not be carried forward to subsequent Policy Year.
4. The Policy shall not cover the expenses if under double sum insured benefit if :
 - i. The Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the commencement of the Policy Period and the Insured Person has not previously been insured continuously and without interruption under a Policy.
 - ii. The Insured Person has already made a claim for the same Critical Illness.
 - iii. All other terms & conditions, exclusions & deductibles stay as per your basic Policy

5. Waiting Period of 90 days from the date of inception of this cover with us. However this exclusion would not be applicable in case of continuous renewal of this cover and without break in cover.

6. If double Sum Insured option is not opted by the insured, then the waiting period applicable for these Critical illnesses would be as per the base Top up health Insurance policy. However this exclusion would not be applicable in case of continuous renewal of the policy without break in cover.

7. When the insured is admitted for any other illness other than the defined critical illness and in this course of admission and he has been diagnosed subsequently of the defined critical illness he shall be indemnified under this coverage

List of Critical illnesses plans for Double Sum Insured

Sr. No.	Particulars	Plan name				
		(09 CI) Standard	(12 CI) Standard	(15 CI) Standard	(18 CI) Standard	(25 CI) Standard
1	Cancer Of Specified Severity	Yes	Yes	Yes	Yes	Yes
2	Kidney Failure Requiring Regular Dialysis	Yes	Yes	Yes	Yes	Yes
3	Multiple sclerosis With Persisting Symptoms	Yes	Yes	Yes	Yes	Yes
4	Major organ/Bone marrow transplant	Yes	Yes	Yes	Yes	Yes
5	Open heart replacement or repair of heart valves	Yes	Yes	Yes	Yes	Yes
6	Open chest coronary artery bypass graft (CABG)	Yes	Yes	Yes	Yes	Yes
7	Permanent Paralysis of limbs	Yes	Yes	Yes	Yes	Yes
8	Myocardial infarction (First heart attack of specific severity)	Yes	Yes	Yes	Yes	Yes
9	Stroke resulting in permanent symptoms	Yes	Yes	Yes	Yes	Yes
10	Benign brain tumour	X	Yes	Yes	Yes	Yes
11	Motor neuron disease with Permanent Symptoms	X	Yes	Yes	Yes	Yes
12	Coma of specified severity	X	Yes	Yes	Yes	Yes
13	End stage liver failure	X	X	Yes	Yes	Yes
14	Primary (idiopathic) pulmonary hypertension	X	X	Yes	Yes	Yes
15	Surgery of aorta	X	X	Yes	Yes	Yes
16	Third degree burns	X	X	X	Yes	Yes
17	Deafness	X	X	X	Yes	Yes
18	Loss of speech	X	X	X	Yes	Yes
19	Muscular dystrophy	X	X	X	X	Yes
20	Alzheimer's disease	X	X	X	X	Yes
21	Parkinson's disease	X	X	X	X	Yes
22	Pulmonary artery graft surgery	X	X	X	X	Yes
23	Medullary cystic disease	X	X	X	X	Yes
24	Systemic Lupus Erythematosus with lupus nephritis	X	X	X	X	Yes
25	Pneumonectomy	X	X	X	X	Yes

Please refer Annexure 1 for coverage illustrations

7. Assistance Services – Within India & Worldwide

Here the Eligible Domestic or Global Participant means “ Insured person who is covered under this policy”

All the below mentioned assistance services would be provided by Us /through our appointed service provider. No claims for reimbursement will be applicable for this service. Hence to avoid any discomfort to insured it is advisable that insured should inform/intimate us in advance to utilize this services.

1. Medical Referrals- On Assistance Services basis

Insured Person(s) will have tele-access to an operations center of Our Service Provider, who with their multilingual staff on duty will provide reference of doctors in the vicinity where the insured person is located for medical consultation.

Insured Person(s) will have telephone access to operations centre staff 24 hours a day every day of the year with multi lingual personnel for medical referral.

This cover is applicable if it is shown on your schedule.

2. Emergency Medical Evacuation - On Assistance service basis

Definitions:

Emergency Evacuation means:

(a) Your/ Insured Person(S) medical condition warrants immediate Transportation from the place where You / Insured Person(s) are injured or sick to the nearest Hospital where appropriate medical treatment can be obtained; or (b) after being treated at a local Hospital, Your/ Insured Person(s) medical condition warrants Transportation to the place where the Trip commenced to obtain further medical treatment or to recover; or (c) both (a) and (b) above.

Transportation - means any land, water or air conveyance required to transport You during an Emergency Evacuation.

When an adequate facility is not available proximate to the Insured Person(s) , as determined by service providers consulting physician and eligible participants attending physician, our service provider will arrange transportation under appropriate medical supervision, by an appropriate mode of transport to the nearest medical facility capable of providing the required care

This cover is applicable if it is shown on your schedule.

3. Medical Repatriation - On Assistance Services basis

Our service provider will arrange for transportation under medical supervision to the Insured Person(s) residence in India or to a medical or rehabilitation facility near such residence when our service provider's consulting physicians and the attending physician determines that transportation is medically necessary, at such time the Insured Person(s) is medically cleared for travel by our service provider's consulting physician and attending physician.

This cover is applicable if it is shown on your schedule.

4. Compassionate Visit – On Assistance service basis

When an Insured Person(s) will be hospitalized for more than 7 consecutive days and is travelling in India without a companion, service provider will arrange for a family member or friend to travel to visit the Insured Person(s) in India by providing an appropriate means of transportation via economy carrier transportation as determined by our service provider. The family member or friend is responsible to meet all VISA and travel document requirements if applicable.

This cover is applicable if it is shown on your schedule.

5. Medical Monitoring – On Assistance service basis

Medical Personnel will monitor Insured Person(s) condition and will i) Stay in regular communication with the attending Physician and / or Hospital and ii) Relay necessary and legally permissible information to family members.

This cover is applicable if it is shown on your schedule.

6. Second Medical Opinion – On Assistance service basis

Our appointed service provider will arrange for second medical opinions for Insured person(s) for such services upon request in the following instances: i) When a Participant's medical condition is undiagnosed by a treating physician; ii) when a Participant seeks an additional medical opinion following an original diagnosis; and iii) when the determination of the most appropriate course of medical treatment is required based on a current diagnosis. The participant may contact our Assistance Service Provider's operation centre to initiate the request for a medical consultation and the Participant is responsible for gathering, obtaining, and submitting to our Assistance Service Provider all required medical reports, charts, data, and medical history pertaining to the Participant's condition and responding to follow up requests for additional information. All information provided to Assistance Service Provider must be legible. The medical review will be undertaken by a physician licensed to practice medicine and within a discipline that relates to the condition / diagnosis.

