CUSTOMER INFORMATION SHEET

(Description is illustrative and not exhaustive)

S. No	TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
1	**Product Name**	**Health Insurance Policy - Retail**	
2	**What am I covered for**	Following are covered as basic cover up to the limit specified in the policy schedule	Scope of Cover
		1. Room, Board & Nursing expenses	
		2. Medical Practitioner, Surgeon, Anesthetist, Consultants, and Specialists Fees	
		3. Anesthesia, Blood, Oxygen, Operation Theatre Expenses, Surgical Appliances, Medicines & consumables, Diagnostic expenses and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, prosthesis/ internal implants and any medical Expenses incurred which is integral part of the operation	
		4. Cataract Treatment	
		5. Pre-Hospitalisation Expenses	
		6. Post-Hospitalisation Expenses.	
		7. Day Care Expenses.	
		8. Ambulance Expenses	
		9. Ayurvedic Medicine.	
		10. Homeopathic and Unani system of medicine.	
		11. Domiciliary Hospitalisation	
		12. Organ Donor	
		13. Free medical check-up	
		14. Parental Care	
		15. Accidental Hospitalisation	
		16. Child Care	
		17. Co-pay	
		18. Convalescence Benefit	
		Add on covers (available on payment of additional premium):	
		1. Removal of Room & ICU rent sub-limits	
		2. Removal of sub-limits on operation and consultancy charges	
		3. Removal of Ayurvedic and homeopathic cover	
		Note: Insurer's Liability in respect of all claims admitted during the period of insurance shall not exceed the Sum Insured for the Insured person as mentioned in the schedule.	
3	**What are the major Exclusions in the policy**	1. Any hospital admission primarily for investigation / diagnostic purpose	Exclusions
		2. Pregnancy, infertility, congenital/genetic conditions,	
		3. Epidemics recognized by WHO or/and Indian government. Government screening programs	
		4. Treatment taken outside India.	
		5. Circumcision, sex change surgery ,cosmetic surgery & plastic surgery,	
		6. Refractive error correction, hearing impairment correction, corrective & cosmetic dental surgeries,	
		7. Vaccination or inoculation except as part of post-bite treatment for animal bite.	
		8. Substance abuse, self-inflicted injuries, STDs and HIV / AIDS,	
		9. Participation in hazardous sports, war and allied perils	
		10. Treatment for any mental illness or psychiatric or psychological ailment / condition.	
		(Note: the above is a partial listing of the policy exclusions. Please refer to the policy clauses for the full listing).	
4	**Waiting period**	1. Initial waiting period: 30 days for all illnesses (not applicable on renewal or for accidents)	Exclusions
		2. 1 year for some diseases and surgeries.	
		3. 2 years for some diseases and surgeries.	
		4. 3 years for joint replacement due to degenerative condition (not applicable for	

<table>
<tr><td></td><td></td><td>accidents)</td><td></td></tr>
<tr><td></td><td></td><td>5. Pre-existing diseases: Covered after 48 months unless otherwise provided</td><td></td></tr>
<tr><td>5</td><td>Payout basis</td><td>Indemnity basis for covered expenses up to specified sum insured.</td><td>Scope of Cover</td></tr>
<tr><td>6</td><td>Cost sharing</td><td>In case of a claim, this policy requires you to share the following costs:
10% of each claim as co-payment in case of non network hospitalisation</td><td>Scope of Cover</td></tr>
<tr><td>7</td><td>Renewal Conditions</td><td>Ordinarily renewals will not be refused /cancellation will not be invoked by Insurer except on ground of fraud, moral hazard or misrepresentation. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein before mentioned and that nothing is known to the Insured that may increase the risk to the Insurer under the coverage provided hereunder. In case any disease /illness is contracted during the last 12 months (whether a claim is made or not with the Insurer), the information on the same needs to be provided to us at the time of renewal. The Policy will automatically terminate at the end of the Policy Period and we are under no obligation to give notice that it is due for renewal.
In case of a Policy that has expired/ not renewed with the Insurer before the end date of period of Insurance and being renewed upon specific acceptance by the Insurer within30 days from the date of expiry, the cover would be without loss of continuity benefits of waiting period and coverage of Pre-existing diseases. However, Coverage is not available for the period for which no premium is received and any complications arising from any illness/disease/accident during such period of break in Insurance is not covered under the Policy. In the event of any renewal of the policy after 30 days from the expiry of the policy, the same will be treated as a fresh policy and all the terms and conditions of the policy will be applicable.</td><td>General Conditions (Condition no.15)</td></tr>
<tr><td>8</td><td>Renewal Benefits</td><td>Continuity benefits for the 1/2/3/ PED exclusions</td><td></td></tr>
<tr><td>9</td><td>Cancellation</td><td>Insurer may cancel this insurance by giving Insured at least 15 days written notice and shall refund a pro-rata premium for the unexpired Policy Period. Insured may cancel this insurance by giving Insurer at least 15 days written notice, and if no claim has been made then the Insurer shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.
<table>
<tr><td>Period on risk</td><td>Rate of premium refunded</td></tr>
<tr><td>Up to one month</td><td>75% of annual rate</td></tr>
<tr><td>Up to three months</td><td>50%of annual rate</td></tr>
<tr><td>Up to six months</td><td>25% of annual rate</td></tr>
<tr><td>Exceeding six months</td><td>Nil</td></tr>
</table></td><td>General Conditions (Condition no. 15)</td></tr>
</table>

(LEGAL DISCLAIMER) NOTE: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the Customer Information Sheet and the policy document the terms and conditions mentioned in the policy document shall prevail.

HEALTH INSURANCE POLICY –RETAIL

This **Policy** is issued to the **Insured** based on the **Proposal** and declaration together with any statement, report or other document which shall be the basis of this contract and shall be deemed to be incorporated herein, to **Insurer** upon payment of the Premium. This **Policy** records the agreement between **Insurer** and **Insured** and sets out the terms of insurance and the obligations of each party.

The Policy, the Schedule and any Endorsement shall be read together and any word or expression to which a specific meaning has been attached in any part of this Policy or of Schedule shall bear such meaning whenever it may appear.

Subject to the terms, Conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, Insurer undertakes to pay the Insured Person the hospitalization expenses arising out of an Injury or Illness/Disease and that are reasonably and necessarily incurred by or on behalf of such Insured Person, but not exceeding the sum Insured for the insured person as mentioned in the schedule of the policy. The following benefits are covered under this policy subject to the sub-limits as stipulated in the policy contract.

1. Room, Boarding Expenses
2. Medical Practitioners fees
3. Intensive Care Unit
4. Nursing Expenses
5. Surgical fees, operating theatre, Anesthetist, Anesthesia, Blood, Oxygen and their administration,
6. Physio therapy while being treated as inpatient and being part of the treatment.
7. Drugs and medicines consumed during hospitalization period.
8. Hospital miscellaneous services (such as laboratory, X-ray, diagnostic tests)
9. Dressing, ordinary splints and plaster casts.
10. Cost of Prosthetic devices if implanted during a surgical procedure.

Note: Insurer's Liability in respect of all claims admitted during the period of insurance shall not exceed the Sum Insured for the Insured person as mentioned in the schedule.

DEFINITIONS

The following words or terms shall have the meaning ascribed to them wherever they appear in this Policy, and references to the singular or to the masculine shall include references to the plural and to the feminine wherever the context so permits:

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

"**Injury**" means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible means which is verified and certified by a **Medical Practitioner**.

"**Administrator**" means any third party administrator engaged by the **Insurer** for providing **Policy** and claims facilitation services to the **Insured** as well as to the **Insurer** and who is duly licensed by IRDA for the said purpose.

"**Age**" means completed years as at the Commencement Date of the **Policy Period**.

"Alternative treatments" mean forms of treatments other than treatment "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

"**Any One Illness**" means continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

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

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

"Congenital Anomaly" refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

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

"Condition Precedent" means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

"Contribution" means essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured**.**

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

"Day Care Expenses" means the Reasonable and Customary Charges incurred towards medical treatment for a Day Care Treatment /Procedure preauthorized by the Administrator and done in a Network Provider / Day Care Centre to the extent that such cost does not exceed the Reasonable and Customary charges in the locality for the same Day Care Treatment / Procedure.

