SURAKSHA AUR BHAROSA DONO

SBI General Group Mediclaim Policy

Policy Wordings

1. Preamble

This Policy is a contract of insurance issued by SBI General (hereinafter called We/Us/'The Company') to the proposer Specified in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the "Insured Persons). The Policy is based on the statements and declaration provided in the Proposal form by the proposer and is subject to receipt of the requisite premium.

Note: This Policy Wording provides detailed terms, conditions and exclusions for all Sections available under this Product. Kindly refer to the Policy Schedule / Certificate of Insurance to know exact details of Sections opted by You. Only Wordings related to Sections Specified in Your Policy Schedule/Certificate of Insurance are applicable

Disclaimer: The Description Specified under this wording throughout the Insurance Policy is only to aid Your understanding of the Coverage/ Benefit Offered. In case of dispute, the Terms and Conditions detailed in the Policy Document and Policy Schedule/ Certificate of Insurance shall prevail.

SECTION NO. 1 DEFINITIONS

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

1.1 Standard Definitions

1. Accident means sudden, unforeseen, and involuntary event caused by external, visible, and violent means.
2. Any one Illness means continuous period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where treatment was taken.
3. AYUSH Hospital means an AYUSH Hospital is a healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   i. Central or State Government AYUSH Hospital; or
   ii. Teaching Hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/ Central Council for Homeopathy; or
   iii. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
   a) Having at least 5 in-patient beds;
   b) Having qualified AYUSH Medical Practitioner in charge round the clock;
   c) Having dedicated AYUSH therapy sections as required and / or has equipped operation theatre where Surgical Procedures are to be carried out;
   d) Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
4. AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical / para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner in charge round the clock;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where Surgical Procedures are to be carried out;
   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
5. Break in Policy means the period of gap that occurs at the end of the existing Policy term/ installment premium due date, when the premium due for Renewal on a given Policy or installment premium due is not paid on or before the premium Renewal date or Grace period.
6. Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization is approved.
7. Complainant means a Policyholder or prospect or Nominee or assignee or any beneficiary of an insurance Policy who has filed a Complaint or Grievance against an Insurer and /or distribution channel.
8. Complaint or Grievance means written expression (includes communication in the form of electronic mail or voice based electronic scripts) of dissatisfaction by a Complainant with respect to Solicitation or sale or purchase of an insurance Policy or related services by insurer and /or by distribution channel.
9. Condition Precedent means a Policy term or condition

upon which the Insurer's liability under the Policy is conditional upon.

10. Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure, or position.
    i. Internal Congenital Anomaly – Congenital Anomaly which is not in the visible and accessible parts of the body.
    ii. External Congenital Anomaly – Congenital Anomaly which is in the visible and accessible parts of the body
11. Co-payment means a cost sharing requirement under a health insurance Policy that provides that the Policyholder/ insured will bear a specified percentage of the admissible claims amount. A Co-payment does not reduce the Sum Insured.
12. Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium
13. Day Care Centre means any institution established for Day Care Treatment of Illness and/or injuries or a medical setup with a Hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner and must comply with all minimum criterion as under:
    i. has qualified nursing staff under its employment.
    ii. has qualified Medical Practitioner/s in charge;
    iii. has fully equipped operation theatre of its own where Surgical Procedures are carried out
    iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
14. Day Care Treatment means medical treatment, and/or surgical procedure which is
    i. Undertaken under General or Local Anesthesia in a Hospital/day care center in less than 24 hours because of technological advancement, and
    ii. which would have otherwise required Hospitalization of more than 24 hours.

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.
15. 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.
16. Dental Treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions, and Surgery.
17. Disclosure of information norm means the Policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non- disclosure of any material fact.
18. Domiciliary Hospitalization means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at Home under any of the following circumstances:
    i. the condition of the patient is such that he/she is not in a condition to be moved to a Hospital, or
    ii. the patient takes treatment at Home on account of non- availability of room in a Hospital.
19. Emergency Care means management for an Illness 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.
20. Grace period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a Policy in force without loss of continuity benefits pertaining to waiting periods and coverage of Pre-Existing Diseases. Coverage need not be available during the period for which no premium is received. The Grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

    Provided the insurers shall offer coverage during the Grace period, if the premium is paid in instalments during the Policy Period.

    For the purpose of this definition, the Insured Person will get the accrued continuity benefit in respect of the Sum Insured, Cumulative Bonus, No Claim Discount, Specific waiting periods, Waiting Periods for Pre-Existing Diseases, Moratorium period etc in the event of payment of premium within the stipulated Grace period.
21. Hospital means any institution established for In-patient Care and Day Care Treatment of diseases, 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:
    i. has qualified nursing staff under its employment round the clock,
    ii. has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
    iii. has qualified Medical Practitioner(s) in charge round the clock,
    iv. has a fully equipped operation theatre of its own where Surgical Procedures are carried out,
    v. maintains daily records of patients and will make

these accessible to the insurance company's authorized personnel.

22. Hospitalization means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.
23. Injury means accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent, visible, and evident means which is verified and certified by a Medical Practitioner.
24. Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a) Acute condition - Acute condition is a disease, Illness 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 which leads to full recovery
    b) Chronic condition - A chronic condition is defined as a disease, Illness 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 for the patient or for the patient to be specially trained to cope with it
        iv. it continues indefinitely
        v. it recurs or is likely to recur.
25. In-patient Care/Hospitalization means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.
26. 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.
27. ICU Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
28. Maternity Expenses means
    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.
29. Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow up prescription.
30. 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.
31. Medical Necessary Treatment means any treatment, tests, medication, or stay in Hospital or part of stay in Hospital which:
    i. is required for the medical management of the Illness or Injury suffered by the Insured Person.
    ii. must not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity.
    iii. must have been prescribed by a Medical Practitioner.
    iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
32. Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.
33. Migration means a facility provided to Policyholders (including all members under family cover and group policies), to transfer the credits gained for Pre-Existing Diseases and Specific waiting periods from one health insurance Policy to another with the same insurer.
34. Network Provider means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a Cashless Facility.
35. Non-Network Provider means any Hospital, Day Care Centre or other provider that is not part of the Network.
36. New Borne Baby means baby born during the Policy Period and is Aged up to 90 days.
37. Notification of Claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
38. OPD Treatment means the one in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in- patient.
39 Pre-Existing Disease (PED): means any condition, ailment, Injury or disease:
    a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of

the Policy issued by the insurer; or

b) for which Medical Advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the Policy.

40. Pre-Hospitalization Medical Expenses means Medical Expenses incurred during pre- defined number of days preceding the Hospitalization of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

41. Portability means a facility provided to the health insurance Policyholders (including all members under family cover), to transfer the credits gained for, Pre-Existing Diseases and Specific waiting periods from one insurer to another insurer.

42. Post-Hospitalization Medical Expenses means Medical Expenses incurred during pre- defined number of days immediately after the Insured Person is discharged from the Hospital provided that:

i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and

ii. The inpatient Hospitalization claim for such Hospitalization is admissible by the insurance company.

43. Proposal form means a form to be filled in by the prospect in physical or electronic form, for furnishing the information including material information, if any, as required by the Insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

Explanation:

i. "Material Information" for the purpose of these regulations shall mean all important, essential and relevant information and documents explicitly sought by insurer in the Proposal form.

ii. The requirements of "disclosure of material information" regarding a proposal or Policy, apply both to the insurer and the prospect, under these regulations.

44. Qualified Nurse is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India.

45. Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace period for treating the Renewal continuous for the purpose of gaining credit for Pre-Existing Diseases, time-bound exclusions and for all waiting periods.

46. 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.

47. Solicitation means the act of approaching a prospect or a Policyholder by an Insurer or by a distribution channel with a view to persuading the prospect or a Policyholder to purchase or to renew an insurance Policy.

48. Senior citizen means any person, who has attained the Age of sixty years or above.

49. Specific waiting period means a period up to 0/12/24/36 months as specified in the Policy Schedule/ Certificate of Insurance from the commencement of a health insurance Policy during which period specified diseases/treatments (except due to an Accident) are not covered. On completion of the period, diseases/ treatments shall be covered provided the Policy has been continuously renewed without any break.

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

51. Unproven/Experimental Treatment is a treatment including drug experimental therapy, which is based on established medical practice in India, is a treatment experimental or unproven.

1.2 Specific Definitions

1. Adventurous/Hazardous Sports means any sport or activity involving physical exertion and skill in which an Insured Person participates or competes for entertainment or as part of his profession whether he / she is trained or not.

2. Age means completed years on last birthday as on Commencement Date.

3. Ambulance means a motor vehicle operated by a licensed/ authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

4. Attendant is a person who performs personal services for those unable to care for themselves. Attendant is not authorized to provide any medical treatment.