The second medical opinion will be provided to the Insured Person(s) in the electronic format and such opinion will be reached and rendered within 5 business days after all required medical history, data, reports, charts are properly submitted for consultation and review. The services solely relate to the provision of a medical opinion and does not include personal visits or follow-up for discussions for the implementation of course of treatment. If the Insured Person(s) seeks further involvement from the physician rendering the opinion or seeks to converse with or visit the Physician, such must be arranged on a fee for service basis with Assistance Service Provider facilitating such arrangements. All opinions rendered by the physician are the opinions of the physician and neither Zuno General Insurance Limited nor Assistance Service Provider is responsible or liable for the content of such opinions.

Exclusions:

Second Medical Opinion is not included for any health related claim where the second medical opinion will serve as a means to evaluate the Insured Person(s) claim in connection with coverage determination.

This cover is applicable if it is shown on your schedule.

7. Return of Mortal Remains – On Assistance Service basis

In the case of Insured Person(s) death in India, our service provider will arrange and pay for the return of mortal remains to an authorized funeral home proximate to the Insured Person(s) residence in India.

This cover is applicable if it is shown on your schedule.

Exclusion applicable to all Assistance services – applicable to coverage both within India and worldwide:

Service provider will not provide any of these services to an Insured Person(s) if i) the Insured Person(s) undertook travel for the purpose of obtaining medical treatment, ii) injuries are sustained as a result of participation in acts of war or insurrection iii) injuries are incurred while participating in criminal activity or as a result of unlawful consumption of drugs iv) injuries are sustained as a result of attempted suicide Service provider will not repatriate or evacuate an Insured Person(s) if the Insured Person(s) has i) no medical authorization ii) mild lesions, simple injuries such as sprain, simple fractures or mild sickness which can be treated by local doctors and do not prevent the Insured Person(s) from continuing the trip and returning home iii) if Insured Person(s) is pregnant and beyond the end of 28th week and with respect to the child born from the pregnancy, service provider will not evacuate or repatriate a child born while the Insured Person(s) was traveling beyond 28th week or Service provider will not provide services for trips exceeding 90 days from legal residence.

Claims Process Note for Availing services for Medical Referral, Emergency Medical Evacuation, Medical Repatriation, Compassionate Visit, Return of Mortal Remains:

1. Insured / Nominee calls our Assistance Service Provider operations to avail the medical assistance service.
2. Our empanelled Assistance Service Provider will do the validation and proceed with the case for the eligible member.
3. If member is eligible as defined, our Assistance Service Provider will activate the service.
4. If member is not eligible, explanation will be given to insured in a courteous manner.
5. Our Assistance Service Provider will inform to EGIC about the case and the case will be dealt with accordingly.

Claims Process Note for Availing services for Second Medical Opinion:

Option 1

- 1) Insured will call for SMO to our empanelled Assistance Service Provider operations centre
- 2) Our empanelled Assistance Service Provider will verify member eligibility based on enrolment data and send the Second Medical Opinion portal link to the member via email with a unique reference of EGIC.
- 3) Once the case is registered in portal, our empanelled Assistance Service Provider sends an auto mailer to member about the documents received.
- 4) Followed by notification email by our empanelled Assistance Service Provider to insured stating that your request has been received and proceed with the request.
- 5) Any further information required if any, our empanelled Assistance Service Provider to call the member directly/send email asking for additional information.
- 6) Once the insured submits the addition requested information, our empanelled Assistance Service Provider will begin working on Second Medical Opinion & from that date of the receipt of the medical report, Second Medical Opinion will be ready usually within five (5) to seven (7) business days.
- 7) Insured will receive the direct link on registered email address once report is ready. Insured can download the report can access in e-format or print it.

Option 2

- 1) Insured will call/email for Second Medical Opinion to our empanelled Assistance Service Provider Operations centre and our empanelled Assistance Service Provider will verify member eligibility based on enrolment data.
- 2) In case the Insured shows any apprehension to upload report on the Second Medical Opinion portal, our empanelled Assistance Service Provider's coordinator to fill the details on portal on behalf of the member and request member for the reports either by scan copy via email and in case of hard copy will instruct the member to send the reports to address of our empanelled Assistance Service Provider operations centre.
- 3) Our empanelled Assistance Service Provider to check the report and revert in case of any deficiency to member.
- 4) Once the insured submits the addition requested information, the SMO team may begin working on SMO opinion & from that date report will be ready within five (5) to seven (7) business days.
- 5) Our empanelled Assistance Service Provider will send the soft copy of the Report to Member on the registered email address.

8. Hospital Cash

If, during the Policy Period, an Insured Person sustains bodily Injury or illness which, directly results in the Insured Person being in a Hospital as an In-patient, the Company will pay the amount as specified in the Policy Schedule for each continuous and completed period of 24 hours through which the Insured Person is Hospitalised.

The claim is admissible as per section I. 1 (In-Patient Hospitalization) or Section II.1(In-Patient Hospitalization) of the policy as opted.

We will not make payment for the deductible period per event, as mentioned in the Policy Schedule.

This Benefit shall not be payable for more than the number of days per Policy Year, as specified in the Policy Schedule.

Our Maximum liability will be as mentioned in the policy schedule which is over and above the basic sum insured.

9. Dental OPD Cover

Under this Benefit, We will pay Reasonable and Customary Charges to cover the fees of a dental practitioner and associated costs for carrying out the following routine Dental Treatment procedures in respect of an Insured Person:

- Clinical Oral examinations;

- Palliative treatment for dental pain;
- Tooth cleaning;
- Normal compound fillings; or
- Simple non-surgical extractions.

This Benefit excludes orthodontic treatment, restorative treatment and dental implants.

Exclusions Applicable to Dental Benefit

We will not pay benefit for the following treatment:

- a) Instruction for plaque control, oral hygiene and diet;
- b) Bite registration
- c) a request for Treatment or dental surgery which is not advised and/or recommended by a Dentist, including any Dental Services which are not Medically Necessary
- d) any Dental Service solely for cosmetic and/or aesthetics purposes.
- e) medications that need to be taken post treatment, expenses for toothbrushes, toothpaste, dental floss, mouthwash

Deductible mentioned in section I /II will not be applicable for this cover.

Our Maximum liability will be as mentioned in the policy schedule which is over and above the basic sum insured.