"Day Care Hospital/Centre" means any institution established for day care treatment of illness and / or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under

a. has qualified nursing staff under its employment
b. has qualified medical practitioner (s) in charge
c. has a fully equipped operation theatre of its own where surgical procedures are carried out
d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

"Day care Treatments" refers to medical treatment, and/or surgical procedure which is:

a. undertaken under General or Local Anaesthesia in a Hospital/day care centre in less than 24 hrs because of technological advancement, and
b. which would have otherwise required a Hospitalisation of more than 24 hours.

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

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

"Diagnostic Centre" means the diagnostic centers which have been empanelled by Insurer or Administrator as per the latest version of the Schedule of diagnostic centers maintained by Insurer or Administrator, which is available to Insured on request.

"Disclosure to information norm" The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

"Dental treatment" means treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

"Dependent Child/Children" means children / a child (natural or legally adopted), who are/is financially dependent on the Insured or Proposer aged between 3 months and twenty three (23) years and who are unmarried

"Disease / Illness" means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

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

b. **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics
    i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
    ii. it needs ongoing or long-term control or relief of symptoms
    iii. it requires your rehabilitation or for you to be specially trained to cope with it
    iv. it continues indefinitely
    v. it comes back or is likely to come back.

"Domiciliary Hospitalisation" means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

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

"Eligible Hospitalisation Expenses" means the expenses which the Insured/Insured Person is entitled for applicable room rent and other charges as given in the scope of cover under the policy.

"Emergency Care" means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

"Epidemic Disease" means a Disease which occurs when new cases of a certain Disease, in a given human population, and during a given period, substantially exceed what is the normal "expected" Incidence Rate based on recent experience (the number of new cases in the population during a specified period of time is called the "Incidence Rate").

"**Family**" means and includes **Insured Person/Insured Person**'s legal Spouse, **Insured Person**'s legal & dependent children and dependent parents

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

"**Hospital**": means any institution established for in- patient care and day care treatment of illness and / or injuries and which has been registered as a **Hospital** with the local authorities, under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

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

"**Hospitalisation**" means admission in a Hospital for a minimum period of 24 In Patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

"**Insured**" means You/Your/Self/the person named in the **Schedule**, who is a citizen and resident of India and for whom the insurance is proposed and appropriate premium paid.

"Insured Person" means the person named in the **Schedule**/ who is a resident of India and for whom the insurance is proposed and appropriate premium paid. This includes Insured Person's family.

"Insurer" means Us/Our/We SBI General Insurance Company Limited.

"Inpatient Care" means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

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

"Maternity expenses" shall include—

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

"Medical Advise" means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

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

"Medically Necessary" Medically necessary treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

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

"Medical Practitioner": means a person who holds a valid registration from the medical council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Governmentand is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. The registered Medical Practitioner should not be the Insured or any one of the close family members of the Insured.

"Mental Illness/Disease" means any mental Disease or bodily condition marked by disorganization of personality, mind, and emotions to impair the normal psychological, social or work performance of the individual regardless of its cause or origin.

"Network Provider" means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an Insured on payment by a cashless facility.

"Non- Network" means Any hospital, day care centre or other provider that is not part of the network.

"Notification of claim" means the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

"Newborn baby" means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

"Other Insurer" means any of the registered Insurers in India other than Us/Our/We SBI General Insurance Company Limited.

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

"Package Service Expenses": means expenses levied by the Hospitalfor treatment of specific surgical procedures/medical ailments as a lump sum amount under agreed package charges based on the room criteria as defined in the tariff Schedule of the Hospital.

"Pre-existing Disease" means any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months prior to the first Policy issued by the Insurer.

"Policy Period" means the period commencing with the commencement date of the Policy & terminating with the expiry date of the Policy as stated in the Policy Schedule.

"Portability" means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

"Pre-hospitalization Medical Expenses" means Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:

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

"Post-hospitalization Medical Expenses" means medical Expenses incurred immediately after the Insured Person is discharged from the hospital, provided that:

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

"Proposal" means the written application or a standard form which the Insured duly fills and signs in with complete details seeking insurance are provided by him and includes any other information Insured provides to the insurer in the said form or in any communication with the Insurer seeking such insurance.

"Proposer" means the person furnishing complete details and information in the Proposal form for availing the benefits either for himself or towards the person to be covered under the Policy and consents to the terms of the contract of Insurance by way of signing the same.

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

"Renewal" means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

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

"Room Rent" means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

"**Schedule**" means that portion of the **Policy** which sets out **Insured** details, the type of **Insurance** cover in force, the **Policy Period** and the **Sum Insured**. Any Annexure and/or Endorsement to the **Schedule** shall also be a part of the **Schedule**.

Subrogation means the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

"**Sum Insured**" means the specified amount mentioned in the **Schedule** to this Policy which represents the **Insurer's** maximum liability for any or all claims under this policy during the currency of the Policy subject to terms and conditions as stated in the Policy.

"Surgery/Surgical Procedure" means manual and/or operative procedures required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of **Diseases**, relief of suffering or prolongation of life, performed in a **Hospital** or day care centre by a **Medical Practitioner**.

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

"**Waiting Period:**" No benefit shall be payable during the term of the **Policy** for the claim which occurs or where the hospitalisation for the claim has occurred within 30 days of first **Policy** issue Date. **Waiting period** is not applicable for the subsequent continuous uninterrupted renewals and hospitalisation due to accidents.

SCOPE OF COVER

Insurer shall pay the expenses reasonably and necessarily incurred by or on behalf of the Insured Person under the following categories but not exceeding the Sum Insured and subject to deduction of any deductible as reflected in the policy schedule in respect of such **Insured person** as specified in the Schedule:

1. Room, Board & Nursing expenses as charged by the Hospital Excluding registration and service Expenses are covered up to 1% of the **Sum Insured** per day and if admitted into Intensive Care Unit up to 2% of the **Sum Insured** per day under the policy.

   All admissible claims under Room, Board & Nursing Expenses including ICU, during the policy period are restricted maximum up to 25% of the **Sum Insured** per illness/injury.

2. **Medical Practitioner**, Surgeon, Anesthetist, Consultants, and Specialists Fees - All admissible claims under this section during the policy period restricted maximum up to 40% of the **Sum Insured** per illness/injury.

3. Anesthesia, Blood, Oxygen, Operation Theatre Expenses, Surgical Appliances, Medicines & consumables, Diagnostic expenses and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, prosthesis/internal implants and any medical Expenses incurred which is integral part of the operation - All admissible claims under this section during the policy period restricted maximum up to 40% of the Sum Insured per illness/injury.

   The amounts payable under points no. 2 and 3 shall be at the rate applicable to the entitled room category. In case the Insured opts for a room with rent higher than the entitled category as under point no. 1, the charges payable under point 1, 2 and 3 shall be limited to the charges applicable to the entitled category.

4. **Cataract Treatment:** Our obligation to make payment in respect of any claim for treatment of Cataract including surgery thereof under the policy is limited to 15 % of the **Sum Insured** subject to a maximum of INR 25000 per eye and further subject to first two years exclusion for cataract as provided under the Policy.

5. **Pre-Hospitalisation Expenses:** Pre-hospitalisation medical expenses incurred in 30 days subject to the condition that maximum amount that can be claimed under this head is limited to 10% of the **Eligible Hospitalisation Expenses** for each of the admitted hosipitalisation claim under the Policy.

6. **Post-Hospitalisation Expenses:** Post-hospitalisation medical expenses incurred in 60 days subject to the condition that maximum amount that can be claimed under this head is limited to 10% of the **Eligible Hospitalisation Expenses** for each of the admitted hosipitalisation claim under the Policy.

7. **Day Care Expenses: Insurer** shall pay for Day Care Expenses incurred on technological surgeries and procedures requiring less than 24 hours of **Hospitalisation** as per Annexure A (day care procedure in the Policy), forming part of this Policy up to the **Sum Insured**. The day care Expenses will be payable only if, prior approval has been provided by the **Administrator** or **Insurer** for such a day care procedure.

8. **Ambulance Expenses:** 1% of **Sum Insured** per Policy period up to a maximum of INR 1500 will be reimbursed to **Insured** for the cost of ambulance transportation. Ambulance services used should be of a licensed ambulance operator.

9. **Ayurvedic Medicine:** Ayurvedic Treatment covered up to maximum 15% of **Sum Insured** per Policy Period up to a maximum of INR 20000 subject to treatment taken in a government hospital or in any institute recognised by government and/or accredited by Quality Council of India/National Accreditation Board on Health.

10. **Homeopathic and Unani system of medicine:** Homeopathy and Unani Treatment covered up to maximum 10% of **Sum Insured** per Policy Period up to a maximum of INR 15000 subject to treatment taken in a government hospital or in any institute recognised by government and/or accredited by Quality Council of India/National Accreditation Board on Health.