5. Associated Medical Expenses means expenses which shall include nursing charges including RMO charges, operation theatre charges, fees of Medical Practitioner/ surgeon /anesthetist/specialist conducted within the same Hospital where the Insured Person has been admitted. The below expenses are not part of associate Medical Expenses.

a) Cost of pharmacy and consumables;

b) Cost of implants and medical devices;

c) Cost of diagnostics

6. Alternative Treatment (AYUSH) means the medical and / or Hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
7. Bank Rate means Bank Rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due.
8. Base Sum Insured/ Sum Insured means the pre-defined limit specified in the Policy Schedule/Certificate of Insurance.
9. Break in Policy means the period of gap that occurs at the end of the existing Policy term/installment premium due date, when the premium due for Renewal on a given Policy or installment premium due is not paid on or before the premium Renewal date or Grace period.
10. Biological Attack or Weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/ or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.
11. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
12. Commencement Date means the date of commencement of insurance coverage under the Policy as specified in the Policy Schedule/Certificate of Insurance.
13. Dependents means only the family members listed below:
    i. Legally married spouse as long as continues to be married or Live-in partner (For : Live-in partner, HR/ Group Manager`s declaration would be required)
    ii. Children (natural or legally adopted), Aged from day 1 and onwards up to the day as specified in the Policy Schedule/Certificate of Insurance.
    iii. Natural parents or Legal parents.
    iv. Parent-in-law.
    v. Any other dependent where there is Insurable Interest.
14. Diagnostic Centre means a place where diagnostic tests and exploratory or therapeutic procedures required for the detection, identification and treatment of a medical condition are done.
15. Disability for the purpose of this Policy means a person with not less than forty percent of a specified Disability as per the Act, where, specified Disability has not been defined in measurable terms and includes an Insured Person with Disability where specified Disability has been defined in measurable terms, as Certified by the Medical Board appointed by the government for certifying Disability.
16. Franchise means the Insurer is not responsible for the loss which does not exceed an agreed amount (as specified in the Policy Schedule/Certificate of Insurance), but is responsible for the entire amount of the loss which exceeds the agreed Franchise amount (as specified in the Policy Schedule/Certificate of Insurance).
17. HIV means Human Immunodeficiency Virus
18. Home means the Insured Person's place of permanent residence as specified in the Policy Schedule/ Certificate of Insurance.
19. Immediate Family means any one of the relationships with the Insured Person: spouse, father, mother, father-in-law, mother-in-law, brother, sister-in-law, sister, brother-in-law, son or daughter or legal guardian wherever applicable.
20. Insured Person/You/Your means persons named in the Policy Schedule/Certificate of Insurance who are insured under the Policy and are resident of India in respect of whom the applicable premium has been received.
21. Life-threatening situation shall mean a serious medical condition or symptom resulting from Injury or Illness which is not Pre-Existing Disease, which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long-term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an Emergency anymore.
22. Material Facts means all relevant information sought by the Company in the Proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.
23. Mental Illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence.
24. Medical Practitioner for treatment of Mental Illnesses means a Medical Practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognized by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognized by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognized by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge

and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Act;

25. Mental Health Establishment means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with Mental Illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with Mental Illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general Hospital or general nursing Home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with Mental Illness resides with his relatives or friends;
26. Permanent means lasting twelve calendar months and at the expiry of that period being beyond reasonable hope of improvement.
27. Permanent Total Disability (PTD) means disability, as the result of a bodily Injury, which:
    i. Continues for a period of twelve (12) consecutive months, and
    ii. Is confirmed as total, continuous and permanent by a physician after the twelve (12) consecutive months, and
    iii. Entirely prevents an Insured Person from engaging in or giving attention to gainful occupation of any and every kind for the remainder of his/her life.
28. Permanent Partial Disability (PPD) means the Insured Person has suffered a permanent loss of physical function or anatomical loss of use of a body part, substantiated by a diagnosis by a physician.
29. Policy means these Policy wordings, the Policy Schedule// Certificate of Insurance and any applicable endorsements or extensions attaching to or forming part thereof, as amended from time to time, and shall be read together. The Policy contains details of the extent of cover available to the Insured Person, applicable exclusions and the terms & conditions applicable under the Policy.
30. Policy Period means the period between the Commencement Date and either the Expiry Date specified in the Policy Schedule/Certificate of Insurance or the date of cancellation of this Policy, whichever is earlier.
31. Policy holder means the entity or person named as such in the Policy Schedule/Certificate of Insurance.
32. Policy Schedule/Certificate of Insurance means the Policy Schedule/Certificate of Insurance attached to and forming part of this Policy specifying the details of the Insured Persons, the Sum Insured, the Policy Period and the Sub-limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
33. Policy Year means a period of twelve months beginning from the Commencement Date and ending on the last day of such twelve-month period. For the purpose of subsequent years, Policy Year shall mean a period of twelve months commencing from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Expiry Date, as specified in the Policy Schedule.
34. Post-Natal Medical Expenses means Medical Expenses incurred for the insured mother post the delivery for a period of 6 weeks.
35. Pre-Natal Medical Expenses means Medical Expenses incurred for the insured mother during the maternity period prior to delivery.
36. Room Rent means the amount charged by a Hospital towards Room and Boarding expenses.
37. Health Check-up means a package of the medical test(s) undertaken for a general assessment of health status, excluding any diagnostic or investigative medical tests for evaluation of Illness or a disease.
38. Second medical opinion cover means a procedure whereby upon request of the Insured Person, an independent Medical Practitioner reviews and opines on the treating Medical Practitioner's recommendation as to care and treatment of the Insured Person by reviewing Insured Person's medical status and history. Such an opinion shall not be deemed to substitute the Insured Person's physical visit or consultation to an independent Medical Practitioner.
39. Sub-limit means a cost sharing requirement under a health insurance Policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit. The Sub- limit as applicable under the Policy is specified in the Policy Schedule/Certificate of Insurance against the relevant Cover in force under the Policy.
40. Telemedicine means Medical consultation service availed via telecommunications and digital communication technologies by the Insured Person from a Medical Practitioner while taking treatment for the health condition that has resulted in an admissible Claim under a cover in this Policy. Such Telemedicine services shall be delivered in compliance with the Medical Council of India's 'Telemedicine Practice Guidelines' dated March 2020 or its subsequent amendments, if any.
41. Waiting Period means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the Waiting Period, diseases/ treatments shall be covered provided the Policy has been continuously renewed without any break.

42. We/Our/Us/Company means the SBI General Insurance Company Limited.

SECTION NO. 2 COVERAGE

SECTION A : BASE COVER

HOSPITALIZATION COVER

We will pay under below listed Covers on Medically Necessary Hospitalization of an Insured Person due to Illness or Injury sustained or contracted during the Policy Period. The payment is subject to Sum Insured and limits including Loyalty Credit if applicable as specified on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance. Subject to otherwise terms and conditions of the Policy.

A.1 Inpatient Care:

We will indemnify Reasonable and Customary Charges that are incurred during the Hospitalisation of the Insured Person for Medically Necessary treatment required due to an Illness or Injury sustained by the Insured Person during the Policy Period for the below listed Medical Expenses:

i. Room Rent as specified in the Policy Schedule/ Certificate of Insurance;

ii. Nursing charges for Hospitalization as an Inpatient excluding private nursing charges;

iii. Medical Practitioners' fees, excluding any charges or fees for Standby Services;

iv. Physiotherapy, investigation and diagnostics procedures directly related to the current admission;

v. Anesthesia, Blood, Oxygen expenses.

vi. Medicines and drugs as prescribed by the treating Medical Practitioner;

vii. Intravenous fluids, blood transfusion, injection administration charges, allowable consumables and / or enteral feedings.

viii. Operation theatre charges;

ix. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery; ICU Charges.

x. Any other cover as requested by Policy holder or present in expiring Policy.

Condition

i. In case of admission to a room at rates exceeding the limits as specified in the Policy Schedule/ Certificate of Insurance the reimbursement of all other Associated Medical Expenses incurred at the Hospital, shall be payable in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges.

ii. Proportionate deductions shall not apply in respect of the Hospitals which do not follow differential billings or for those expenses in respect of which differential billing is not adopted based on the room category.

iii. If Insured Person is admitted in an ICU category those specified in the Policy Schedule/Certificate of Insurance of this Policy, then proportionate deductions shall not be applicable on the total Associated Medical Expenses in the proportion of the ICU Charges.

iv. Voluntary Co-payment/ Franchise and Super Top up cover if opted will be applicable to this cover.

v. The expenses related to or subsumed into room charges / procedure charges / costs of treatment are Specified in Annexure II are not covered, unless otherwise Specified in the Policy Schedule/ Certificate of Insurance.