10. Restoration

The Company will restore 100% of the Sum Insured once in a policy year on indemnity basis in case the Total Sum Insured inclusive of earned No claim Bonus (if any) is insufficient due to claims paid or accepted as payable during the Policy Year, subject to the conditions specified below:

1. This restored Sum Insured can be utilized only for illness / disease unrelated to the illness / diseases for which claim/s was / were made in the particular policy year.
2. The Restoration Benefit will be triggered by Section I.1 & Section II.1(In-Patient Hospitalization), Section I.2, II.2, I.3 & II.3, (Pre Hospitalization and Post Hospitalization), Section I.7 & II.7 (Domiciliary Hospitalization), Section I.6 & II.4 (Day Care treatment), Section III.16 (Emergency Ambulance if opted), Section III.15 (Organ Donor if opted), Section I.4 and Section II.5, (AYUSH), Section III.14 (Maternity if opted)
3. Restoration will not trigger on the first claim.
4. In case the Restored Sum Insured is not utilized in a Policy Year, it shall not be carried forward to subsequent Policy Year.
5. Any restored Sum Insured will not be used to calculate the No claim Bonus.
6. No Claim Bonus shall not be considered while calculating restored Sum Insured.
7. For Individual policies, restored Sum Insured will be available on individual basis whereas in case of a Family Floater policy it will be available on floater basis.
8. For any single claim during a policy year, the maximum claim amount payable shall be sum of:
 - i. The Sum Insured
 - ii. No Claim Bonus (if earned).
9. During a Policy Year, the aggregate claim amount payable, subject to admissibility of the Claim, shall not exceed the sum of:
 - i. The Sum Insured
 - ii. No Claim Bonus (if earned)
 - iii. Restored Sum Insured.
10. In case of Portability, the credit for continuity in Sum Insured would be available only to the extent of Sum Insured of the expiring policy, including Restoration.
11. This benefit would be applicable if specially opted for by the Insured.
12. Deductibles if any will stay as per this Policy.

Please refer Annexure 1 for coverage illustrations

11. Recharge

The Company will replenish 100% of the Sum Insured on indemnity basis once in a policy year in case the Total Sum Insured inclusive of earned No Claim Bonus (if any) is insufficient due to claims paid or accepted as payable during the Policy Year, subject to the conditions specified below:

1. The Recharge Benefit will be triggered by Section I.1 & Section II.1(In-Patient Hospitalization), Section I.2, II.2, I.3 & II.3, (Pre Hospitalization and Post Hospitalization), Section I.7 & II.7 (Domiciliary Hospitalization), Section I.6 & II.4 (Day Care treatment), Section III.16 (Emergency Ambulance if opted), Section III.15 (Organ Donor if opted), Section I.4 and Section II.5, (AYUSH), Section III.14 (Maternity if opted)
2. Recharge Benefit can be utilized even for the same hospitalization or for the treatment of diseases / illness / injury / for which claim was paid / payable under the policy.
3. In case the Recharge Sum Insured is not utilized in a Policy Year, it shall not be carried forward to subsequent Policy Year.
4. Any Recharge Sum Insured will not be used to calculate the No claim Bonus.
5. No Claim Bonus shall not be considered while calculating the Recharge Sum Insured.
6. For Individual policies, Sum Insured will be available on individual basis whereas in case of a Family Floater policy it will be available on floater basis.
7. In case of Portability, the credit for continuity in Sum Insured would be available only to the extent of Sum Insured of the expiring policy.

8. It is not mandatory that Restoration benefit amount should be triggered or exhausted for Recharge benefit to apply. In case of valid and accepted claim for the same illness, we will honour the claim by paying through the recharge benefit. In such circumstance, the exhaustion of Sum insured would not take into account the restored Sum Insured.

9. This benefit would be applicable if specially opted for by the Insured.

10. Deductibles if any will stay as per this Policy.

Please refer Annexure 1 for coverage illustrations

12. Worldwide Coverage (Extended Coverage)

On payment of additional premium, coverage of this policy will be extended to world wide except Domiciliary Hospitalization (Section I.7 and Section II.7).

This cover will be applicable only if mentioned in policy schedule.

If the insured has opted for worldwide coverage on Renewal, then waiting period will apply afresh for any treatment taken outside India.

Terms and conditions for Worldwide coverages for Assistance Services are as per the "Section III Optional Benefits" sub coverage 7 Assistance Services – Within India & Worldwide

13. Maternity

On Payment of additional premium we will pay the Medical Expenses related to pregnancy, childbirth or medically recommended and lawful termination of pregnancy, limited to maximum 2 deliveries or termination(s) or either, during the lifetime of the insured person as below:-.

i. We will cover the Medical expenses for maternity including complications of maternity over and above the deductible specified against this cover in the policy schedule.

ii. We will also cover expenses towards lawful medical termination of pregnancy during the Policy period.

iii. In patient Hospitalization Expenses of pre-natal and post-natal hospitalization

Conditions:

i. Waiting Period of 12 months from the date of inception of this cover with us. However this 12 months exclusion would not be applicable in case of continuous renewal of this cover and without break in cover.

ii. Medical Expenses for ectopic pregnancy are not covered under this Benefit. However, these expenses are covered under Section I.1/II.1(In-Patient Hospitalization) as opted.

Our Maximum Liability will be within the basic sum insured mentioned in the policy.

Exclusion XVIII will get waived by opting this cover.

14. Organ Donor

The Company will indemnify the Policy Holder/Insured Person, through Cashless or Reimbursement Facility, up to the amount specified against this Benefit, for the Medical Expenses incurred for an organ donor's in-patient treatment for the harvesting of the organ donated, subject to the conditions specified below:

1. The donation conforms to the Transplantation of Human Organs Act 1994 and amendments thereafter and the organ is for the use of the Insured Person.

2. We only pay for transplants carried out and also the the organ procurement is in accordance with applicable laws of particular country.

3. The recipient Insured Person has been Medically Advised to undergo an organ transplant.

4. The Company has accepted the recipient Insured Person's claim under Section I.1/II.1 (Inpatient Hospitalization Expenses) as opted.

The Company shall not be liable to make any payment in respect of below:

1. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.

2. Screening or Medical Expenses of the organ donor.

3. Costs directly associated with the acquisition of the donor's organ.

4. Expenses related to organ transportation or preservation.

5. medical treatment or complication in respect of the donor, consequent to harvesting.

6. We do not pay for any:

- Stem cell harvesting,

- Tissue transplants including those from the patient's own body (other than bone marrow transplants),

Our Maximum Liability will be within the basic sum insured mentioned in the policy.

All other terms & conditions, exclusions & deductibles stay as per this Policy.

15. Emergency Ambulance

The Company will indemnify the Policy Holder/Insured Person, through Cashless or Reimbursement Facility, up to the amount specified against this Benefit, for the Reasonable and Customary Charges necessarily incurred on availing Ambulance services offered by a Hospital or by an Ambulance service provider for the Insured Person's necessary transportation, provided that the necessity of such Ambulance transportation is certified by the treating Medical Practitioner, subject to the conditions specified below:

1. Such Transportation is from the place of occurrence of Medical Emergency of the Insured person, to the nearest Hospital; and/or
2. Such Transportation is from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Person, following an Emergency.
3. The Company will not make a payment under this Benefit if the insured person is transferred to a Hospital or diagnostic centre for evaluation purposes only and not for treatment purpose.

All other terms & conditions, exclusions stay as per this Policy

Deductible mentioned in section I /II will not be applicable for this cover.