11. **Domiciliary Hospitalisation: Insurer** will cover **Reasonable and CustomaryCharges** towards Domiciliary **Hospitalisation** exceeding 3 days ,subject to 20% of the **Sum Insured** maximum up to INR 20000 whichever

is less and according to the definition of domiciliary **Hospitalisation** as given in the policy **Schedule**. however domiciliary **Hospitalisation** benefits shall not cover:-

a. Expenses incurred for pre and post Domiciliary Hospitalisation treatment or
b. Expenses incurred for treatment for any of the following **Disease**s
    i. Asthma
    ii. Bronchitis
    iii. Chronic Nephritis and Nephritic Syndrome
    iv. Diarrhea and all type of Dysenteries including Gastro-enteritis
    v. Diabetes Mellitus and Insipidus
    vi. Epilepsy
    vii. Hypertension
    viii. Influenza, Cough and Cold
    ix. All Psychiatric or Psychosomatic Disorders
    x. Pyrexia of unknown Origin for less than 10 days
    xi. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharingitis
    xii. Arthritis, Gout and Rheumatism

12. **Organ Donor:** The Medical Expenses incurred for extraction of the required organ from the organ donor are covered under the policy subject to **Insurer** accepting the inpatient **Hospitalisation** claim made by the **Insured** and further provided that:
    a. The organ donor is the **Insured Person**'s blood relative or is an individual who can donate the organ as per the local law and as approved by the medical board of the hospital where the organ extraction is taking place and the organ donated is for the use of the **Insured Person**, and
    b. We will not pay the donor's pre- and post-**Hospitalisation** expenses or any other medical treatment for the donor consequent on the organ extraction.
    c. All the expenses incurred on the donor/donee, as above would be within the overall **Sum Insured** of the **Insured Person** under the **Policy** and as specified in the policy **Schedule**.

    However, all admissible claims under above coverage's during the policy period restricted maximum up to the **Sum Insured** as stated in the **Policy Schedule** per **Policy Period.**

13. **Free medical check-up:** For every four claim-free consecutive years during which policyholder has been **Insured** with **Insurer** without any break in insurance, **Insurer** may arrange a free medical check-up for **Insured** in **Insurer's** empanelled diagnostic centre or **Insurer** shall reimburse the cost incurred by **Insured** for the check-up subject to maximum 1% of **Sum Insured** up to a maximum of INR 2500.

14. **Parental Care:** Available for persons above 60 years of age. **Insurer** shall pay for the attendant nursing Expenses after discharge from the hospital for INR 500 or actual whichever is lesser per day up to a maximum 10 days per **Hospitalisation** of such **Insured Person** subject to the treating **Medical Practitioner** at the hospital where the **Hospitalisation** took place, recommending the duration of such nursing care requirement. The Expenses can be reimbursed for a period not exceeding 15 days during the entire Policy period. The attendant nurse must qualify **Insurer's** definition and attendance is required as per treating **Medical Practitioner**'s opinion.

15. **Accidental Hospitalisation** -In case of hospitalization following an Accident, Sum Insured limit available for the **Insured Person** will be 125% of the amount arrived after deducting the claims paid and/or outstanding from sum insured as on the date of accident for the **Insured Person** under the policy and excluding cumulative bonus accrued. Any such increase in sum insured over and above the base sum insured due to

the operation of this clause would be restricted to a maximum of INR 1,00,000/- only. This benefit is payable only once per Insured Person during the policy period and only once irrespective of number of such accidental hospitalisations during the policy period for policies covered under Family Floater cover.

16. **Child Care: Insurer** shall pay for the attendant escort Expenses of INR 500 for each completed day of **Hospitalisation** of a child below 10 years of age, subject to maximum of 30 days during the Policy Period. Escort person includes mother, father, grandfather, grandmother and any immediate family member.

17. **Co-pay:** For all admissible claims in non-network hospitals, **Insured** shall bear 10% of the admissible claim in addition to the deductible as per terms of insurance

18. **Convalescence Benefit:** This benefit is available for **Insured Person's aged** above 10 years & below 60 years and we shall pay an amount of INR 5,000/- per Insured, if the **Insured Person** is hospitalised for any bodily injury or illness as covered under the Policy, for a period of 10 consecutive days or more. This benefit is payable only once per **Insured** during the policy period.

EXCLUSIONS

We will not pay for any expenses incurred by **Insured** in respect of claims arising out of or howsoever related to any of the following:

1. Pre existing Diseases Exclusion:

Benefits will not be available for Any condition, whether diagnosed or not, ailment or injury or related condition(s) for which **Insured** has been diagnosed, received medical treatment, had signs and / or symptoms, prior to inception of **Insured's** first Policy, until 48 consecutive months have elapsed, after the date of inception of the first Policy with **Insurer**. It would also mean any direct or indirect complications arising out of pre-existing diseases whether known or unknown to the **Insured**.

This Exclusion shall cease to apply if **Insured** has maintained the Health Insurance Policy with **Insurer** for a continuous period of a full 4 years without break from the date of **Insured's** first Health Insurance Policy with **Insurer**.

This Exclusion shall also apply to the extent of the amount by which the limit of indemnity has been increased if the Policy is a renewal of the Health Insurance Policy with Insurer without break in cover.

In case of rollover/renewal policies issued by any **Other Insurer** which are accepted by us the following conditions would be applicable for coverage of exclusion of Pre-Existing diseases but only up to the sum insured limit under the expiring policy held by the insured.

a. If the **Insured** is covered continuously and without interruption for at least 4 years under any **Other Insurer's** individual health insurance policy for the reimbursement of medical costs for inpatient treatment in a Hospital, then the pre-existing disease exclusion stands waived.
b. If the **Insured** is covered continuously and without interruption for at least 3 years under any other **Insurer's** individual health insurance policy for the reimbursement of medical costs for inpatient treatment in a Hospital, then the pre-existing disease exclusion stands waived after a waiting period of 1 year from commencement of Policy.
c. If the **Insured** is covered continuously and without interruption for at least 2 years under any other **Insurer's** individual health insurance policy for the reimbursement of medical costs for inpatient treatment in a Hospital, then the pre-existing disease exclusion stands waived after a waiting period of 2 years from commencement of Policy.

d. If the **Insured** is covered continuously and without interruption for at least 1 year under any other **Insurer's** individual health insurance policy for the reimbursement of medical costs for inpatient treatment in a Hospital, then the pre-existing disease exclusion stands waived after a waiting period of 3 year from commencement of Policy.

2. Exclusions applicable to first 30 days of cover from commencement of Policy:
   Medical Expenses incurred for any disease / illness or diagnosable within 30 days, of the commencement (Commencement Date of first Health Insurance Policy with us) of the Policy Period except those incurred as a result of Accidental Bodily **Injury.**
   This Exclusion shall also apply to the extent of the amount by which the limit of indemnity has been increased if the Policy is a renewal of the Health Insurance Policy with **Insurer** without break in cover.
   If the policy is a renewal / rollover from any **Other Insurer** and if the **Insured** is covered continuously for at least 1 year under a individual health insurance policy for the reimbursement of medical costs for inpatient treatment in a Hospital, this exclusion stands waived
3. Exclusions applicable to first year of cover from commencement of the Policy, from the following Diseases / Illness and its related complications:
   a. Any types of gastric or duodenal ulcers,
   b. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty
   c. Surgery on all internal or external tumor /cysts/nodules/polyps of any kind including breast lumps
   d. All types of Hernia and Hydrocele
   e. Anal Fissures, Fistula and Piles

   This Exclusion shall also apply only to the extent of the amount by which the limit of indemnity has been increased if the Policy is a renewal of the Health Insurance Policy with **Insurer** without break in cover.
   If the policy is a renewal / rollover from any **Other Insurer** and if the **Insured** is covered continuously for at least 1 year under a individual health insurance policy for the reimbursement of medical costs for inpatient treatment in a Hospital, this exclusion stands waived provided that the **Insured** establishes to the **Insurer's** satisfaction that **Insured** was unaware of and had not taken any advice or medication for such Illness or treatment.
4. Exclusions applicable to first two years of cover from commencement of the Policy, from the following Diseases / Illness and its related complications:
   a. Cataract
   b. Benign Prostatic Hypertrophy
   c. Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus
   d. Hypertension, Heart Disease and related complications
   e. Diabetes and related complications
   f. Non infective Arthritis, Treatment of Spondylosis / Spondylitis, Gout & Rheumatism
   g. Surgery of Genitourinary tract
   h. Calculus Diseases of any etiology
   i. Sinusitis and related disorders
   j. Surgery for prolapsed intervertebral disc unless arising from accident
   k. Surgery of varicose veins and varicose ulcers
   l. Chronic Renal failure including dialysis

   This Exclusion shall also apply only to the extent of the amount by which the limit of indemnity has been increased if the Policy is a renewal of the Health Insurance Policy with **Insurer** without break in cover.
   If the policy is a renewal / rollover from any **Other Insurer** and if the **Insured** is covered continuously and without interruption/break in insurance for at least 2 years under a individual health insurance policy for the reimbursement of medical costs for inpatient treatment in a Hospital, this exclusion stands waived provided

that the **Insured** establishes to the **Insurer's** satisfaction that **Insured Person** was unaware of and had not taken any advice or medication for such Illness or treatment.