A.2 Organ Donor Expenses

We will indemnify Reasonable and Customary Charges for the Medical Expenses incurred in respect of donor for any of the organ transplant Surgery conducted on the Insured Person during the Policy Period, provided that:

Conditions:

i. The organ donated is for the use of the Insured Person who has been asked to undergo an organ transplant on Medical Advice; and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

ii. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organs (Amendment) Bill, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable laws and rules and the organ donated is for the use of the Insured Person, and

iii. We have accepted an inpatient Hospitalization claim for the Insured Person under Section 2 A.1 (In-Patient Care).

iv. The Organ Donor's Pre-Hospitalization and Post-Hospitalization expenses are excluded under the Policy

v. Any donor screening charges or other Medical Expenses or Hospitalization consequent to the harvesting of organ for the donor is excluded under the Policy. vi. This benefit shall be limited to maximum amount as Specified in Policy Schedule/ Certificate of Insurance.

A.3 Day Care Treatment:

We will indemnify the Reasonable and Customary Charges for Medical Expenses incurred on the Insured Person's Day Care Treatment/ Procedure for Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner during the Policy Period.

Conditions:

i. The list of admissible Day Care Treatment/

Procedures would be as per the list in Annexure III (The list of Day Care Treatment is an indicative list and any other treatment which may get included in future shall be covered by the virtue of standard definition of "Day Care Treatment")

ii. We shall not cover any OPD Treatment and Diagnostic Services under this Benefit.

A.4 Pre-Hospitalization Medical Expenses:

We will indemnify the Reasonable and Customary Charges for Insured Person's Pre-Hospitalization Medical Expenses incurred prior to Hospitalization up to 30 days.

Conditions:

i. We have accepted a claim under Section 2 A.1 (Inpatient Care) or A.3 (Day Care Treatment) or A.6 (Modern Treatment) or A.7 (Inpatient Care under Alternative Treatments) or A.8 (Domiciliary Hospitalization) or A.9 (Bariatric Surgery) or B.32 (Home Health Care) in respect of that Insured Person.

ii. Pre-Hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

A.5 Post-Hospitalization Medical Expenses:

We will indemnify the Reasonable and Customary Charges for Insured Person's Post-Hospitalization Medical Expenses incurred immediately from the day of discharge from the Hospital up to 60 days.

Conditions:

i. We have accepted a claim under Section 2 A.1 (Inpatient Care) or A.3 (Day Care Treatments) or A.6 (Modern Treatment) or A.7 (Inpatient Care under Alternative Treatments) or A.8 (Domiciliary Hospitalization) or A.9 (Bariatric Surgery), B.32 (Home Health Care) in respect of that Insured Person.

ii. Post-Hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

A.6 Modern Treatment

We will indemnify the Reasonable and Customary Charges for Medical Expenses incurred on the Insured Person's Treatment for any Illness/ Injury where treatment undertaken is from below listed Modern treatment methods or Advanced procedures up to 50% of Base Sum Insured or as per the limits specified in Policy Schedule/Certificate of Insurance not limited to the following:

i. Uterine Artery Embolization and HIFU

ii. Balloon Sinuplasty

iii. Deep Brain stimulation

iv. Oral chemotherapy

v. Immunotherapy- Monoclonal Antibody to be given as injection

vi. Intra vitreal injections

vii. Robotic surgeries

viii. Stereotactic radio Surgeries

ix. Bronchial Thermoplasty

x. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

xi. IONM- (Intra Operative Neuro Monitoring)

Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions

Note: Any other advance procedure/ treatment as approved by IMA and specifically Specified in the Policy Schedule/Certificate of Insurance will be covered.

A.7 Inpatient care under Alternative Treatment (AYUSH):

We will indemnify the Reasonable and Customary Charges for Medical Expenses incurred by Alternative/ AYUSH treatment methods involving Inpatient Care availed in AYUSH Hospitals up to Base Sum Insured.

Conditions:

1. The treatment shall not be taken on an outpatient basis.
2. The treatment shall be undertaken in a government Hospital or AYUSH Hospital as defined under Section 1.
3. Treatment shall be availed within India.
4. AYUSH Treatment shall be subject to the Guidelines and Standard Treatment Protocols issued by the Ministry of AYUSH, as applicable from time to time.

A.8 Domiciliary Hospitalization:

We will indemnify the Reasonable and Customary Charges for Medical Expenses for the Insured Person's Domiciliary Hospitalization during the Policy Period, provided that the condition for which the medical treatment is required for at least twenty-four hours.

Conditions:

i. The Domiciliary Hospitalization is for Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.

ii. Medical Expenses can be claimed under this Section on a Reimbursement basis only and shall be limited to 20% of Base Sum Insured or as per the limits specified in Policy Schedule/Certificate of Insurance.

Expenses incurred due to following diseases will not be payable-

1. Asthma
2. Bronchitis
3. Chronic Nephritis and Nephritic Syndrome
4. Diarrhea and all type of Dysenteries including Gastroenteritis
5. Diabetes Mellitus and Insipidus
6. Epilepsy
7. Hypertension
8. Influenza, Cough and Cold
9. All Psychiatric or Psychosomatic Disorders

10. Pyrexia of unknown Origin for less than 10 days
11. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis
12. Arthritis, Gout and Rheumatism

A. 9 Bariatric Surgery

We will indemnify the Reasonable and Customary Charges for Medical Expenses incurred towards Surgical Procedure for obesity, subject to below conditions:

Eligibility:

For adults Aged 18 years or older, presence of severe obesity documented in contemporaneous clinical records, defined as any of the following: Body Mass Index (BMI);

a. Greater than or equal to 40 or
b. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
    1. Obesity-related cardiomyopathy
    2. Coronary heart disease
    3. Severe Sleep Apnoea
    4. Uncontrolled Type 2 Diabetes

Conditions

1. Bariatric Surgery performed for Cosmetic reasons is excluded.
2. The indication for the procedure should be found appropriate by two qualified surgeons and the Insured shall obtain prior approval for cashless treatment from the Company.
3. The expenses incurred for Bariatric Surgery shall be limited to 20% of Base Sum Insured or as per the limits specified in Policy Schedule/Certificate of Insurance.
4. Standard Exclusion A. III. (Obesity / Weight Control) shall not be applicable to the extent of Sum Insured covered under this benefit.

SECTION B OPTIONAL COVERS UNDER HOSPITALIZATION COVER

n consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that We will pay the expenses under below listed Covers subject to all other terms, conditions, exclusions and waiting periods applicable to the Policy.

These Covers are optional and applicable only if opted for and up to the Sum Insured or limits specified under the Schedule of Coverage in the Policy Schedule/ Certificate of Insurance.

B.1 Modification of Pre-Hospitalization Medical Expenses:

If You avail this option, Pre-Hospitalization Medical Expenses under section 2 A.4 will stand modified as Specified under the Schedule of Coverage in the Policy Schedule/Certificate of Insurance.

All other terms and Conditions of the respective Section and Policy shall remain unaltered.

B.2 Modification of Post-Hospitalization Medical Expenses:

If You avail this option, Post-Hospitalization Medical Expenses under section 2 A.5 will stand modified as Specified under the Schedule of Coverage in the Policy Schedule/Certificate of Insurance.

All other terms and Conditions of the respective Section and Policy shall remain unaltered.

B.3 Modification of Modern Treatment

If You avail this option, Modern Treatment under section 2 A.6 will stand modified as Specified under the Schedule of Coverage in the Policy Schedule/ Certificate of Insurance.

All other terms and Conditions of the respective Section and Policy shall remain unaltered.

B.4 Modification of Domiciliary Hospitalization:

If You avail this option, Domiciliary Hospitalization under section 2 A.8 will stand modified as Specified under the Schedule of Coverage in the Policy Schedule/ Certificate of Insurance.

All other terms and Conditions of the respective Section and Policy shall remain unaltered.

B.5 Modification of Bariatric Surgery

If You avail this option, Bariatric Surgery under section 2 A.9 will stand modified as Specified under the Schedule of Coverage in the Policy Schedule/Certificate of Insurance.

All other terms and Conditions of the respective Section and Policy shall remain unaltered.

B.6 Maternity Expenses:

We will indemnify the Reasonable and Customary Charges for Medical

Expenses incurred towards Medically Necessary Treatment of the Insured Person in case of normal delivery, routine or elective Caesarean or Maternity related Complications including Pre-natal Medical Expenses and Post-Natal check-ups and miscarriage during the Policy Period.