Our Maximum liability will be as mentioned in the policy schedule which is over and above the basic sum insured.

16. 241 Optional Cover

On receipt of additional premium, we agree to waive the first renewal premium of this Policy, provided:

1. There is no claim paid/ admissible to you during the term of this optional coverage
2. There is no claim paid/admissible against the policy in particular policy year. In Individual policy, the claim paid/admissible will be considered on respective member who has made the claim. For other members who have not made a claim, premium waiver will be applicable in case of renewal.
3. There is no claim paid/admissible against any members in a floater policy. In case if any member has made a claim, premium will be applicable for all the members in a floater policy in case of renewal.
4. This coverage has been purchased with this policy for the first time (Individual + Floater), and not an existing policy.
5. This premium waiver benefit is applicable only for the first renewal of the policy and not available at subsequent renewals.
6. This coverage benefit is offered only once at the time of initial entry of the insured of this Policy.
7. This optional cover is applicable for 1 year policy term only

I. Specific conditions for this Add-on cover:

1. This coverage can be taken only with this Policy that we've issued you.
2. If you make a claim under this Policy and/or other optional covers (except Dental Benefit and Vaccination Cover) that you've taken, it will be considered as a Claim even for the purpose of this cover. The benefits of this cover will end once you make such a Claim.
3. In case of claim in first policy year is reported by insured in a renewal policy where premium is waived, then we will communicate the insured for payment of requisite premium in renewal policy and policy will continue with continuity benefit. If premium is not received within 15 days of receipt of communication from client, then renewal policy will get cancelled ab Initio, Company will not be on risk during the period when the premium is not received by us.
4. You can't cancel only this cover in between the policy year, the entire policy needs to be cancelled, but if the policy is within free look period, then customer can cancel this cover without this Zuno Health Top Up Insurance policy being canceled. Similarly, if you cancel Zuno Health Top Up Insurance Policy, this cover is also cancelled automatically.
5. You can't include new members for this cover in the middle of your policy term. It has to be taken only at the start.

This cover is subject otherwise to the terms, exceptions, conditions and limitations of Zuno Health Top Up Insurance Policy.

Section IV

Discount Covers –

- Voluntary Co-pay
- In Lieu of Insured Person opting a voluntary co-pay cover, the Company shall only pay 90% for 10% co-pay option or 80% for 20% co-pay option of the claim amount that is assessed for the payment or reimbursement under the Policy. Balance of 10% or 20% as the case may be will be borne by the Insured Person.
- This co-pay is applicable for each and every claim made by the Insured Person except fixed Benefit Covers and Maternity.
- Eligible Insured person will get discount on premium on opting this optional cover.

Discounts/Loadings

Discounts Type	Discounts Percentage
1. Family Discount- A discount of 5% on total premium will be given if two or more family members are covered under the same policy under the individual policy option	5%
2. Long Term Discount- A discount of 7.5% and 10% on total premium will be given if a policyholder chooses to pay upfront premium for 2 years and 3 years respectively	2 year: 7.5% 3 year: 10%
3. Edelweiss Group Employee Discount - A 5% discount on the premium if he/she is an employee of Edelweiss Group	5%
4. Online Discount (A discount of 15% on total premium will be given. Applicable only if taken from Zuno website)	15%

5. Renewal discount A discount of 5% will be given on each continuous renewal of policy irrespective of whether insured has made claim in past. (Not Applicable if customer has opted for 241 Optional Cover in his first renewal but in second and subsequent renewals, the insured will get this discount)	5%
6. Edelweiss Customer Discount- A discount of 5% shall be given to any proposer who has a valid and existing Unique Customer Identification Number as issued by the Edelweiss Group. Edelweiss Customer discount shall only be given to the proposer when (a) the person is verified customer of the Edelweiss Group as defined on the date when the proposal is made and (b) it is sold through direct sales mode only and not through the intermediaries	5%
7. Loyalty Discount - A discount of 5% will be given to insured who is having any active policy with Zuno General Insurance Limited	5%

Maximum Discount

The maximum total per policy discount after considering all the discounts (excluding voluntary co-payment discount and family floater discount) will be as per the table below:

Policy Term	Maximum discount available
1 year	20%
2 years	25%
3 years	30%

3. Exclusions Applicable:

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

I. Pre-Existing Diseases - Code- Excl01

- Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the 36 months of continuous coverage as specified in the policy schedule, after the date of inception of the first policy with insurer.
- In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- Coverage under the policy after the expiry of specified months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

II. Specified disease/procedure waiting period- Code- Excl02

1 24 months waiting period

- 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.
- In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- 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.
- The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage
- List of specific diseases/procedures
 - Any treatment related to Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism, Spinal Disorders (unless caused by accident), Joint Replacement Surgery (unless caused by accident), Arthroscopic Knee Surgeries/ACL Reconstruction/Meniscal and Ligament Repair
 - Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal Septum Deviation, Sinusitis and related disorders
 - Benign Prostatic Hypertrophy
 - Cataract
 - Dilatation and Curettage
 - Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers
 - Surgery of Genito-urinary system unless necessitated by malignancy
 - All types of Hernia & Hydrocele
 - Hysterectomy, unless necessitated by malignancy
 - Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant
 - Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone
 - Myomectomy for fibroids
 - Varicose veins and varicose ulcers

2. 90 Days Waiting Period

- Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90 days 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.

- b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
- f. List of specific diseases/procedures
 - i. Diabetes & Related complications include: Diabetic Retinopathy, Diabetic Nephropathy, Diabetic Foot / Wound, Diabetic Angiopathy, Diabetic Neuropathy, Hyper /Hypoglycaemic Shocks.
 - ii. Hypertension & Related complications include: Coronary Artery Disease, Cerebrovascular Accident, Hypertensive Nephropathy, Internal Bleed / Haemorrhages.
 - iii. Cardiac disorder:

III. 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.

IV. 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.

V. Rest Cure, rehabilitation and respite care- Code- Excl05

- a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
 - i. 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.
 - ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

VI. Obesity/ Weight Control: Code- Excl06

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

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

VII. 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.

VIII. 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.

IX. 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.

X. 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.

XI. Excluded Providers: Code- Excl11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

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

XIV. 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

XV. Refractive Error: Code- Excl15

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

XVI. 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.

XVII. Sterility and Infertility: Code- Excl17

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

XVIII Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

XIX. Any Treatment that arises from or is in any way connected with attempted suicide or any injury or illness that the Insured Person or dependant inflicts upon himself.

XX. Any Treatment by way of the intentional Termination of Pregnancy.

XXI. Any expenses relating to OPD treatments are not covered.

XXII. Injury or disability directly caused or contributed to whilst engaging in or taking part in war, invasion, terrorist activities, rebellion (whether war be declared or not), civil war, commotion, military or usurped power, martial law, riot or the act of any lawfully constituted authority, or while the Insured Person(s) is / are carrying out army, naval or air services operations, whether or not war has been declared.