5. Exclusions applicable to first three years of cover from commencement of the Policy, from the following Diseases / Illness and its related complications:
   Medical Expenses incurred during or in connection with joint replacement surgery due to Degenerative condition, Age related osteoarthritis and Osteoporosis unless such joint replacement surgery is necessitated by accidental Bodily **Injury.**
   This Exclusion shall apply only to the extent of the amount by which the limit of indemnity has been increased if the Policy is a renewal of the Health Insurance Policy with **Insurer** without break in cover.
   If the policy is a renewal / rollover from any **Other Insurer** and if the **Insured** is covered continuously and without interruption/break in insurance for at least 3 years under an individual health insurance policy for the reimbursement of medical costs for inpatient treatment in a Hospital, this exclusion stands waived provided that the **Insured** establishes to the **Insurer's** satisfaction that **Insured** was unaware of and had not taken any advice or medication for such Illness or treatment.
6. Treatment outside India.
7. Epidemics recognized by WHO or/and Indian government. Government screening programs, etc are not covered by this policy.
8. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.
9. Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons/materials.
10. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or, as may be necessitated due to an accident
11. Cosmetic or aesthetic treatments of any description, treatment or surgery for change of life/gender, Lasik treatment for refractive error. Any form of plastic surgery (unless necessary for the treatment of Illness or accidental Bodily Injury).
12. The cost of spectacles, contact lenses, hearing aids, crutches, wheelchairs, artificial limbs, dentures, artificial teeth and all other external appliances. Prosthesis and/or devices.
13. Expenses incurred on Items for personal comfort like television, telephone, etc. incurred during hospitalization and which have been specifically charged for in the hospitalisation bills issued by the hospital.
14. External medical equipment of any kind used at home as post **Hospitalisation** care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Ambulatory Peritoneal Dialysis (C.A.P.D) and Oxygen concentrator for Bronchial Asthmatic condition.
15. Dental treatment or surgery of any kind unless required as a result of Accidental Bodily Injury to natural teeth requiring hospitalization treatment.
16. Convalescence, general debility, "Run-down" condition, rest cure, Congenital Internal and /or external illness/disease/defect.
17. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.
18. Any complications arising out of or ailments requiring treatment due to use or abuse of any substance, drug or alcohol and treatment for de-addiction.
19. Any condition directly or indirectly caused by or associated with Human Immunodeficiency Virus or Variant/mutant viruses and or any syndrome or condition of a similar kind commonly referred to as AIDS.
20. Venereal disease or any sexually transmitted disease or sickness.
21. Treatment arising from or traceable to pregnancy childbirth, miscarriage, abortion or complications of any of this, including caesarian section. However, this exclusion will not apply to abdominal operation for extra

uterine pregnancy (Ectopic Pregnancy), which is proved by submission of Ultra Sonographic Report and certification by Gynecologist that it is life threatening.

22. Any fertility, sub fertility or assisted conception operation or sterilization procedure and related treatment.
23. Vaccination or inoculation except as part of post-bite treatment for animal bite.
24. Vitamins, tonics, nutritional supplements unless forming part of the treatment for injury or disease as certified by the attending **Medical Practitioner**.
25. Surgery to correct deviated septum and hypertrophied turbinate unless necessitated by an accidental body injury and proved to our satisfaction that the condition is a result of an accidental injury.
26. Treatment for any mental illness or psychiatric or psychological ailment / condition.
27. **Medical Practitioner**'s home visit Expenses during pre and post hospitalization period, Attendant Nursing Expenses unless more than 60 years as specified in the parental care benefit.
28. Outpatient Diagnostic, Medical and Surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.
29. Any treatment required arising from **Insured's** participation in any hazardous activity including but not limited to all forms of skiing, scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc unless specifically agreed by the **Insurer**.
30. Genetic disorders and stem cell implantation / surgery/storage.
31. Expenses incurred at Hospital primarily for diagnosis irrespective of 24 hours hospitalization without diagnosis of any disease which does not require any follow up treatment covered under this policy. This would also include stay in a hospital without undertaking any treatment or where there is no active regular treatment by the **Medical Practitioner**, which ordinarily can be given without hospitalization.
32. Treatments in health hydro, spas, nature care clinics and the like.
33. Treatments taken at any institution which is primarily a rest home or convalescent facility, a place for custodial care, a facility for the aged or alcoholic or drug addicts or for the treatment of psychiatric or mental disorders; even if the institution has been registered as a hospital with the Appropriate Authorities
34. Treatment with alternative medicines like acupuncture, acupressure, osteopath, naturopathy, chiropractic, reflexology and aromatherapy.
35. Expenses incurred primarily for diagnostics, x-ray or laboratory examinations, or other diagnostics studies not consistent with or incidental to diagnosis and treatment of the positive existence or presence of any disease, illness or injury, for which confinement is required at a hospital or at home under domiciliary hospitalization as defined.
36. Hospitalization for donation of any body organs by an **Insured Person** including complications arising from the donation of organs.
37. Treatment for obesity, weight reduction or weight management.
38. Experimental and unproven treatment.
39. Costs of donor screening or treatment
40. Disease / injury illness whilst performing duties as a serving member of a military or police force.
41. Any kind of Service charges, Surcharges, Admission fees / Registration charges etc levied by the hospital.

GENERAL CONDITIONS

1. Free Look Period

The insured will be allowed a period of at least 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable If the insured has not made any claim during the free look period, the insured shall be entitled to-

a. A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or;
b. where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or;
c. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

2. Due Care

Where this Policy requires Insured to do or not to do something, then the complete satisfaction of that requirement by Insured or someone claiming on Insured behalf is a precondition to any obligation under this Policy. If Insured or someone claiming on Insured behalf fails to completely satisfy that requirement, then Insurer may refuse to consider Insured claim. Insured will cooperate with Insurer at all times.

3. Mis-description

This Policy shall be void and premium paid shall be forfeited to Insurer in the event of misrepresentation, mis-description or non-disclosure of any materials facts pertaining to the proposal form, written declarations or any other communication exchanged for the sake of obtaining the Insurance policy by the Insured. Nondisclosure shall include non-intimation of any circumstances which may affect the insurance cover granted. The Misrepresentation, mis-description and non-disclosure is related to the information provided by the proposer/insured to the Insurer at any point of time starting from seeking the insurance cover in the form of submitting the filled in proposal form, written declarations or any other communication exchanged for the sake of obtaining the Insurance policy and ends only after all the Contractual obligations under the policy are exhausted for both the parties under the contract.

4. Insured Person

Only those persons named as the Insured Person in the Schedule shall be covered under this Policy. The details of the Insured Person are as provided by Insured. A person may be added as an Insured Person during the Policy Period after Insured's Proposal has been accepted by Insurer, an additional premium has been paid and Insurer's agreement to extend cover has been indicated by it issuing an endorsement confirming the addition of such person as an Insured. Cover under this Policy shall be withdrawn from any Insured Person upon such Insured giving 15 days written notice to be received by Insurer

5. Package Service Expenses as defined under the policy will be payable only if prior approval for the said package service is provided by Administrator / Insurer upon the request of the Insured Person or Insured

6. Communications

a. Any communication meant for **Insurer** must be in writing and be delivered to **Insurer's** address shown in the **Schedule**. Any communication meant for **Insured** will be sent by **Insurer** to **Insured's** address shown in the **Schedule**/Endorsement.
b. All notifications and declarations for **Insurer** must be in writing and sent to the address specified in the **Schedule**. Agents are not authorized to receive notices and declarations on **Insurer's** behalf.
c. **Insured** must notify **Insurer** of any change in address.