Conditions:

This Benefit is available only if:

i. The Insured Person in respect of whom a claim for Maternity Expenses is made must have been covered as an Insured Person since the inception of the First Policy with Us for at least the period of continuous coverage as specified in the Policy Schedule/Certificate of Insurance of, with maternity as a Benefit.

ii. The maximum liability per pregnancy (delivery/ termination) will be subject to the specified sub-limit as shown in the Policy Schedule/Certificate of Insurance and may be claimed by the eligible Insure Person(s) under the Policy to cover the Maternity Expenses up to three living children including IUD, irrespective of number of deliveries, unless the Maternity Sum Insured is enhanced by Multiplier

option.

iii. Multiplier benefit for maternity shall provide enhanced coverage as Specified in Policy Schedule/ Certificate of Insurance for multiple births (Twins, Triplets & etc), if opted.

iv. Any treatment related to the complication of pregnancy or termination will be treated within the maternity limits unless specifically Specified as over and above the maternity limits up to the limits specified in the Policy Schedule/Certificate of Insurance.

v. The expenses related to medically recommended lawful termination of pregnancy shall be covered but only in life threatening situation under the advice of Medical Practitioner

vi. We will cover Reasonable and Customary Charges for Pre- natal Medical Expenses incurred on Hospitalisation prior to the date of delivery and Reasonable and Customary Charges for Post- natal Medical Expenses incurred on Hospitalisation following the date of delivery provided for duration as Specified in the Policy Schedule/Certificate of Insurance.

vii. SECTION NO. 3. B.15 (Code-Excl 18) of the Exclusions shall not apply only to the extent that this Benefit is applicable.

viii. The claim admitted under this benefit will fall within the Base Sum Insured for the Policy Period. We shall not be liable to make any payment in respect of the following:

i. Expenses incurred in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future Illnesses;

ii. Medical Expenses for ectopic pregnancy will be covered under Section 2 A.1 (Inpatient Care) and shall not fall under this Benefit.

iii. Section 2 B.28 Sum Insured Reinstatement shall not be applicable for claim under this benefit

B.7 New Born Baby Cover:

We will indemnify the Reasonable and Customary Charges for Medical Expenses incurred during the Policy Period, towards the Medically Necessary Treatment of the New Born Baby for the specified period from the date of delivery up to the Base Sum Insured as specified in the Policy Schedule/Certificate of Insurance.

Conditions:

i. A New Born Baby older than the eligible number of days of coverage as Specified in the Policy Schedule/Certificate of Insurance can be covered under the Policy as an Insured Person only by way of an endorsement or at the next Renewal, whichever is earlier, on payment of the additional premium (if applicable).

ii. If this benefit is opted then claim under Section B.9 (Well Baby Cover for New Born) shall not be payable.

iii. Any claim admitted under this Section shall reduce the Base Sum Insured as opted and Specified in Policy Schedule/Certificate of Insurance.

B.8 Child Vaccination Cover:

We will indemnify the Reasonable and Customary Charges for expenses incurred during the Policy Period on vaccination of the child till he/she completes 12 years of Age, provided that the new born/ child is covered as an Insured Person under the Policy.

Conditions:

i. Coverage of the Baby on birth shall be subject to the addition of the Baby as an Insured Person under the Policy by way of an endorsement or at the next Renewal whichever is earlier on payment of the requisite premium.

ii. This benefit shall cover the charges for the vaccines of the Insured child during the Policy Period which are listed by the Ministry of Health and Family welfare under National Immunization Schedule.

iii. Expenses can be claimed under this Section on a Reimbursement basis only and could be within or above Base Sum Insured or as opted and specified in the Policy Schedule/Certificate of Insurance.

Section 3 C.11 of Specific Exclusions shall not apply only to the extent that this Benefit is applicable.

B.9 Well Baby Cover for New Born:

We will indemnify the Reasonable and Customary Charges for the necessary Expenses incurred during the Policy Period, towards the new born baby's well-being after birth and before discharge from the Hospital. These expenses include doctor check-up and any other check-up / tests performed to ensure that the baby is well at birth.

Conditions:

The claim admitted under this benefit will fall within the Base Sum Insured for the Policy Period.

B.10 Stem Cell Preservation Cover

We will indemnify the Reasonable and Customary Charges related to Expenses incurred during the Policy Period, in respect to testing, processing and storage of the umbilical cord blood for one episode of pregnancy in the Policy Period

The Expenses claimed under this Section could be within the Base Sum Insured as per limit specified in Policy Schedule /Certificate of Insurance or within the Maternity Sum Insured as opted.

Conditions:

i. The cover can be opted only if Section B.6 (Maternity expenses) is opted under the Policy or as required by the Insured Person.

ii. The claim under this benefit shall be payable only once during the Policy Period.

iii. Our maximum liability for this cover shall be as per the limit specified in Policy Schedule/Certificate of

Insurance.

B.11 Infertility Cover and Surrogacy Cover

We will indemnify the Medical Expenses related to any type of contraception, sterilization, reversal of sterilization, Gestational Surrogacy, Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI. This cover will be applicable for both Male and Female Insured Persons covered under the Policy.

Section 3 B.14 (Code-Excl 17) of the Exclusions shall not apply only to the extent that this Benefit is applicable.

Specific Conditions applicable to ART

i. Under Assisted Reproduction technology if advised and necessitated by a registered Medical Practitioner, We will also cover the Medical Expenses of oocyte donor during the process of oocyte retrieval as per the provisions of Assisted Reproductive Technology (Regulation) Act, 2021.

ii. Our maximum liability for this cover shall be as per the limit Specified in Policy Schedule/Certificate of Insurance.

iii. The cover can be opted only if Maternity Expenses benefit is opted under the Policy.

Specific Conditions applicable to Surrogacy:

i. To claim under this benefit, the Insured Person must provide a 'Certificate of Essentiality/Infertility' as recommended in THE SURROGACY (REGULATION) ACT, 2021.

ii. The medical condition that necessitates this option and should be confirmed by a Registered Medical Practitioner

iii. Insured Person(s) has repeatedly failed to conceive after multiple IVF/ICSI attempts (Recurrent implantation failure) or has medical conditions as absent uterus or missing uterus/or abnormal uterus (like hypoplastic uterus/intrauterine adhesions/ thin endometrium/small uni-cornuate uterus, T-shaped uterus) or the uterus is surgically removed due to any medical conditions as gynecological cancers or Multiple pregnancy losses resulting from an unexplained medical reason or any Illness that makes it impossible for woman to carry a pregnancy.

iv. The Insured shall be a legally married Indian man and woman, and shall not have any previous biological, adopted, or surrogate child.

v. Claim under Surrogacy for commercial purpose shall be excluded.

vi. Pre and Post natal expenses shall be covered up to the limits as mentioned under maternity benefit

vii. Our maximum liability for this cover shall be as per the limit Specified in Policy Schedule/Certificate of Insurance.

B.12 Accident Multiplier

We will enhance the Base Sum Insured under Section 2 A.1 (Inpatient Care) as per the Multiplier opted and specified in Policy Schedule / Certificate of Insurance to indemnify Insured Person towards, Reasonable and Customary Medical Expenses incurred for In-patient Hospitalization Treatment resulting from an Accident.

B.13 Emergency Ground Ambulance

We will indemnify the Insured Person up to the amount specified in the Policy Schedule/Certificate of Insurance, per Hospitalization, for expenses incurred on availing Road Ambulance services offered by a Hospital or by an Ambulance service provider.

Conditions:

We will reimburse payments under this Benefit provided that

i. The medical condition of the Insured Person requires immediate Ambulance services from the place where the Insured Person is Injured or is suffering from an Illness to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital as advised by the treating Medical Practitioner in writing.

ii. The Ambulance service is offered by a healthcare or Registered Ambulance Service Provider.

iii. The original Ambulance bills and payment receipt is submitted to Us.

iv. We have accepted a claim under Section 2 A.1 (Inpatient Care) above in respect of the same period of Hospitalization or A.3 (Day Care Treatment) or A.6 (Modern Treatment) or A.7

v. (Inpatient Care under Alternative Treatment) or B.3 (Modification of Modern Treatment) or B.6 (Maternity Expenses) or B.7 (New born Baby Cover) or B.9 (Well Baby Cover for New Born).

vi. We will not make any payment under this Benefit if the Insured Person is transferred to any Hospital or diagnostic center for evaluation purposes only.

B.14 Air Ambulance Cover

We will indemnify the Insured Person up to the amount specified in the Policy Schedule/Certificate of Insurance, per Hospitalization, for expenses incurred on availing Air Ambulance services during the Policy Period.

Conditions:

i. The medical condition of the Insured Person requires immediate Ambulance services from the place where the Insured Person is Injured or is ill to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital as advised by the treating Medical Practitioner in writing

ii. The Ambulance service is offered by a healthcare or Registered Ambulance Service Provider.

iii. Our maximum liability for this cover shall be as per

the limit specified in Policy Schedule/Certificate of Insurance.

iv. Expenses under this benefit shall be payable on reimbursement basis subject to the original Ambulance bills and payment receipt submitted to Us.

v. The Origin and Destination of Air Ambulance Service are within the geographical boundaries of Republic of India

vi. Such Air Ambulance should have been duly licensed for operation by the Competent Authorities of the Government of India.

vii. We have accepted a claim under Section 2 A.1 (Inpatient Care) or A.3 (Day Care Treatment) .

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

B.15 Prosthetics Cover

We will indemnify Reasonable and Customary Charges for expenses incurred on installation of an external Prosthetics if required by an Insured Person as a result of Injury/ Illness during the Policy Period that solely and directly results in physical loss of limb(s) within the Policy Period.