XXIII. Any Treatment availed outside the territorial limits of the policy unless specifically opted for.

XXIV. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.

XXV Any treatment related to Acupressure, acupuncture, magnetic and such other therapies not approved by ICMR or governing authority of respective council.

XXVI. Any charges incurred to procure documents related to treatment or illness pertaining to any period of Hospitalization or illness

XXVII. Alopecia wigs and/or toupee and all hair or hair fall treatment and products.

XXVIII. Charges incurred in connection with cost of spectacles and contact lenses, routine eye and ear examinations, hearing aids, all other external appliances and /or devices whether for diagnosis or treatment, , for the complete exhaustive list, kindly refer, List I - Items for which coverage is not available in the Policy.

Permanent Exclusions

Irrespective of waiting period or Portability, below mentioned disease are permanently excluded under this policy in case where such disease are pre-existing or disclose by the customer in the proposal form at the time of first proposal of this product with us. These pre-existing illnesses will not be covered even if the optional cover Pre-existing Waiting Period Waiver/Reduction has been opted. We will permanently exclude these conditions with due consent of proposer or persons to be insured.

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs • C40-C41 Malignant neoplasms of bone and articular cartilage • C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue • D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25) Ischemic heart diseases, I50 Heart failure, I42 Cardiomyopathy; I05-I09 - Chronic rheumatic heart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system • Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0 Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta-(super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 - Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 -G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37

13	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
14	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
15	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

4. Migration:

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

For Detailed Guidelines on Migration, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987&flag=1

5. 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/frmGuidelines_Layout.aspx?page=PageNo3987&flag=1

6. Claims Procedure and Management

6.1. Pre-requisite for admissibility of claim

Any claim being made by an Insured Person or attendant of Insured Person during Hospitalization on behalf of the Insured person, should comply with the following conditions:

1. The Condition Precedent Clause has to be fulfilled.
2. The medical condition caused, Medical Expenses incurred, subsequently the Claim being made, should be with respect to the Insured Person only. The Company will not be liable to Indemnify the Insured Person for any loss other than the covered benefits and any other person who is not accepted by the Company as an Insured Person.
3. The holding Policy should be in force at the event of the Claim. All the Policy Terms and Conditions, waiting periods and exclusions are to be fulfilled including the realization of premium by their respective due dates.
4. All the required and supportive Claim related documents are to be furnished within the stipulated timelines. The Company may call for additional documents wherever required.

6.2. Duties of a Claimant/ Insured Person in the event of Claim:-

On the occurrence of any loss, within the scope of cover under the Policy

You shall:

1. The Policyholder / Insured Person shall check the updated list of Network Provider before submission of a pre-authorization request for Cashless Facility.
2. Forthwith file/submit a Claim Form in accordance with 'Claim Procedure' Clause as provided in the Policy.
3. Assist and not hinder or prevent Us or any of Our representative from taking any reasonable steps in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.
4. The Company's Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Person's medical and Hospitalization records and to investigate the facts and examine the Insured Person and shall be provided with complete necessary documentation and information to establish company's/ its liability for the Claim, its circumstances and its quantum.
5. If You do not comply with the provisions of this Clause or other obligations cast upon You under this Policy, in terms of the other clauses referred to herein or in terms of the other clauses in any of the Policy documents, all benefits under the Policy shall be forfeited, at Our option.

6.3. Claims Procedure

Intimation must be given at least 72 hours prior to planned hospitalization. In case of emergency hospitalization, intimation must be given within 48 hours of hospitalization or before discharge whichever is earlier.

We may consider the delay in extreme cases of hardship where it is proved to our satisfaction that under the circumstances in which the insured person was placed it was not possible from him/her or any other person to intimate/ notify / submit / file claim within the prescribed time limit.

I. Cashless Facility

The Company extends Cashless Facility as a mode to Indemnify the Medical Expenses incurred by the Insured Person at a Network Provider. In order to avail Cashless Facility, the following process must be followed:

1. Submission of Pre-authorization Form: A Pre-authorization form which is available on the Company's Website or with the Network Provider, has to be duly filled and signed by the Insured Person and the treating Medical Practitioner, as applicable, which has to be submitted electronically by the Network Provider to the Company for approval. Only upon due approval from the Company, Cashless Facility can be availed only at Network Hospital. A health card issued to the insured person at the time of Policy purchase, should be preserved and produced at any of the Network Providers in the event of Claim being made, to avail Cashless Facility.

i. For Planned Treatment: The Company must be contacted to pre-authorize Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Once the request for pre-authorization has been granted, the treatment must take place within 10 days of the pre-authorization date at a Network Provider.

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

iii. Identification documents: Health Card issued by the company and Valid Photo Identification like Voter ID card, Driving License, Passport, PAN Card, Aadhaar Card or any other identification proof.

2. Company's Approval: The Company will confirm in writing, authorization or rejection of the request to avail Cashless Facility for the Insured Person's Hospitalization.

3. Please note that rejection of a Pre-authorization request is in no way construed as rejection of coverage or treatment. The Insured Person can proceed with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.

4. The Company may modify the list of Network Providers or modify or restrict the extent of Cashless Facilities that may be availed at any particular Network Provider.

Insured can also look upon our website and click on the below link of network hospitals available under cashless facility:

<https://www.hizuno.com/health-insurance/-/section/health-home>

II. Re-imbusement Facility

1. It is agreed and understood that in all cases where intimation of a Claim has been provided under Reimbursement Facility and/or the Company specifically states that a particular coverage is payable only under Reimbursement Facility, the following information details should be provided to the Company 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. Nature of Illness or Injury and the treatment/Surgery taken

iv. Hospital where treatment/Surgery was taken

v. Date of admission and date of discharge.

2. In the event of death of the Policyholder, the Company will pay the nominee and in case of no 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.

6.4. Documents to be submitted for filing a valid Claim

The Company shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense within 15 days of the Insured Person's discharge from Hospital (in the case of Pre-hospitalization Medical Expenses and Hospitalization Medical Expenses) or within 15 days of the completion of the Post-hospitalization Medical Expenses period (in the case of Post-hospitalization Medical Expenses). For those claims for which the use of Cashless Facility has been authorized, the Company will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital as follows.

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

1. In-patient Treatment /Day Care Procedures

2. Duly filled and signed Claim Form.

3. Photocopy of ID card / Photocopy of current year policy.

4. Original Detailed Discharge Summary / Day care summary from the hospital. Original consolidated hospital bill with bill no and break up of each Item, duly signed by the insured.

5. Original payment Receipt of the hospital bill with receipt number

6. First Consultation letter and subsequent Prescriptions. Original bills, original payment receipts and Reports for investigation supported by the note from Attending Medical Practitioner / Surgeon demanding such test.