7. Unhindered access

The Insured/Insured person shall extend all possible support & co-operation including necessary authorisation to the insurer for accessing the medical records and medical practitioners who have attended to the patient.

8. Claims Procedures

a. Claims Procedure for Reimbursement

i. The **Insured** shall without any delay consult a Doctor and follow the advice and treatment recommended, take reasonable step to minimize the quantum of any claim that might be made under this Policy and intimation to this effect must be forwarded to **Insurer** accordingly.

ii. **Insured** must provide intimation to **Insurer** immediately and in any event within 48 hours from the date of **Hospitalisation** . However the **Insurer** at his sole discretion may relax this condition subject to a justifiable reason/evidence being produced by the **Insured** on the reasons for such a delay beyond the stipulated 48 hours up to a maximum period of 7 days.

iii. **Insured** has to file the claim with all necessary documentation within 15 days of discharge from the Hospital, provide **Insurer** with written details of the quantum of any claim along with all the original bills, receipts and other documents upon which a claim is based and shall also give **Insurer** such additional information and assistance as **Insurer** may require in dealing with the claim. In case of delayed submission of claim and in absence of a justified reason for delayed submission of claim, the **Insurer** would have the right of not considering the claim for reimbursement.

iv. In respect of post hospitalization claims, the claims must be lodged within 15days from the completion of post **Hospitalisation** treatment subject to maximum of 75 days from the date of discharge from hospital.

v. The Insured shall submit himself for examination by the Insurer's medical advisors as often as may be considered necessary by the Insurer for establishing the liability under the Policy. The Insurer will reimburse the amount towards the expenses incurred for the said medical examination to the Insured.

vi. **Insured** must submit all original bills, receipts, certificates, information and evidences from the attending **Medical Practitioner** /Hospital /Diagnostic Laboratory as required by **Insurer**.

vii. On receipt of intimation from **Insured** regarding a claim under the policy, **Insurer/Administrator** is entitled to carry out examination and obtain information on any alleged Injury or Disease requiring **Hospitalisation** if and when **Insurer** may reasonably require.

b. Claims procedure for Cashless

Administrator will provide the User guide & identity card to **Insured**. User guide will have following details:

a. Contact details of all **Administrator** offices
b. Website address of **Administrator**
c. Network list of hospitals with their contact details
d. Claim submission guidelines.

c. Claims Submission

Insured will submit the claim documents to administrator. Following is the document list for claim submission:

i. Duly filled Claim form,
ii. Valid Photo Identity Card
iii. Original Discharge card/certificate/ death summary
iv. Copies of prescription for diagnostic test, treatment advise, medical references
v. Original set of investigation reports

vi. Itemized original hospital bill and receipts Hospital and related original medical expense receipt Pharmacy bills in original with prescriptions

d. Claims Processing

On receipt of claim documents from **Insured**, **Insurer/Administrator** shall assess the admissibility of claim as per Policy terms and conditions. Upon satisfactory completion of assessment and admission of claim, the **Insurer** will make the payment of benefit as per the contract. In case the claim is repudiated **Insurer** will inform the **Insured** about the same in writing with reason for repudiation.

9. Penal Interest Provision

Upon acceptance of an offer of settlement by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the insured. In the cases of delay in the payment, the insurer shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

10. Cumulative Bonus

If no claim has been made under the policy with us and the policy is renewed with us and without any break or within the Grace period as defined under the policy, we will allow a cumulative bonus to the renewal policy upon receipt of premium automatically by increasing the **Sum Insured** by 5%. The maximum cumulative bonus shall not exceed 25% of the **Sum Insured** in any policy year. The cumulative bonus to be offered is as mentioned below:

a. In case of a family floater cover, the cumulative bonus so applied will depend on the claim/claims made under the expiring policy and will be 5% of **Sum Insured** for a claim free year and subject to a maximum of 25% of **Sum Insured** in any policy year.

b. In case of a claim in the Policy the Cumulative Bonus if any under the policy will get reduced by 5% at the time of renewal, in the renewed policy. Also, in case of a policy issued to a **Family** with specific **Sum Insured** to **Insured Persons,** the Cumulative Bonus, if any for the **Insured Person** who has made the claim under the policy gets reduced by 5% in the following year in the renewed policy.

c. In case of a policy being renewed with us and which was previously covered with other Indian **Insurer**s, we will be offering a maximum cumulative bonus of 20% of **Sum Insured** provided the **Insured** submits the renewal notice and policy copy reflecting a no claim bonus/cumulative bonus equivalent or more than 25%. In case of no claim bonus enjoyed with previous **Insurer**s being less than 25%, a deduction of 5% will be made from the % of no claim bonus enjoyed and the balance will be allowed under the policy, as no claim bonus/cumulative bonus. However, this benefit will be restricted only up to the sum insured as provided under the previous or expiring policy obtained by the Insured from Other Insurer.

d. In case of increase in the **Sum Insured** on renewal of the Policy Cumulative bonus will be applicable on the increased **Sum Insured** only from the next year subject to no claims and will start from 5% and may / may not be similar to the cumulative bonus on the basic **Sum Insured** at the inception of the Policy with us.

e. The accumulated cumulative bonus is available to the insured person only upon exhaustion of the basic sum insured under the policy and all the eligibility criteria for the ascertaining the applicable limits under the policy will be calculated basing on the base sum insured.

11. Basis of claims payment

a. If **Insured** suffer a relapse within 45 days of the discharge from Hospital, obtaining medical treatment or consulting a Doctor and for which a claim has been made, then such relapse shall be deemed to be part of the same claim, as long as the relapse occurs within the Policy Period.
b. The day care procedures listed are subject to the exclusions, terms and conditions of the Policy and will not be treated as independent coverage under the Policy.
c. The plan which **Insured** is covered for will be shown on the **Schedule**. The table below sets out the percentage of the eligible claim amount that **Insurer** will be accountable for where a claim cost is incurred in a Location other than that prescribed in the **Schedule**.

Benefit Plan	**Treatment Location A-Mumbai and Delhi**	**Treatment Location B -Chennai, Kolkata, Bangalore, Ahmedabad, Hyderabad**	**Treatment Location C- Rest of India**
Plan A (Normal residential location -Mumbai & Delhi)	100%	100%	100%
Plan B (Normal residential location -Chennai, Kolkata, Bangalore, Ahmedabad, Hyderabad)	80%	100%	100%
Plan C (Normal residential location -Rest of India)	70%	80%	100%

- Plan A - 100% of the admissible claim amount for all Locations subject to the Policy terms and conditions.
- Plan B - 100% of the admissible claim amount for Locations B and C, and 80% for Location A subject to the Policy terms and conditions.,
- Plan C - 100% of the admissible claim amount for Locations C, 80% for Location B and 70% for Location A subject to the Policy terms and conditions.

The percentage of amount shown in the above table is with respect to the admissible claim amount. The **Insurer** will make payments only after being satisfied, with the necessary bills and documents submitted with reference to the claim.

12. Multiple policies

At any point of time, if it is found that there are multiple policies obtained by the Insured covering hospitalisation reimbursement benefit provided by this policy and such information on other existing hospitalisation reimbursement/health insurance policies is not declared/provided to us in the proposal form, the policy issued thereof stands cancelled ab initio treating the same as violation of General Condition no. 3

a. **Mis-description** under the general conditions in the policy and no liability exists under the policy for the disease/illness contracted by the insured. In such an event the premium collected under the policy would be refunded to the insured without any deduction for the expense incurred by the insurer for issuance of such policy and without any interest. In case of full and complete declaration of policies held with us and or with Other Insurers, our liability under the policy would be as under
b. If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, insured shall have the right to require a settlement of his claim in terms of any of his policies.
    i. In all such cases where insured opts the settlement of claim under this policy, we will be obliged to settle the claim without insisting on the contribution clause as long as the claim is within the limits of and according to the terms of the policy.

ii. If the amount to be claimed exceeds the sum insured under policy issued by us after considering the deductibles or co-pay, the insured shall have the right to choose other insurers by whom the claim to be settled. In such cases, we will settle the claim with contribution clause.

iii. Except in benefit policies, in cases where an insured person has policies from other insurer(s) to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the policy.

Contribution clause shall not be applicable where the cover/benefit offered is on benefit basis.

c. All the policies being insured with us, the maximum liability for the company would be the sum insured under all such policies put together.