For the purpose of this Benefit,

1. Prosthetics means the articles or equipment that replaces all or a part of a limb where limb is defined as the arm / the leg of a person,
2. External prosthetics would mean the following external prosthesis: -
   a) Transradial prosthesis: It is the artificial prosthesis limb which replaces the missing arm from under the elbow with an artificial limb.
   b) Transhumeral prosthesis: It is the artificial prosthesis limb that replaces the missing arm above the elbow.
   c) Transtibial prosthesis: It is the artificial prosthesis limb which replaces a missing leg, right below the knees.
   d) Transfemoral prosthesis: It is the artificial prosthesis limb which replaces the missing leg above the knees.

Conditions:

i. We have accepted a claim under Section 2 A.1(Inpatient Care) or A.3(Day Care Treatment) above.

ii. Medical Expenses can be claimed under this Section on a Reimbursement basis only.

iii. The permanence of total and irreversible loss of limb shall be proved with a Disability certificate issued by a Medical Practitioner

iv. Any repairs or replacement of the Prosthetic which is implanted during the Policy Period or which was an already existing prosthetic previous to purchase of Policy will not be covered.

v. Any Orthotics, which means devices that are designed to support a weakened body part shall not be covered.

vi. Our maximum liability for this cover shall be as per the limit specified in Policy Schedule/Certificate of Insurance

vii. Section 3 C.7 (Specific Exclusions) shall not apply only to the extent that this Benefit is applicable.

B.16 Convalescence Benefit

We shall pay lump-sum amount per Hospitalization, during the Policy Period if the Insured Person suffers an Injury due to an Accident, and that Injury solely and directly results in Hospitalization of the Insured Person under Section 2 A.1 (Inpatient Care) for more than 7 consecutive and continuous days in the Hospital,

This benefit will be over and above the Base Sum Insured.

Our maximum liability for this cover shall be as per the limit specified in Policy Schedule/Certificate of Insurance.

B.17 Funeral and Repatriation Cover

In the event of death of the Insured Person We will indemnify Reasonable and Customary Charges towards funeral and Repatriation expenses including transportation of mortal remains of the Insured Person from the place of the incident or the Hospital to his/her residence.

Conditions:

i. Expenses can be claimed under this Section on a Reimbursement basis only.

ii. We have accepted claim under Section 2 (Hospitalization Cover)

iii. Our maximum liability for this cover shall be as per the limit specified in Policy Schedule/Certificate of Insurance.

iv. Any claim admitted under this Section shall reduce the Base Sum Insured for the Policy Period.

B.18 Compassionate visit

We will indemnify the Reasonable and Customary Charges for expenses incurred in respect of travel of one Immediate Family member of the Insured Person to the place of Hospitalization of the Insured Person, if an Insured Person suffers an Injury or an Illness during the Policy Period that solely and directly results in the Insured Person's Hospitalization for more than seven (7) continuous and consecutive days.

Conditions:

i. Expenses can be claimed under this Section on a Reimbursement basis only, provided we have accepted a claim under Section 2 A.1(Inpatient

Care)

ii. We will reimburse two-way airfare/road transport in a licensed carrier or two-way railway tickets for the travel of the companion to the place of Hospitalization of the Insured Person. iii. Our maximum liability for this cover shall be as per the limit specified in Policy Schedule/Certificate of Insurance.

B.19 Accompanying Person Cover:

If an Insured Person suffers an Injury or an Illness during the Policy Period that solely and directly results in the Insured Person's Hospitalization, We will pay per day amount as specified in Policy Schedule/Certificate of Insurance towards the accompanying person.

Conditions

i. We have accepted a claim under Section 2 A.1 (Inpatient Care)

ii. Our maximum liability for this cover shall be as per the limit chosen subject to completion of 1/2/3 days of continuous and consecutive Hospitalization as opted and specified in the Policy Schedule/ Certificate of Insurance.

iii. The claim pay-out under the benefit shall be limited to maximum 20 days of Hospitalization.

iv. For the purpose of this Benefit Immediate Family means any one of the relationships with the Insured Person: spouse, father, mother, legal guardian, father-in-law, mother-in-law, brother, sister-in-law, sister, brother-in-law, son or daughter.

B.20 Health Check-up

The Insured Person can avail preventive Health Check-up anytime during the Policy Period

Conditions:

i. The eligibility of the Insured Person under this Benefit and the specified limit / frequency of Health Check-ups will be as specified in the Policy Schedule/Certificate of Insurance.

ii. This benefit is available once per Insured Person during the Policy Period

iii. Any unutilized test or amount under this cover in a Policy Period cannot be carried forward to the next Policy Period.

iv. Health checkup will be provided at Our wellness partner or empaneled Diagnostic Centers on Cashless basis.

v. The claim admitted under this benefit will fall within the Base Sum Insured for the Policy Period.

B.21 Zero deductions in claim in case of death of Insured

In the event of death of Insured Person during Hospitalization period where claim is admissible under Section 2 A.1 (Inpatient care) or A.3 (Day Care) or or A.6 (Modern Treatment) or A.7 (Inpatient care under Alternative Treatment) or A.8(Domiciliary Hospitalization) or B.3 (Modification of Modern Treatment) or B.6(Maternity Expenses) or B.7(New born Baby Cover) or B.9(Well Baby Cover for New Born) or B.32. (Home Health Care) due to any Illness/ Injury, there will be zero deductions applicable for such Hospitalization expenses.

All admissible Hospitalization claim will be paid without any deduction for non-payable expenses under Annexure II/ Co- payment

B.22 Sub-limit on Specified Illness/Conditions:

If an Insured Person is Hospitalized during the Policy Period for any of the Specified Illnesses or Conditions then it is agreed that Our maximum liability in respect of any claim made under the Policy for the entire Policy Period will be subject to the list of Illnesses/ sub-limits/ waiting periods as specified in Policy Schedule/ Certificate of Insurance.

Conditions:

Any claim admitted under this shall reduce the Base Sum Insured for the Policy Period.

B.23 Loyalty Credit

If the Insured Person's renews his Policy with us without any break, then for each successive Renewal, We will increase the Base Sum Insured under the renewed Policy/Certificate of Insurance by an opted percentage of Base Sum Insured. The Sum Insured increase will be limited to 100% of Base Sum Insured.

Conditions:

i. If the Base Sum Insured has been reduced at the time of Renewal, the applicable Loyalty Credit shall be reduced in the same proportion to the Base Sum Insured.

ii. If the Base Sum Insured under the Policy has been increased at the time of Renewal, the Loyalty Credit shall be calculated on the Base Sum Insured of the last completed Policy Period.

iii. The sub-limits applicable to various benefits shall remain the same and shall not increase proportionately.

B.24 Weekly Benefit:

If the Primary Insured Person suffers from any Illness or Injury which occurs during the Policy Period resulting in Hospitalisation extending beyond 15 continuous and consecutive days and which solely and directly results in the Insured Person's temporary inability to go to work, then we will pay up to the limits as specified in the Policy Schedule/Certificate of Insurance.

Conditions:

i. We have accepted a claim under Section 2 A.1 (Inpatient Care)

ii. We will make payment under Section B.24 (Weekly Benefit) for only a part of the week if the Insured Person has suffered Temporary inability for that part of the week.

iii. The Medical Practitioner has certified in writing that the Insured Personal is temporarily unfit to work with specified period of recovery.

iv. Our maximum liability to pay the claim under this benefit shall be limited to the limits specified in Policy Schedule/Certificate of Insurance, provided in any case the payment for weekly benefit shall not exceed 100 continuous and consecutive weeks and opted Sum Insured under this benefit.

v. The payment under this benefit shall be payable only after the exhaustion of official leaves of that particular Insured Person or as specified in the Policy Schedule, provided the confirmation from the Employer of Primary Insured Person is mandatory.

vi. The claim payment under this benefit is over and above the Base Sum Insured.

For the purpose of this benefit, Primary Insured Person shall mean the person covered as Self under the Policy. For the purpose of this benefit "Week" is a period of seven consecutive days

Note: In the event of a dispute arising as to when Temporary enablement ceased, a Physician commissioned by the Us shall finally determine the date.

B.25 Voluntary Co-payment

Under this benefit, the Insured Person will pay the pre-determined percentage as specified in the Policy Schedule/Certificate of Insurance as Voluntary Co-payment on each and every claim.

Conditions:

i. If opted, Voluntary Co-payment will be applicable on the covers as specified in the Policy Schedule/ Certificate of Insurance unless agreed otherwise.

ii. Voluntary Co-payment will be applied in addition to the existing Co-payment if any.

B.26 E-Opinion

Under this benefit, the Insured Person may avail E-Opinion on his/her medical condition occurring during the Policy Period from a Medical Practitioner from our empanelled network.