7. Surgeons certificate stating nature of Operation performed and Surgeons Bills and Receipts

8. Attending Doctors/ Consultants/ Specialist's/ Anesthetist Bill and receipt and certificate regarding same

9. Original medicine bills and receipts with corresponding Prescriptions.

10. Original invoice/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts.

11. Hospital Registration Number and PAN details from the Hospital

12. Doctors registration Number and Qualification from the doctor

13. For Road Traffic Accident in addition to in patient treatment documents, below details are required:

a. Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.

14. For Non Medico legal cases

a. In addition to in patient treatment documents we would require treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)

15. For Accidental Death cases

a. In addition to in patient treatment documents, Copy of Post Mortem Report (if conducted) & Death Certificate.

16. Pre and Post-hospitalisation expenses

17. Duly filled and signed Claim Form.

18. Photocopy of ID card / Photocopy of current year policy.

19. Original Medicine bills, original payment receipt with prescriptions.

20. Original Investigations bills, original payment receipt with prescriptions and report.

21. Original Consultation bills, original payment receipt with prescription.

22. Copy of the Discharge Summary of the main claim.

We may call for additional documents/ information as relevant to the claim.

6.5. Claim Assessment

1. The Company shall scrutinize the Claim and supportive documents, once received. In case of any deficiency, the Company may call for any additional documents or information as required, based on the circumstances of the Claim.

2. All admissible Claims under this Policy shall be assessed by the Company in the following progressive order:

i. If the provisions in Clause 8.8(Multiple Policies) are applicable, the Company's liability to make payment under that Claims shall first be apportioned accordingly.

3. The Claim amount assessed in Clause 7.5 (2) above would be deducted from the following amounts in the following progressive order:

i. Sum Insured

ii. No Claims Bonus (if applicable)

iii. Additional Sum Insured for Critical Illness (if applicable)

iv. Restoration (if applicable)

v. Recharge (if applicable)

6.6. Claim Settlement (provision for Penal Interest)

1. This Policy covers only medical treatment taken entirely within India (and worldwide if opted). All payments under this Policy shall be made in Indian Rupees.

2. The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Person during the Policy Period, once the Total Sum Insured for that Insured Person is exhausted.

3. The Company shall settle or reject a claim, as the case may be, within 15 days (other than cashless) from the date of receipt of last necessary document.

4. 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.

5. 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.

6. 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)

7. Premium Payment in Instalments (Wherever applicable)

The policy will be issued for a period of 1 year, 2 year or 3 years. The Sum Insured and Benefit will be applicable on Policy Year basis.

The Insured person can choose to pay Premium for this Policy on any one of the following basis:

i. Single premium

ii. Instalment premium

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

i. Grace Period of 15 days would be given to pay monthly instalment premium due for the policy. and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium.

ii. During such grace period, If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.

iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the grace period, the policy will get cancelled.

vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

8. Tax Benefit

The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act.

9. Standard Terms and Conditions

9.1. Alterations in the Policy

1. This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company. However, change or alteration with respect to increase/ decrease of the Sum Insured shall be permissible only at the time of renewal of the Policy. On renewal, the policy could be subject to certain changes in terms and conditions including change in premium rate.

2. Where an individual is added to this Policy either by way of endorsement or at the time of Renewal, the Pre-existing Disease clause, exclusions and waiting periods will be applicable considering such Policy Year as the first year of the Policy with Us.

9.2. Cancellation / Termination

1. The policyholder may cancel this policy by giving 7days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

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

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.

2. 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.

3. In case of demise of the Policyholder,

i. Where the Policy covers only the Policyholder, this Policy shall stand null and void from the date and time of demise of the Policyholder. The premium would be refunded for the unexpired period of this Policy at pro-rata basis.

ii. Where the Policy covers other Insured Persons, this Policy shall continue till the end of Policy Period for the other Insured Persons. If the other Insured Persons wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of a policyholder provided that:

- a) Written notice in this regard is given to the Company before the Policy Period End Date; and
- b) A person of Age 18 years or above, who satisfies the Company's criteria applies to become the Policyholder.

9.3. Complete discharge

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

9.4. Disclosure to Information

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

9.5. Electronic Transactions

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

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 thirty days 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

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

9.7 Limitation of Liability

Any Claim under this Policy for which the notification or intimation of Claim is received 12 calendar months after the event or occurrence giving rise to the claim shall not be admissible, unless the Policyholder proves to the Company's satisfaction that the delay in reporting of the Claim was for reasons beyond his control.

9.8 Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder shall immediately notify the Company in writing of any material change in the risk. The Company may adjust the scope of cover and / or the premium paid or payable accordingly.

9.9 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.

Notices

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

1. You/the Insured Person at the address specified in the Policy Schedule or at the changed address of which the Company must receive written notice.
2. Us at the following address: :- Zuno General Insurance Limited, 2nd Floor, Tower 3, Kohinoor City Mall, Kohinoor City, Kirod Road, Kurla (West), Mumbai - 400070, Toll Free No.: 1800 12000.
3. No insurance agents, brokers or other person/entity is authorized to receive any notice on the Company's behalf.
4. In addition, the Company may send You/the Insured Person other information through electronic and telecommunications means with respect to Your Policy from time to time.

9.11 No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder or Insured Person which is in possession of the Company other than that information expressly disclosed in the Proposal Form or otherwise in writing to the Company, shall not be held to be binding or prejudicially affect the Company.

9.12 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.

9.13. Obligations in case of a minor

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

9.14 Observance of Terms and Conditions

The due observance and fulfilment of the terms and conditions of this Policy (including the realization of premium by their respective due dates and compliance with the specified procedure on all Claims) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, shall be Condition Precedent to the Company's liability under the Policy

9.15 Overriding effect of Policy Schedule

In case of any inconsistency in the terms and conditions in this Policy vis-a-vis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

9.16 Premium Loading

1. Based on the Board approved Company's underwriting guidelines, upon the disclosure of the health status of the persons proposed for insurance and declarations made in the Proposal, the Company may apply underwriting loading on the premium payable (excluding statutory levies and taxes). The maximum underwriting loading applicable will not exceed more than 100% of the premium for a individual member in case of Individual policies and on a policy level in floater policies.
2. These loadings will be applied from inception date of the First Policy including subsequent Renewal(s) with Us.
3. The Company may apply a specific personal waiting period on a medical condition/ailment depending on the past history or additional waiting periods on Pre-existing Diseases as part of the special conditions on the Policy but it will not exceed the 36 months waiting period. However the permanent exclusions can be applied for diseases as mentioned under Clause 3, Subclause Permanent Exclusion.

9.17. Policy Disputes

Any and all disputes or differences under or in relation to the validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and in accordance with Indian law.