13. Fraudulent Claims

If any claim 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** / **Insured Person** or anyone acting on his or her behalf to obtain any benefits under the Policy, all benefits under this Policy shall be forfeited. The **Insurer** will have the right to reclaim all benefits paid in respect of a claim which is fraudulent as mentioned above under this Condition as well as under General Condition No 4 of this Policy.

14. Subrogation

Insured and/or any Insured Persons shall at their own expense do or concur in doing or permit to be done all such acts and things that may be necessary or reasonably required by Insurer for the purpose of enforcing and/or securing any civil or criminal rights and remedies or obtaining relief or indemnity from any other party to which Insurer would become entitled upon Insurer making reimbursement under this Policy, whether such acts or things shall be or become necessary or required before or after our payment. Neither Insured nor any Insured Person shall prejudice these subrogation rights in any manner and shall at your own expense provide Insurer with whatever assistance or cooperation is required to enforce such rights. Any recovery Insurer make pursuant to this clause shall first be applied to the amounts paid or payable by Insurer under this Policy and our costs and expenses of affecting a recovery, where after Insurer shall pay any balance remaining to Insured. However, this clause will not apply to the benefit based sections of this policy.

15. Renewal & Cancellation

Ordinarily renewals will not be refused /cancellation will not be invoked by **Insurer** except on ground of fraud, moral hazard or misrepresentation. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein before mentioned and that nothing is known to the **Insured** that may increase the risk to the **Insurer** under the coverage provided hereunder. In case any disease /illness is contracted during the last 12 months (whether a claim is made or not with the **Insurer**), the information on the same needs to be provided to us at the time of renewal. The Policy will automatically terminate at the end of the Policy Period and we are under no obligation to give notice that it is due for renewal.

In case of a Policy that has expired/ not renewed with the **Insurer** before the end date of period of Insurance and being renewed upon specific acceptance by the **Insurer** within30 days from the date of expiry, the cover would be without loss of continuity benefits of waiting period and coverage of Pre-existing diseases. However, Coverage is not available for the period for which no premium is received and any complications arising from any illness/disease/accident during such period of break in Insurance is not covered under the Policy. In the event of any renewal of the policy after 30 days from the expiry of the

policy, the same will be treated as a fresh policy and all the terms and conditions of the policy will be applicable.

Insurer may cancel this insurance by giving **Insured** at least 15 days written notice and shall refund a pro-rata premium for the unexpired Policy Period. **Insured** may cancel this insurance by giving **Insurer** at least 15 days written notice, and if no claim has been made then the **Insurer** shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Period on risk	**Rate of premium refunded**
Up to one month	75% of annual rate
Up to three months	50%of annual rate
Up to six months	25% of annual rate
Exceeding six months	Nil

16. Termination of Policy

This Policy terminates on earliest of the following events-

a. Cancellation of policy as per the cancellation provision.

b. On the policy expiry date.

17. Withdrawal of Product

In case of withdrawal of this product insurer will communicate to Insured at least 3 months prior to the withdrawal. Existing policy will continue to remain in force till its expiry, and at the time of renewal, Insured will have option to migrate to insurer's indemnity based individual health insurance products available at that time subject to portability condition.

18. Nomination and Assignment

This Policy is not assignable and no person(s) other than Insured or Insured's nominee(s) as mentioned in the schedule or legal representatives, wherever is applicable, can claim or sue the Insurer under this policy. The payment by the Insurer to the Insured, his/her nominee or legal representative of any compensation or benefit under the policy shall in all cases be an effectual discharge to the Insurer.

19. Portability

This policy is portable as per Insurance Regulatory and Development Authority (Health Insurance) Regulation, 2013 and you should initiate action to approach another insurer, to take advantage of portability, well before the renewal date to avoid any break in the policy coverage due to delay in acceptance of the proposal by the other insurer.

20. Dispute Resolution

a. If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole Arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single Arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 Arbitrators, one arbitrator to be appointed by each of the parties to the dispute/difference and the third Arbitrator to be appointed by such two Arbitrators and the arbitration

shall be conducted under and in accordance with the provisions of the Arbitration and Conciliations Act 1996.

b. It is hereby agreed and understood that no dispute or difference shall be referable to arbitration, as hereinbefore provided, if the **Insurer** has disputed or not accepted liability under or in respect of this Policy.
c. It is expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such Arbitrator/Arbitrators of the amount of the loss shall be first obtained.
   The law of the arbitration shall be Indian law and the seat of the arbitration and venue for all the hearings shall be within India.

21. Examination of Medical Records:

Insurer may examine **Insured Person's** medical records/reports and related documents relating to the insurance under this Policy at any time during the Policy Period and up to three years after the Policy expiry, or until final adjustment (if any) and resolution of all claims under this Policy

22. Geographical limits:

All medical/surgical treatments under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency. All matters or disputes arising hereunder the policy shall be determined in accordance with the law and practice of such Court within the Indian Territory.

23. Observance of terms and conditions:

The due observance and fulfillment of the terms, conditions and endorsements of this Policy in so far as they relate to anything to be done or complied with by the **Insured** / **Insured Person**, shall be a condition precedent to any liability of the **Insurer** to make any payment under this Policy.

24. Forfeiture of claims:

If any claim is made and rejected and no court action or suit commenced within 12 months after such rejection or, in case of arbitration taking place as provided herein, within 12 calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

25. Position after a claim:

As from the day of receipt of the claim amount by the **Insured/Insured Person**, the **Sum Insured** and / or duration of cover for the remainder of the period of insurance shall stand reduced by a corresponding amount.

26. Payment of Claims in case of death during hospitalisation:

In the event of death of Primary Insured person on whose behalf covered medical expenses are incurred, such admissible claim amount would be payable to the legal heirs of the Primary Insured Person and If the diseased person is other than the primary insured person under the policy, we will pay such admissible claim amounts to the Primary Insured Person. The primary insured person is the head of the family and who is the primary earning member for the family.

27. Section 80 D Income-Tax Act:

The premium paid is exempted from Income Tax under Sec 80 D of Income Tax act.

28. GRIEVANCE REDRESSAL PROCEDURE

The Grievance Redressal Cell of the **Insurer** looks into complaints from **Insureds**. If the **Insured** has a grievance that the **Insured** wishes the **Insurer** to redress, the **Insured** may approach the person nominated as 'Grievance Redressal Officer' with the details of his grievance.

Name, address, e-mail ID and contact number of the Grievance Redressal Officer will appear in the Policy document as well as on **Insurer's** website. Further, the **Insured** may approach the nearest Insurance Ombudsman for redressal of the grievance. List of Ombudsman offices with contact details are attached for ready reference. For updated status, Please refer to website www.irdaindia.org.

Office Details	**Jurisdiction of Office Union Territory, District)**
AHMEDABAD - Office of the Insurance Ombudsman, 2nd floor, Ambica House,Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - **Shri. M. Parshad** Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@gbic.co.in	Karnataka.
BHOPAL - Shri. R K Srivastava 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@gbic.co.in	Madhya Pradesh, Chattisgarh.
BHUBANESHWAR - Shri. B. N. Mishra Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.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 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
CHENNAI - Shri Virander Kumar Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI - Smt. Sandhya Baliga Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in	Delhi.
GUWAHATI - Sh. / Smt. Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri. G. Rajeswara Rao 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.	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.

Office Details	Jurisdiction of Office Union Territory, District)
Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in	
JAIPUR - Shri. Ashok K. Jain Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.co.in	Rajasthan.
ERNAKULAM - Shri. P. K. Vijayakumar Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@gbic.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA - Shri. K. B. Saha Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@gbic.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW - Shri. N. P. Bhagat Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in	Some Districts of Uttar Pradesh
MUMBAI - Shri. A. K. Dasgupta Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri. Ajesh Kumar Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@gbic.co.in	State of Uttaranchal and some Districts of Uttar Pradesh
PATNA - Shri. Sadasiv Mishra Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@gbic.co.in	Bihar, Jharkhand.
PUNE - Shri. A. K. Sahoo 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 - 32341320 Email: bimalokpal.pune@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

STATUTORY NOTICE: INSURANCE IS THE SUBJECT MATTER OF THE SOLICITATION

ANNEXURE: ENDORSEMENTS

1. Removal of Room & ICU rent sub-limits:

Notwithstanding anything contrary to it stated in the policy, It is hereby agreed and declared that insured having paid the premium to remove the limits prescribed on room and ICU rent the, Insurer shall pay the reasonable costs incurred during Hospitalisation subject to minimum 24hours Hospitalisation & covered illness or Accident during the policy period.

All other terms and conditions will remain the same.