Condition:

It is agreed and understood that the E- Opinion will be based only on the information and documentation provided to Us, which will be shared with the Medical Practitioner and is subject to the conditions specified below:

i. The Insured Person may have an option to choose E-Opinion from the list of Specialist as provided by Us on Our Website/App from our empaneled network.

ii. It is agreed and understood that Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.

iii. Appointments to avail this benefit shall be requested through Our Website/App or by calling Our call center on the toll-free number specified in the Policy Schedule/Certificate of Insurance.

iv. Under this benefit, We are only providing You with access to an E-opinion and We shall not be deemed to substitute Your visit or consultation to an independent Medical Practitioner

v. The E-Opinion provided under this benefit is not for Emergency Care and shall not be valid for any medico legal purposes.

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

B.27 Corporate Floater

Under this benefit, in case the Base Sum Insured under the Policy gets exhausted, then additional Sum Insured would be available to the Insured Persons during the Policy Period, subject to Terms and Conditions as specified in the Policy Schedule/Certificate of Insurance.

The individual or floater Base Sum Insured would be first exhausted followed by the corporate floater amount which would be availed as per the eligibility criteria and up to the limits as specified in the Policy Schedule/Certificate of Insurance.

Conditions

i. Any unutilized Sum Insured accrued under this cover shall not be carried forward to the subsequent Policy Period.

ii. All other terms, exclusions and conditions contained in the Policy or endorsed thereon remains unchanged.

B.28 Sum Insured Reinstatement

In the event of complete exhaustion of the Base Sum Insured due to any claim admitted during the Policy Period, We shall restore the Sum Insured up to the limit of Base Sum Insured. (as applicable under the current Policy Period)

Conditions:

i. For a claim to be admissible under this benefit it should be admissible under the Benefit- 2A.1 Inpatient Care.

ii. The Reinstated Sum Insured will be applicable only after the Base Sum Insured have been completely exhausted in that Policy Period;

iii. The Reinstatement of Sum Insured shall be applicable only on subsequent claim.

iv. For Reinstatement of Sum Insured, the amount reinstated shall be equivalent/ limited to the Base Sum Insured or multiples of Base Sum Insured as specified in Policy Schedule/Certificate of Insurance.

v. The Reinstatement of Sum Insured will be applied only once during the Policy Period.

vi. The unutilized Reinstated Sum Insured shall not be carried forward to any subsequent Policy Period.

vii. The reinstatement of Sum Insured shall be provided on both related or unrelated Illness/Injury on subsequent claim.

viii. The sequence of utilization of Reinstated Sum Insured will be as below:

a. Base Sum Insured followed by;

b. Loyalty Credit (if any) followed by;

c. Accident Multiplier (if opted and in case of Accident/Injury) followed by

d. Sum Insured Reinstatement

B.29 Claim settlement in network only

Under this benefit the coverage provided to the Insured Person shall be applicable if an Insured Person is Hospitalized in a Network Hospital only. The coverage would be as per the terms and conditions specified in Policy Schedule/Certificate of Insurance.

Conditions:

Any Hospitalisation treatment taken at Non-Network Provider shall not be covered under this Policy

B.30 Claim settlement on Reimbursement only

Under this benefit, if the Insured Person is Hospitalised the claim settlement shall be carried out on Reimbursement basis only, subject to Terms and Conditions as specified in the Policy Schedule/ Certificate of Insurance.

Conditions:

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

ii. Any claim initiated for a cashless payment or claims that are beyond the reimbursement timelines specified in the Policy Wordings shall not be covered unless the delay is proved for the reason beyond the Insured Person(s) control.

B.31 Physiotherapy and Rehabilitation cover

We will indemnify the Reasonable and Customary charges for Medical Expenses incurred during the Policy Period for physiotherapy and rehabilitation of the Insured Person for physical therapies aimed at restoring Insured Person's normal physical function as prescribed by the treating Medical Practitioner(s) in writing.

Conditions:

i. The Physiotherapy and Rehabilitation is Medically Necessary Treatment.

ii. This benefit is over and above the Base Sum Insured.

iii. Our maximum liability for this cover shall be as per the limit/ number of days as specified in Policy Schedule/Certificate of Insurance.

For the purpose of this cover Rehabilitation means a treatment or treatments designed to facilitate the process of recovery from Injury, Illness, or disease to as normal a condition as possible. Only the rehabilitation services provided by a certified Medical Practitioner will be considered.

B.32 Home Health Care

We will cover the Reasonable and Customary Charges towards Medical Expenses incurred for Home Health Care Services during the Policy Period availed through empanelled Service Provider on Cashless

Facility basis, only if the following conditions are fulfilled:

Conditions:

i. The treatment in normal course would require In-patient Care at a Hospital, and be admissible under Section 2 A.1 (Inpatient Care) but is actually taken while confined at Home.

ii. The benefit shall not be available for any emergency treatment/care.

iii. The Treatment is availed from the Company's empanelled service provider as per procedure given under "Section 4.3 Conditions when a claim arises"

iv. Records of the treatment administered, duly signed by the treating Medical Practitioner, are maintained for each day of the Home treatment.

v. This Cover is not available on reimbursement basis

B.33 Non-medical/Consumables Expenses

If We have accepted a claim under Hospitalization cover, then the items which are not payable as per List I– 'Expenses not covered' under Annexure II related to that particular claim will become payable.

Conditions:

i. Such Non-Medical/Consumables items are prescribed by the treating Medical Practitioner and are medically necessary for the treatment of the same condition for which Insured Person has taken In-Patient Care (2.A.1) or Day Care Treatment (2.A.3) and

ii. We have accepted a claim under Section 2.A.1 to 2.A.9

B.34 External Congenital Anomalies

We will indemnify the Reasonable and Customary Charges for Medical Expenses incurred for "Inpatient Care" up to the Base Sum Insured unless restricted by "Sub-limit on specified Illness / conditions" towards treatment for External Congenital Anomalies causing functional Disability.

Conditions:

i. If the treatment is taken only for aesthetic / cosmetic appearance without any positive effect or restoration of physiological function, such claims shall not be payable.

ii. Any claim admitted under this section shall fall within the Base Sum Insured.

B.35 Cancer Care

We will enhance the Base Sum Insured as per the percentage specified in Policy Schedule/Certificate of Insurance to cover the Reasonable and Customary Medical Expenses incurred for the Section 2.A.1 (In-Patient Care) and/or A.3 (Day Care) Hospitalization due to Cancer of the Insured Person during the Policy Period.

Our maximum liability for this cover shall be as per the limit as specified in Policy Schedule/Certificate of Insurance subject to exhaustion of Waiting Period as opted for this cover.

B.36 Attendant Charges Cover

If this cover is opted, We will pay a fixed weekly benefit amount for actual number of weeks if an Attendant/ Registered Nurse is engaged to take care of the Insured Person following Hospitalisation subject to maximum number of weeks and Sum Insured limit per week.

Conditions:

Cover under this benefit can be availed only if recommended by Medical Practitioner stating reason for providing Attendant Care/ Nursing Care at Home.

i. The benefit will be paid for maximum up to 25 weeks per Policy Period.

ii. The claim is triggered due to a prior Hospitalization within preceding 30 days

iii. Claim under this benefit shall be paid only if we have accepted a Claim for Section 2 A.1 (In-patient Care).

iv. SECTION NO.3.B.2(Code- Excl 05) of the Exclusions shall not apply only to the extent that this Benefit is applicable.

v. The Insured Person is unable to perform 3 out of below 6 activities due to Illness / Injury resulting from preceding Hospitalization.

a) Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene.

b) Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other Surgical Appliances.

c) Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa.

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

e) Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.

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

vi. Our maximum liability for this cover shall be as per the limit specified in Policy Schedule/Certificate of Insurance and any claim admitted under this section shall fall within the Base Sum Insured.

B.37 De-addiction Expenses Cover

We will indemnify Reasonable and Customary In-patient expenses related to De-addiction treatment for Alcohol, Drug and Substance Abuse, provided, the Insured Person(s) treatment is carried out by a registered and specialised Medical Practitioner in a Government Registered Rehabilitation Hospital.

Conditions:

i. To claim under this benefit Pre-authorization from Us is mandatory.

ii. SECTION 3 B.9(Code- Excl 12) of the Exclusions shall not apply only to the extent of this Benefit.

iii. Any claim admitted under this section shall fall within the Base Sum Insured.

iv. Our maximum liability for this cover shall be as per the limit specified in Policy Schedule/Certificate of Insurance subject to exhaustion of waiting period as opted for this cover

v. Any Out Patient Treatment shall be excluded under this benefit.

B.38 Modification of Home/Vehicle

Under this benefit, We will indemnify the reasonable expenses incurred to modify the Insured Person's residence and/or vehicle on the written advice of the treating Medical Practitioner, provided such modification is necessitated as a result of Disability to the Insured Person, arising out of Accident during the Policy Period.

Conditions:

i. We have accepted a claim under section A.1 (Inpatient Care) or A.3 (Day Care)

ii. The modifications have been carried out in India and certified by a Medical Practitioner

iii. Any claim admitted under this section shall fall within the Base Sum Insured.