9.18 Renewal Terms

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

- i. The Company shall endeavour 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 fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium to maintain continuity of benefits without break in policy. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.
- v. No loading shall apply on renewals based on individual claims experience.
- vi. The Company may carry out underwriting in accordance with its Board approved underwriting policy in relation to any request for change in Sum Insured or Deductible at the time of renewal of the Policy.
- vii. This product may be withdrawn / modified by the Company after due approval from the Authority (IRDAI). In case this product is withdrawn / modified by the Company, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by the Authority (IRDAI). The Company shall duly intimate the Policyholder at least three months prior to the date of such modification / withdrawal of this product and the options available to the Policyholder at the time of Renewal of this Policy.
- viii. The Company may revise the renewal premium payable under the Policy provided that revisions to the renewal premium are in accordance with the Authority's (IRDAI) rules and regulations as applicable from time to time. Change in rates will be applicable from the date of approval by the Authority and shall be applied only prospectively thereafter for new policies and at the date of renewal for renewals.
- ix. Loading if applicable on expiring policy will be applicable on subsequent renewals with the Company

10. Geography

This Policy applies to events or occurrences taking place within India and can be extended worldwide as specified in the policy schedule.

Policy Type	Individual	Floater
Relationship covered	Self	Self
	Spouse	Legally wedded Spouse
	Dependent Children	
	Dependent Children	Dependent Parent(s)
	Parent(s)	Dependent Parent In Law(s)
	Parent(s)-in-law	Dependent Children (natural or legally adopted) between the age 3 months to 25 years
	Son-in-law	
	Daughter-in-law	
	Grandparent(s)	
	Grand Child/Children	
	Brother In Law	
	Sister In Law	

	Siblings	
	Niece	
	Nephew	
Minimum Age	91 days (Proposer 18 years)	91 days
Maximum Age	No upper Limit	No upper Limit
Cover ceasing age	No	No

12. 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.

13. 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.

14. Moratorium Period

After completion of five continuous years under the policy no look back to be applied. This period of five years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 5 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.

15. 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

16. Customer Services and Grievances Redressal:

In case of any Grievance of the Complainant sent in a written communication to the Company at any of the touch points as mentioned, shall be addressed within 14 days of the receipt of the complaint.

The Company is committed to extend the best possible services to its customers.

- If you are not satisfied with our services and wish to connect with us , please feel free to call our 24X7 Toll free number 1800-12000 or 022-42312000 (tolled) or you may email to the customer service desk at support@hizuno.com.

Escalation Level 1

For lack of a response or if the resolution still does not meet your expectations, you can contact our Grievance Cell on 1800-120-216216 or write to grievance@hizuno.com . After investigating the matter internally and subsequent closure, we will send our response within a period of 7 days from the date of receipt at this email id.

Escalation Level 2

For lack of a response or if the resolution still does not meet your expectations, you can write to the Grievance Redressal Officer at grievanceofficer@hizuno.com or call us at 022-42312022 After examining the matter, we will send you our final response within a period of 7 days from the date of receipt of your complaint on this email id.

Escalation Level 3

If you are not satisfied with the response or do not receive a response from the Company, within 14 days of your complaint, you may approach the Grievance Cell of the Insurance Regulatory and Development Authority of India ('IRDAI')/(Bima Bharosa) on the following contact details: IRDAI Grievance Call Centre (IGCC) TOLL FREE NO: 155255 Email ID: complaints@irda.gov.in Register online at: [http:// irda.gov.in/igms1/](http://irda.gov.in/igms1/) . Address for communication for complaints by fax/paper: Consumer Affairs Department Insurance Regulatory and Development Authority of India Sy. No. 115/1, Financial District Nanakramguda, Gachibowli, Hyderabad – 500032.

Escalation Level 4

In case you are not satisfied with the response provided by the company or no response is received, you may approach the Insurance Ombudsman in your region for the resolution post 30 days from the date of registration of the complaint.

Details of the Insurance Ombudsman Offices are available on below link: <https://www.cioins.co.in/ombudsman>



Ombudsman and addresses

Mentioned below are contact details of Ombudsman:

Office details	Jurisdiction of office union territory, district
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL 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@cioins.co.in	Madhya Pradesh, Chattisgarh
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar-751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 -4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonapat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu PuducherryTown and Karaikal (which are part of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 – 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.

GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(Assam). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. 0141 – 2740363 / 2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
ERNAKULAM Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082/ 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Ballia, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Mau, Bahraich, Barabanki, Raebareilly, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajganj, Santkabirnagar, Azamgarh, Deoria, Kushinagar, Gorkhpur, Ghazipur, Chandauli, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038800 /27/29//31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddha Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001 Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Prohibition of Rebates (Section 41 Of the Insurance Act, 1938 as amended)

1. No person shall allow or offer to allow either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of whole or part of the commission payable or any rebate of premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer.
2. Any person making default in complying with the provisions of this section shall be liable for penalty which may extend to Rupees Ten Lakhs.

Annexure-A

List I - Items for which coverage is not available in the Policy

The details of the excluded items can also be viewed on our website: www.hizuno.com

Link: <https://www.hizuno.com/contact-us>

Sl. No.	Item
1	Baby food
2	Baby utilities charges
3	Beauty services
4	Belts/braces
5	Buds
6	Cold pack/hot pack
7	Carry bags
8	Email/ internet charges
9	Food charges (other than patient's diet provided by hospital)
10	leggings
11	Laundry charges
12	Mineral water
13	Sanitary pad
14	Telephone charges
15	Guest services
16	Crepe bandage
17	Diaper of any type
18	Eyelet collar
19	Slings
20	Blood grouping and cross matching of donors samples
21	Service charges where nursing charge also charged
22	Television charges
23	Surcharges
24	Attendant charges
25	Extra diet of patient (other than that which forms part of bed charge)
26	birth certificate
27	Certificate charges
28	Courier charges
29	Conveyance charges
30	Medical certificate
31	Medical records
32	Photocopies charges
33	Mortuary charges
34	Walking aids charges
35	Oxygen cylinder (for usage outside the hospital)
36	spacer
37	Spirometre
38	Nebulizer kit
39	Steam inhaler
40	Armsling
41	Thermometer
42	Cervical collar
43	Splint
44	Diabetic foot wear
45	Knee braces (long/ short/ hinged)
46	Knee immobilizer/shoulder immobilizer
47	Lumbo sacral belt

48	Nimbus bed or water or air bed charges
49	Ambulance collar
50	Ambulance equipment
51	Abdominal binder
52	Private nurses charges- special nursing charges
53	Sugar free tablets
54	Creams powders lotions (toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG electrodes
56	Gloves
57	Nebulisation kit
58	Any kit with no details mentioned [delivery kit, orthokit, recovery kit, etc]
59	Kidney tray
60	Mask
61	Ounce glass
62	Oxygen mask
63	Pelvic traction belt
64	Pan can
65	Trolley 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	Flex! Mask
17	Hand holder
18	Sputum cup
19	Disinfectant lotions
20	Luxury tax
21	Hvac
22	House keeping charges
23	Air conditioner charges
24	Im iv injection charges
25	Clean sheet
26	Blanket/warmer blanket
27	Admission kit
28	Diabetic chart charges
29	Documentation charges/ administrative expenses
30	Discharge procedure charges
31	Daily chart charges
32	Entrance pass/ visitors pass charges
33	Expenses related to prescription on discharge
34	File opening charges