The following exclusion appearing under the policy hereby stand deleted -

Insurer shall pay the costs incurred during Hospitalisation subject to minimum 24hours Hospitalisation & covered illness or Accident during the policy period which would include the following:

Room, Board & Nursing Charges as provided by the Hospital/Nursing Home Excluding registration and service Expenses: up to 1% of the Sum Insured per day. If admitted into Intensive Care Unit up to 2% of the Sum Insured per day. In case the Insured opts for a higher room category, all incremental Expenses pertaining to room rent, Medical Practitioners / specialists fees and other incidental Expenses to be borne by the Insured.

All admissible claims under Room, Board & Nursing Expenses including ICU, during the policy period are restricted maximum up to 25% of the Sum Insured per illness/injury.

2. Removal of sub-limits on operation and consultancy charges:

Notwithstanding anything contrary to it stated in the policy, It is hereby agreed and declared that insured having paid the premium to remove the limits prescribed on operation , consultancy and other such related charges, Insurer shall pay the reasonable costs incurred during Hospitalisation which would include the following:

a. Medical Practitioner, Surgeon, Anaesthetist, Consultants, and Specialists Fees
b. Anaesthesia, Blood, Oxygen, Operation Theatre Expenses, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, prosthesis/internal implants and any medical Expenses incurred which is integral part of the operation

All other terms and conditions will remain the same.

The following exclusion appearing under the policy hereby stand deleted

Medical Practitioner, Surgeon, Anaesthetist, Consultants, and Specialists Fees - All admissible claims under this section during the policy period restricted maximum up to 40% of the Sum Insured per illness/injury.

Anaesthesia, Blood, Oxygen, Operation Theatre Expenses, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, prosthesis/internal implants and any medical Expenses incurred which is integral part of the operation - All admissible claims under this section during the policy period restricted maximum up to 40% of the Sum Insured per illness/injury.

3. Removal of Ayurvedic and homeopathic cover

Notwithstanding anything contrary to it stated in the policy, It is hereby agreed and declared that insured having availed the discount in premium the policy excludes the expenses incurred on alternative medicines like ayurvedic, homeopathy, unani, acupuncture, acupressure, osteopath, naturopathy, chiropractic, reflexology and aromatherapy .

All other terms and conditions will remain the same.

Further following appearing in the scope of cover of the policy stand deleted -

Ayurvedic Medicine: Ayurvedic Treatment covered up to maximum 15% of Sum Insured per Policy Period up to a maximum of Rs. 20000 subject to treatment taken at a Ayurvedic hospital confirming with our definition of hospital and which is registered with any of the local Government bodies..

Homeopathic and Unani system of medicine: Homeopathy and Unani Treatment covered up to maximum 10% of Sum Insured per Policy Period up to a maximum of Rs. 15000 subject to treatment taken at a Homeopathic / Unani hospital confirming with our definition of hospital and which is registered with any of the local Government bodies.

ANNEXURE A - DAY CARE LIST

The following are the listed Day care procedures and such other Surgical Procedures that necessitate less than 24 hours **Hospitalisation** due to medical/technological advancement / infrastructure facilities and the coverage of which is subject to the terms, conditions and exclusions of the policy

Microsurgical operations on the middle ear

1. Stapedectomy
2. Revision of a stapedectomy
3. Other operations on the auditory ossicles
4. Myringoplasty (Type -I Tympanoplasty)
5. Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
6. Revision of a tympanoplasty
7. Other microsurgical operations on the middle ear

Other operations on the middle & internal ear

8. Myringotomy
9. Removal of a tympanic drain
10. Incision of the mastoid process and middle ear
11. Mastoidectomy
12. Reconstruction of the middle ear
13. Other excisions of the middle and inner ear
14. Fenestration of the inner ear
15. Revision of a fenestration of the inner ear
16. Incision (opening) and destruction (elimination) of the inner ear
17. Other operations on the middle and inner ear

Operations on the nose & the nasal sinuses

18. Excision and destruction of diseased tissue of the nose
19. Operations on the turbinates (nasal concha)
20. Other operations on the nose
21. Nasal sinus aspiration

Operations on the eyes

22. Incision of tear glands
23. Other operations on the tear ducts
24. Incision of diseased eyelids
25. Excision and destruction of diseased tissue of the eyelid
26. Incision of diseased eyelids
27. Operations on the canthus and epicanthus
28. Corrective surgery for entropion and ectropion
29. Corrective surgery for blepharoptosis
30. Removal of a foreign body from the conjunctiva
31. Removal of a foreign body from the cornea
32. Incision of the cornea
33. Operations for pterygium
34. Other operations on the cornea

35. Removal of a foreign body from the lens of the eye
36. Removal of a foreign body from the posterior chamber of the eye
37. Removal of a foreign body from the orbit and eyeball
38. Operation of cataract

Operations on the skin & subcutaneous tissues

39. Incision of a pilonidal sinus
40. Other incisions of the skin and subcutaneous tissues
41. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
42. Local excision of diseased tissue of the skin and subcutaneous tissues
43. Other excisions of the skin and subcutaneous tissues
44. Simple restoration of surface continuity of the skin and subcutaneous tissues
45. Free skin transplantation, donor site
46. Free skin transplantation, recipient site
47. Revision of skin plasty
48. Other restoration and reconstruction of the skin and subcutaneous tissues
49. Chemosurgery to the skin
50. Destruction of diseased tissue in the skin and subcutaneous tissues

Operations on the tongue

51. Incision, excision and destruction of diseased tissue of the tongue
52. Partial glossectomy
53. Glossectomy
54. Reconstruction of the tongue
55. Other operations on the tongue

Operations on the salivary glands & salivary ducts

56. Incision and lancing of a salivary gland and a salivary duct
57. Excision of diseased tissue of a salivary gland and a salivary duct
58. Resection of a salivary gland
59. Reconstruction of a salivary gland and a salivary duct
60. Other operations on the salivary glands and salivary ducts

Other operations on the mouth & face

61. External incision and drainage in the region of the mouth, jaw and face
62. Incision of the hard and soft palate
63. Excision and destruction of diseased hard and soft palate
64. Incision, excision and destruction in the mouth
65. Plastic surgery to the floor of the mouth
66. Palatoplasty
67. Other operations in the mouth

Operations on the tonsils & adenoids

68. Transoral incision and drainage of a pharyngeal abscess
69. Tonsillectomy without adenoidectomy
70. Tonsillectomy with adenoidectomy

71. Excision and destruction of a lingual tonsil
72. Other operations on the tonsils and adenoids
73. Trauma surgery and orthopaedics
74. Incision on bone, septic and aseptic
75. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
76. Suture and other operations on tendons and tendon sheath
77. Reduction of dislocation under GA
78. Arthroscopic knee aspiration

Operations on the breast

79. Incision of the breast
80. Operations on the nipple

Operations on the digestive tract

81. Incision and excision of tissue in the perianal region
82. Surgical treatment of anal fistulas
83. Surgical treatment of haemorrhoids
84. Division of the anal sphincter (sphincterotomy)
85. Other operations on the anus
86. Ultrasound guided aspirations
87. Sclerotherapy etc.
88. Laparoscopic cholecystectomy

Operations on the female sexual organs

89. Incision of the ovary
90. Insufflation of the Fallopian tubes
91. Other operations on the Fallopian tube
92. Dilatation of the cervical canal
93. Conisation of the uterine cervix
94. Other operations on the uterine cervix
95. Incision of the uterus (hysterotomy)
96. Therapeutic curettage
97. Culdotomy
98. Incision of the vagina
99. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
100. Incision of the vulva
101. Operations on Bartholin's glands (cyst)

Operations on the prostate & seminal vesicles

102. Incision of the prostate
103. Transurethral excision and destruction of prostate tissue
104. Transurethral and percutaneous destruction of prostate tissue
105. Open surgical excision and destruction of prostate tissue
106. Radical prostatovesiculectomy
107. Other excision and destruction of prostate tissue
108. Operations on the seminal vesicles

109. Incision and excision of periprostatic tissue
110. Other operations on the prostate

Operations on the scrotum & tunica vaginalis testis
111. Incision of the scrotum and tunica vaginalis testis
112. Operation on a testicular hydrocele
113. Excision and destruction of diseased scrotal tissue
114. Plastic reconstruction of the scrotum and tunica vaginalis testis
115. Other operations on the scrotum and tunica vaginalis testis