B.39 Expenses for External Aids and Medical Equipment

We will reimburse the reasonable and customary expenses incurred by the Insured Person for medical equipment/ external aids that may be required for normal day to day activities to be carried out in a convenient and safe manner post Hospitalization resulting from an Accident/ Illness subject to acceptance of claim under Section A.1 (Inpatient Care) or A.3 (Day care)

Conditions:

i. The condition and use of medical equipment or external Aids shall be certified by a treating Medical Practitioner, to be necessary and directly required as a result of the Accident/Illness.

ii. Our maximum liability for this cover shall be as per the limit specified in Policy Schedule/Certificate of

Insurance

iii. Any claim admitted under this section shall fall within the Base Sum Insured

B.40 Modification of Waiting period for Pre- Existing Diseases (PED)

If You avail this option the pre-existing waiting period stands modified as specified in the Policy Schedule/ Certificate of Insurance.

All other terms and condition of respective Policy section shall remain unaltered.

B.41 Modification of Initial Waiting Period

If You avail this option the waiting period stands modified as specified in the Policy Schedule/Certificate of Insurance.

All other terms and condition of respective Policy section shall remain unaltered.

B.42 Modification of Waiting Period for Diseases Specific Exclusions

If You avail this option the waiting period for Specific Diseases stands modified as specified in the Policy Schedule/Certificate of Insurance.

All other terms and condition of respective Policy section shall remain unaltered.

B.43 Franchise

For any admissible claim, the Insured Person shall bear an amount equal to the Franchise amount as opted/specified in the Policy Schedule or Certificate of Insurance, and in case the admissible claim amount exceeds the opted/specified Franchise amount then We will indemnify the admissible claim amount (without deducting Franchise amount, specified in the Policy Schedule/Certificate of Insurance).

Conditions:

If opted, Franchise will be applicable on the covers as specified in the Policy Schedule/Certificate of Insurance unless agreed otherwise.

B.44 Vision Correction

We will indemnify for Reasonable and Customary Medical Expenses incurred by the Insured Person for Laser-Assisted In Situ Keratomileusis (LASIK) Surgery, including refractive keratotomy (RK) and photorefractive keratectomy (PRK) or any other advanced Surgical Procedures conducted to correct the refractive errors beyond +/- 4.5 dioptre to rectify the refraction of one or both eyes.

Condition:

i. Our maximum liability for this cover shall be as per the limit specified in Policy Schedule/Certificate of Insurance.

ii. We will not be liable to make any payment in respect of any other non-Surgical Procedures.

iii. SECTION 3.B.12 (Code-Excl 15) of the Exclusions shall not apply to the extent that this Benefit is applicable

B.45 Per claim Deductible

For any admissible claim amount, the Insured Person shall bear an amount equal to the Per Claim Deductible amount as opted and specified in the Policy Schedule/ Certificate of Insurance.

Per Claim Deductible shall be applicable on each and every claim made by the Insured Person under Section No.2 (Hospitalization Cover).

The Per Claim Deductible shall be applicable only on indemnity based benefits.

Voluntary Co-payment/Franchise (if any) shall be applicable on this benefit.

B.46 Gender Reassignment Cover

We will indemnify for Reasonable and Customary Medical Expenses incurred for Gender Reassignment Treatment taken by Insured Person during the Policy Period, up to the Sum Insured specified in the Policy Schedule/Certificate of Insurance.

The following Treatment/Procedures shall be covered

i. Hormone Therapy: The treatment involves hormone therapy (administered either on an In-patient or outpatient basis) like Testosterone (masculinizing hormones) for Trans Man (Female to Male) and estrogen (feminizing hormones) for Trans Woman (Male to Female).

ii. Surgical Intervention including but not limited to below listed procedures

a. Genital Surgery for Male-to-Female transsexuals

b. Genital Surgery for Female-to-Male transsexuals Condition applicable to Gender Re-assignment Treatment.

iii. Coverage in the Policy would be as per the WPATH(World Professional Association for Transgender Health) protocol subject to applicable Indian Laws.

iv. This include (but not restricted to) primary care, gynecologic and urologic care, reproductive Surgery options, voice related surgeries and communication therapy, mental health support services (e.g., assessment, counselling, psychotherapy), and hormonal and surgical treatments.

v. Active Line of Treatment would not be applicable for this treatment.

vi. SECTION 3.B.4(Code- Excl07) of the Exclusions shall not apply only to the extent that this Benefit is applicable

B.47 Global Cover

We will indemnify the Insured Person, up to the limit specified in the Policy Schedule/Certificate of Insurance, towards Medically Necessary Expenses incurred for In-Patient Treatment or Day Care Treatment for Planned Hospitalization and/or Emergency Care incurred outside India and anywhere across the world, during the Policy Year, provided:

i. This benefit can only be availed by Insured Person(s)

who are Residents of India.

ii. This benefit shall become available only after the expiry of number of months as opted and specified in the Policy Schedule/Certificate of Insurance from the date of inception of the first Policy with Us.

iii. In-Patient Hospitalization, Day Care Treatment taken as Emergency Care shall be covered up to the Sum Insured specified in the Policy Schedule/ Certificate of Insurance, provided the same is critical and cannot be deferred till the Insured Person's return to the Republic of India.

iv. The Coverage is available for maximum up to 45 consecutive days in a single trip and 90 days in a cumulative basis as a whole in a Policy Year.

v. The coverage under Planned Hospitalization shall be covered up to the Sum Insured specified in the Policy Schedule/Certificate of Insurance, provided Illness is diagnosed within India.

vi. In case of Planned Hospitalization, prior intimation at least 7 days in advance of the travel and due approval from Us will be necessary.

vii. The benefit shall be available on Cashless basis and arranged with Our Network Provider. Where the Cashless Facility cannot be arranged by Network Provider, We may provide Reimbursement facility on approval basis.

viii. The Hospitalization is towards Medically Necessary Treatment and follows the written advice of the treating Medical Practitioner.

ix. In case of an addition of any new members to the Policy, Waiting Period of number of months as opted and specified in the Policy Schedule/Certificate of Insurance shall be applicable under this benefit.

x. Pre and Post Hospitalization expenses shall be excluded under this benefit.

xi. The onus of procuring all the medical documents/ requirements to adjudicate any Claim will be on the Insured Person.

xii. The Sum Insured under this benefit shall be within or over and above the Base Sum Insured as specified in the Policy Schedule/Certificate of Insurance.

xiii. The Claim payment under this benefit shall be payable in Indian Rupees.

SECTION C OUT PATIENT EXPENSES

C.1 OPD Cover

We will indemnify the Reasonable and Customary Charges incurred during the Policy Period for OPD Treatment of the Insured Person as per cover/ benefit as opted and specified under Policy Schedule/ Certificate of Insurance.

Conditions:

i. The Insured Person may purchase Pharmacies prescribed by a Registered Medical Practitioner, as mentioned in the Policy Schedule/Certificate of Insurance

ii. Our maximum liability for this cover shall be as per the limit/ terms and conditions as specified in Policy Schedule/Certificate of Insurance

iii. SECTION 3.C.14 (Specific Exclusions) of the Exclusions shall not apply only to the extent that this Benefit is applicable.

What is not covered under OPD Treatments-

a. Replacing any dental appliance which is lost or stolen.

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

c. Cost of frames, any lenses including contact lenses, Sunglasses, unless medically prescribed by the treating Medical Practitioner.

Under Out-Patient Expenses the below optional cover is available at an additional premium.

C.2 Second Medical Opinion Cover

Under this benefit the Insured Person may avail Second Medical Opinion on his/her medical condition occurring during the Policy Period as per the limits specified in the Policy Schedule/Certificate of Insurance.

Condition:

It is agreed and understood that the Second Medical Opinion will be based only on the information and documentation provided to Us, which will be shared with the Medical Practitioner and is subject to the conditions specified below:

i. The Insured Person may have an option to choose Second Medical Opinion from the list of Specialist as provided by Us on Our Website/App.

ii. It is agreed and understood that You are free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.

iii. Appointments to avail this benefit shall be requested through Our Website/App or through calling Our call center on the toll- free number specified in the Policy Schedule/Certificate of Insurance.

iv. Under this benefit, We are only providing You with access to a Second Medical Opinion and We shall not be deemed to substitute Your visit or consultation to an independent Medical Practitioner

v. The Second Medical Opinion provided under this benefit is not for Emergency Care and shall not be valid for any medico legal purposes.

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

SECTION D COMMON DISEASE COVER

We will indemnity Reasonable and Customary Charges for Medical Expenses incurred if Insured Person is Hospitalized on the advice of a Doctor/ Medical Practitioner for non-surgical treatment due to Disease / Illness / Infection(s) (listed as below) contracted during the Policy Period.

This benefit will be over and above the Base Sum Insured.