35	Incidental expenses/ misc. Charges (not explained)
36	patient identification band/ name tag
37	Pulseoxymeter charges

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

Sl. No.	Item
1	Hair removal cream
2	Disposables razors charges (for site preparations)
3	eye pad
4	Eye sheild
5	Camera cover
6	Dvd, cd charges
7	Gause soft
8	Gauze
9	Ward and theatre booking charges
10	Arthroscopy and endoscopy instruments
11	Microscope cover
12	Surgical blades, harmonicscalpel,shaver
13	Surgical drill
14	Eye kit
15	Eye drape
16	X-ray film
17	Boyles apparatus charges
18	Cotton
19	Cotton bandage
20	Surgical tape
21	Apron
22	Torniquet
23	Orthobundle, gynaec bundle

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

Sl. No.	Item
1	Admission/registration charges
2	Hospitalisation for evaluation/ diagnostic purpose
3	Urine container
4	Blood reservation charges and ante natal booking charges
5	Bipap machine
6	Cpap/ capo equipments
7	Infusion pump- cost
8	Hydrogen peroxide\spirit\ disinfectants etc
9	Nutrition planning charges - dietician charges- diet charges
10	Hiv kit
11	Antiseptic mouthwash
12	Lozenges
13	Mouth paint
14	Vaccination charges
15	Alcohol swabes
16	Scrub solutionsterillium
17	Glucometer& strips
18	Urine bag

Day Care Treatment: All the day care treatments are covered which falls under the definition of Day care treatment mentioned in the policy

Illustrations of the Coverages

Annexure 1- Illustrations of the Coverages

Zuno Top Up Insurance with Double Sum Insured for Critical Illness										
2A										
Sr	Scenario	Base Policy Sum insured	Base Policy Deductible	Ailment	Claim of Insured	Claim Amount	Claim Paid	Base Policy Balance SI	Double SI	Remark
1	Claim 1	500000	100000	Dengue	Insured 1	110000	10000	490000	Not Triggered	Deductible of 1 lac applied
2	Claim 2			End stage liver failure	Insured 1	300000	3,00,000	190000	0	CI triggered but amount paid from basic SI
3	Claim 3			End stage liver failure	Insured 1	1000000	690000	0	Triggered	Double SI triggered and claim paid from Critical illness SI

Zuno Top Up Insurance with Recharge , Restore& Double Sum Insured for Critical illness													
2A													
Sr	Scenario	Base Policy Sum insured	Base Policy Aggregate Deductible	Ailment	Claim of Insured	Claimed Amount	Claim Paid	Base Policy Balance SI	Restoration	Restore Balance	Recharge	Recharge balance	Remark
1	Claim 1	500000	100000	End stage liver failure	Insured 1	110000	100000	0	Not Triggered	50000	Triggered	500000	Deductible of 1 lac applied. Insured can choose recharge or Double SI For Critical illness. For Clients benefit we have selected double SI for claim in said example.
2	Claim 2			End stage liver failure	Insured 1	300000	300000	Nil	Not Triggered	50000	Triggered	200000	Double CI sum insured exhausted. Restore not triggered as same illness when balance SI was exhausted.
3	Claim 3			Heart Attack	Insured 2	100000	100000	Nil	Triggered	40000	Triggered	200000	Insured can choose recharge or restore to claim. For Clients benefit we have selected restore in said example.

Zuno Top Up Insurance with Restoration											
2A											
Sr	Scenario	Base Policy Sum insured	Base Policy Deductible	Ailment	Claim of Insured	Claim Amount	Claim Paid	Base Policy Balance SI	Restoration	Restore Balance SI	Remark
1	Claim 1	500000	100000	Dengue	Insured 1	110000	10000	490000	Not Triggered	500000	Deductible of 1 lac applied
2	Claim 2			Heart Attack	Insured 1	500000	4,90,000	0	Not Triggered	500000	Restore is not triggered as base SI was not exhausted and Restore will not get triggered for same illness in policy year.
3	Claim 3			Heart Attack	Insured 1	100000	0	0	Not Triggered	500000	Same insured /Same illness
4	Claim 4			Stroke (CVA)	Insured 1	200000	200000	0	Triggered	3,00,000	Different illness (Hence 2 Lac Paid from Restore SI)
5	Claim 5			Heart Attack	Insured 2	200000	200000	0	Triggered	1,00,000	Different Insured (Hence 2 Lac Paid from Restore SI)

Zuno Top Up Insurance with Recharge											
2A											
Sr	Scenario	Base Policy Sum insured	Base Policy Deductible	Ailment	Claim of Insured	Claimed Amount	Claim Paid	Base Policy Balance SI	Recharge	Balance Recharge SI	Remark
1	Claim 1	500000	100000	Dengue	Insured 1	110000	10000	490000	Not Triggered	500000	Deductible of 1 lac applied
2	Claim 2			Heart Attack	Insured 1	500000	500000	0	yes	490000	(Rs. 5,00,000 - Rs. 4,90,000=10,000) Balance Rs.10,000 Paid from Recharge SI)
3	Claim 3			Heart Attack	Insured 1	100000	100000	0	Yes	390000	

4	Claim 4			Stroke (CVA)	Insured 2	500000	390000	0	Yes	0	Insurance company is not liable to pay balance claimed amount of 1,10,000/- as eligible SI is exhausted
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Zuno Top Up Insurance with Recharge & Restore													
2A													
Sr	Scenario	Base Policy Sum insured	Base Policy Deductible	Ailment	Claim of Insured	Claimed Amount	Claim Paid	Base Policy Balance SI	Restoration	Restore Balance	Recharge	Recharge balance	Remark
1	Claim 1	500000	100000	Dengue	Insured 1	110000	10000	490000	Not Triggered	500000	Not Triggered	500000	Deductible of 1 lac applied
2	Claim 2			Heart Attack	Insured 1	500000	500000	Nil	Not Triggered	500000	Triggered	490000	(Rs. 5,00,000 - Rs. 10000). Restore not triggered as same illness when balance SI was exhausted.
3	Claim 3			Heart Attack	Insured 1	100000	100000	Nil	Not Triggered	500000	Triggered	390000	(Rs.4,90,000-1,00,000)
4	Claim 4			Stroke (CVA)	Insured 2	300000	300000	Nil	Utilised by Customer	200000	Not utilised by Customer	390000	Insured can choose recharge or restore to claim. For Clients benefit we have selected restore in said example.