Operations on the testes
116. Incision of the testes
117. Excision and destruction of diseased tissue of the testes
118. Unilateral orchidectomy
119. Bilateral orchidectomy
120. Orchidopexy
121. Abdominal exploration in cryptorchidism
122. Surgical repositioning of an abdominal testis
123. Reconstruction of the testis
124. Implantation, exchange and removal of a testicular prosthesis
125. Other operations on the penis

Operations on the spermatic cord, epididymis und ductus deferens
126. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
127. Excision in the area of the epididymis
128. Epididymectomy
129. Reconstruction of the spermatic cord
130. Reconstruction of the ductus deferens and epididymis
131. Other operations on the spermatic cord, epididymis and ductus deferens

Operations on the penis
132. Operations on the foreskin
133. Local excision and destruction of diseased tissue of the penis
134. Amputation of the penis
135. Plastic reconstruction of the penis
136. Other operations on the penis

Operations on the urinary system
137. Cystoscopical removal of stones

Other Operations
138. Lithotripsy
139. Coronary angiography
140. Haemodialysis
141. Radiotherapy for Cancer
142. Cancer Chemotherapy

ANNEXURE B : STANDARD LIST OF EXCLUDED EXPENSES IN HOSPITALISATION INDEMNITY POLICIES

SNO	List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy	SUGGESTIONS
TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS		
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	M01STUR1SER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine.
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable

46	CREPE BANDAGE	Not Payable/ Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling in case of upper arm fractures should be considered
ITEMS SPECIFIC ALL Y EXCLUDED IN THE POLICIES		
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in policy unless otherwise specified
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.	Exclusion in policy unless otherwise specified
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Exclusion in policy unless otherwise specified
62	HORMONE REPLACEMENT THERAPY	Exclusion in policy unless otherwise specified
63	HOME VISIT CHARGES	Exclusion in policy unless otherwise specified
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in policy unless otherwise specified
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Exclusion in policy unless otherwise specified
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Exclusion in policy unless otherwise specified
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in policy unless otherwise specified
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in policy unless otherwise specified
69	DONOR SCREENING CHARGES	Exclusion in policy unless otherwise specified
70	ADMISSION/REGISTRATION CHARGES	Exclusion in policy unless otherwise specified
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in policy unless otherwise specified
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable - Exclusion in policy unless otherwise specified
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not payable as per HIV/AIDS exclusion
74	STEM CELL IMPLANTATION/ SURGERY and STORAGE	Not Payable except Bone Marrow Transplantation where covered by policy
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS		
75	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
77	MICROSCOPE COVER	Payable under OT Charges, not separately
78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not separately
79	SURGICAL DRILL	Payable under OT Charges, not separately
80	EYE KIT	Payable under OT Charges, not separately
81	EYE DRAPE	Payable under OT Charges, not separately
82	X-RAY FILM	Payable under Radiology Charges, not as consumable
83	SPUTUM CUP	Payable under Investigation Charges, not as consumable
84	BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
86	ANTISEPTIC or DISINFECTANT LOTIONS	Not Payable -Part of Dressing Charges
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable -Part of Dressing Charges

88	COTTON	Not Payable -Part of Dressing Charges
89	COTTON BANDAGE	Not Payable -Part of Dressing Charges
90	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed , otherwise included as Dressing Charges
91	BLADE	Not Payable
92	APRON	Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU charges
93	TORNIQUET	Not Payable (service is charged by hospitals,consumables can not be separately charged)
94	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
95	URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE		
96	LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sub limits
97	HVAC	Part of room charge not payable separately
98	HOUSE KEEPING CHARGES	Part of room charge not payable separately
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
100	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
101	SURCHARGES	Part of Room Charge , Not payable separately
102	ATTENDANT CHARGES	Not Payable - Part of Room Charges
103	IM IV INJECTION CHARGES	Part of nursing charges, not payable
104	CLEAN SHEET	Part of Laundry/Housekeeping not payable separately
105	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
106	BLANKET/WARMER BLANKET	Not Payable- part of room charges
ADMINISTRATIVE OR NON-MEDICAL CHARGES		
107	ADMISSION KIT	Not Payable
108	BIRTH CERTIFICATE	Not Payable
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
110	CERTIFICATE CHARGES	Not Payable
111	COURIER CHARGES	Not Payable
112	CONVENYANCE CHARGES	Not Payable
113	DIABETIC CHART CHARGES	Not Payable
114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
115	DISCHARGE PROCEDURE CHARGES	Not Payable
116	DAILY CHART CHARGES	Not Payable
117	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
119	FILE OPENING CHARGES	Not Payable
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
121	MEDICAL CERTIFICATE	Not Payable
122	MAINTENANCE CHARGES	Not Payable
123	MEDICAL RECORDS	Not Payable
124	PREPARATION CHARGES	Not Payable
125	PHOTOCOPIES CHARGES	Not Payable
126	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
127	WASHING CHARGES	Not Payable
128	MEDICINE BOX	Not Payable
129	MORTUARY CHARGES	Payable upto 24 hrs, shifting charges not

		payable
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES		
131	WALKING AIDS CHARGES	Not Payable
132	BIPAP MACHINE	Not Payable
133	COMMODE	Not Payable
134	CPAP/ CAPD EQUIPMENTS	Device not Payable
135	INFUSION PUMP - COST	Not Payable
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Device not Payable
137	PULSEOXYMETER CHARGES	Device not Payable
138	SPACER	Not Payable
139	SPIROMETRE	Device not Payable
140	SP 02 PROBE	Not Payable
141	NEBULIZER KIT	Not Payable
142	STEAM INHALER	Not Payable
143	ARMSLING	Not Payable
144	THERMOMETER	Not Payable (paid by patient)
145	CERVICAL COLLAR	Not Payable
146	SPLINT	Not Payable
147	DIABETIC FOOT WEAR	Not Payable
148	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150	LUMBOSACRAL BELT	Essential and should be paid specifically for cases who have undergone surgery of lumbar spine.
151	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia / quadripiegia for any reason and at reasonable cost of approximately Rs 200/ day
152	AMBULANCE COLLAR	Not Payable
153	AMBULANCE EQUIPMENT	Not Payable
154	MICROSHEILD	Not Payable
155	ABDOMINAL BINDER	Essential an d should be paid in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.
ITEMS PA YABLE IF SUPPORTED BY A PRESCRIPTION		
156	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\ DSINFECTANTS ETC	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post hospitalization nursing charges not Payable
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES	Patient Diet provided by hospital is payable
159	SUGAR FREE Tablets	Payable -Sugar free variants of admissable medicines are not excluded
160	CREAMS POWDERS LOTIONS (Toileteries are not payable,only prescribed medical pharmaceuticals payable)	Payable when prescribed
161	Digestion gels	Payable when prescribed
162	ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT o r ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
163	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable

164	HIV KIT	Payable - payable Pre-operative screening
165	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
166	LOZENGES	Payable when prescribed
167	MOUTH PAINT	Payable when prescribed
168	NEBULISATION KIT	If used during hospitalization is payable reasonably
169	NOVARAPID	Payable when prescribed
170	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
171	ZYTEE GEL	Payable when prescribed
172	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE		
173	AHD	Not Payable - Part of Hospital's internal Cost
174	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
175	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
OTHERS		
176	VACCINE CHARGES FOR BABY	Not Payable
177	AESTHETIC TREATMENT / SURGERY	Not Payable
178	TPA CHARGES	Not Payable
179	VISCO BELT CHARGES	Not Payable
180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
181	EXAMINATION GLOVES	Not Payable
182	KIDNEY TRAY	Not Payable
183	MASK	Not Payable
184	OUNCE GLASS	Not Payable
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable, except for telemedicine consultations where covered by policy
186	OXYGEN MASK	Not Payable
187	PAPER GLOVES	Not Payable
188	PELVIC TRACTION BELT	Should be payable in case of PIVID requiring traction as this is generally not reused
189	REFERAL DOCTOR'S FEES	Not Payable
190	ACCU CHECK (Glucometery/ Strips)	Not payable pre hospitalisation or post hospitalisation / Reports an d Charts required / Device not payable
191	PAN CAN	Not Payable
192	SOFNET	Not Payable
193	TROLLY COVER	Not Payable
194	UROMETER, URINE JUG	Not Payable
195	AMBULANCE	P ayable-Ambulance from home to hospital or inter hospital shifts is payable/ RTA as specific requirement is payable
196	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs an d then 1 in 24 hrs
197	URINE BAG	Payable w here medicaly necessary till a reasonable cost - maximum 1 per 24 hrs
198	SOFTOVAC	Not Payable
199	STOCKINGS	Essential for case like CABG etc. where it should be paid.