Disease List	
i. Dengue fever	ii. Malaria
iii. Lymphatic Filariasis	iv. Kala azar
v. Chikungunya fever	vi. Japanese Encephalitis
vii. Zika virus	viii. Avian influenza
ix. HPV	x.Mycobacterium Tuber-culosis
xi. Enteric fever/Typhoid fever	

For the purpose of this benefit, Common Diseases shall cover:

1. Dengue fever

We will cover the Medical Expenses incurred for the Insured Person's, in case of being diagnosed with Dengue confirmed by a Medical Practitioner and Hospitalization being absolutely necessary for more than 24 hours in addition to below specific conditions.

Specific conditions for this cover:

i. The laboratory examination result countersigned by a pathologist/microbiologist must confirm Immunoglobulins/ PCR test showing positive result for Dengue.

ii. Indoor case papers should be obtained and the diagnosis of admission should be Dengue in addition to the above.

2. Malaria

We will cover the Medical Expenses incurred for the Insured Person's Hospitalization for more than 24 hours, in case of being diagnosed of Malaria, which should be confirmed by a Medical Practitioner with confirmatory tests indicating presence of Plasmodium Falciparum/ Vivax/Malariae in the patient's blood by laboratory examination countersigned by a pathologist/ microbiologist in peripheral blood smear or positive rapid diagnostic test (antigen detection test).

Specific conditions for this cover:

i. A continuous Hospitalization of 24 hours should be absolutely necessary along with high fever and shaking chills

ii. Indoor case papers should be obtained and the diagnosis of admission should be malaria and its complications, if any.

3. Lymphatic Filariasis (Commonly known as Elephantiasis)

We will cover the Medical Expenses incurred for the Insured Person's Hospitalization, in case of being diagnosed by a Medical Practitioner and the laboratory examination countersigned by a pathologist must be documented with presence of microfilariae in a blood smear by microscopic examination and along with any two of the following criteria:

- Lymphoedema,
- Elephantiasis,
- Scrotal swelling

Indoor case papers should be obtained and the diagnosis of admission should be Filariasis in addition to the two of the above conditions.

4. Kala-azar (also known as Visceral leishmaniasis)

We will cover the Medical Expenses incurred for the Insured Person's Hospitalization for more than 24 hours, in case of being diagnosed of Visceral leishmaniasis, characterized by irregular bouts of fever, substantial weight loss, swelling of the spleen and liver, and anaemia. for more than 24 hours

Specific Conditions for this cover:

i. The diagnosis must be confirmed by a Medical Practitioner and by parasite demonstration in bone marrow/spleen/lymph node aspiration or in culture medium as the confirmatory diagnosis or positive serological tests for Kala-azar should clearly indicate the presence of this disease.

ii. Indoor case papers should be obtained and the diagnosis of admission should be Kala-azar.

5. Chikungunya

We will cover the Medical Expenses incurred for the Insured Person's Hospitalization for more than 24 hours, in case of being diagnosed of Chikungunya characterized by an abrupt onset of fever with Joint pain. Other common signs and symptoms may include muscle pain, headache, nausea, fatigue and rash.

Specific conditions for this cover:

i. The diagnosis must be documented by a Medical Practitioner and confirmed by Serological tests, such as enzyme-linked immunosorbent assays (ELISA), confirming the presence of IgM and IgG anti-chikungunya antibodies.

ii. Indoor case papers should be obtained and the diagnosis of admission should be Chikungunya.

6. Japanese Encephalitis

We will cover the Medical Expenses incurred for the Insured Person's Hospitalization for more than 24 hours, in case of being diagnosed of Japanese encephalitis characterized by rapid onset of high fever, headache, neck stiffness, disorientation, coma, seizures, spastic paralysis. To confirm Japanese Encephalitis (JE) infection and to rule out other causes of encephalitis requires a laboratory testing of serum or preferably cerebrospinal fluid.

Specific conditions for this cover:

i. The diagnosis must be confirmed by a Medical Practitioner and positive serological test for JE by immunoglobulin M (IgM) antibody capture ELISA (MAC ELISA) for serum and cerebrospinal fluid (CSF).

ii. Indoor case papers should be obtained and the diagnosis of admission should be Japanese Encephalitis.

7. Zika Virus

We will cover the Medical Expenses incurred for the Insured Person's Hospitalization for more than 24 hours, in case of being diagnosed of Zika virus disease characterised by mild fever, skin rash, conjunctivitis, muscle and joint pain, malaise or headache.

Specific conditions for this cover:

i. A diagnosis of Zika virus infection should be confirmed by a Medical Practitioner and by plaque-reduction neutralization testing (PRNT).

ii. PRNT is performed by CDC (Centers for Disease Control and Prevention) or a CDC-designated confirmatory testing laboratory to confirm presumed positive, equivocal, or inconclusive IgM results. iii. Indoor case papers should be obtained and the diagnosis of admission should be Zika virus.

8. Avian Influenza

We will cover the Medical Expenses incurred for the Insured Person's Hospitalization for more than 24 hours, in case of being diagnosed of Avian Influenza, characterised by flu, fever, body ache and confirmed by a Medical Practitioner and by the Specified Diagnostic test as below: Most common affecting variants: A(H5N1) and A(H7N9)

Hospitalization must be necessary, Indoor case papers should be obtained and the diagnosis of admission should be Avian Influenza.

Exclusion:

Patient affected by other than the Specified variant will not be payable.

Diagnostic Tests:

- Viral RNA detection by reverse transcriptase polymerase chain reaction (RT-PCR) and real time RT- PCR assay- which confirms the presence of listed affecting variants.
- Serological identification of antibodies against avian influenza A viruses- including the hemagglutination inhibition test (HI), enzyme immunoassay (EIA), and virus neutralization tests (VN).

9. HPV

We will cover the Medical Expenses incurred for the Insured Person's Hospitalization for more than 24 hours, in case of being diagnosed of Human Papilloma Virus infection characterised by warts in genital and surrounding skin. A diagnosis of HPV infection should be confirmed by a Medical Practitioner and by the below Specified diagnostic tests.

Hospitalization must be necessary, Indoor case papers should be obtained and the diagnosis of admission should be Human Papilloma Virus Infection.

Diagnostic Test:

- Pap test also known as Pap Smear test involving collection of a sample of cells from the cervix or vagina to send for laboratory analysis which would confirm the presence of Human Papilloma Virus.
- DNA test conducted on the cells from insured`s cervix, should confirm presence of the DNA of the high-risk varieties of HPV that have been linked to genital cancers.

10. Mycobacterium Tuberculosis:

We will cover the Medical Expenses incurred for the Insured Person's Hospitalization for more than 24 hours, in case of being diagnosed of Mycobacterium Tuberculosis characterised by cough for 3 or more weeks and or symptoms like coughing up blood and mucus, chest pain, unintentional weight loss, fatigue, fever, nigh sweets and chills.

Specific conditions for this cover:

i. Hospitalization must be necessary, Indoor case papers should be obtained and the diagnosis of admission should be Mycobacterium Tuberculosis.

ii. A diagnosis of Mycobacterium tuberculosis should be confirmed by Medical Practitioner and by the below Specified diagnostic tests.

Diagnostic Test:

- The Mantoux tuberculin skin test (TST)
- TB blood test i.e. Interferon Gamma Release Assay (IGRA)
- Chest radiography
- Sputum Microbiology examination: A positive culture for M. tuberculosis in microbiology report.

Exclusion:

Any TB other than pulmonary TB will not be covered.

11. Enteric fever / Typhoid Fever

We will cover the Medical Expenses incurred for the Insured Person's Hospitalization for more than 24 hours, in case of being diagnosed of Typhoid fever/ Enteric Fever characterised by pain in abdomen and high fever, persistent headache, abdominal discomfort, constipation, diarrhoea, weakness, dizziness, nausea and cough.

A diagnosis of Enteric fever / Typhoid Fever should be confirmed by a Medical Practitioner and by the below Specified diagnostic tests.

Diagnostic tests:

- Widal test – Positive for presence of Salmonella Typhi
- ELISA test confirming S. Paratyphi, S. Typhi.
- Blood culture confirming growth of Salmonella Typhi.

Note: The Insured Person shall be indemnified for the Medical Expenses under Section2 A & B (Hospitalization Cover) and/or under Section 2 E (Common Disease Cover) if both covers are opted.

SECTION E: SUPER TOP UP COVER (Annual Aggregate Deductible)

During the Policy Period, We will indemnify Hospitalization expenses up to limits and in excess of aggregate Deductible as specified in the Policy Schedule/Certificate of Insurance.

Conditions:

i. The Deductible under this benefit shall be applicable on annual aggregate basis i.e will apply once in a Policy Period for all claims added together.

ii. In case of family floater Policy, the annual aggregate Deductible shall be applicable on floater basis.

iii. Annual Aggregate Deductible under this benefit shall not apply to any claim made under Section 2 B.14 (Emergency Ground Ambulance), or B.15 (Air Ambulance cover & Medical Evacuation) or B.16 (Prosthetic cover) or B.19(Funeral and Repatriation Cover), or B.20(Compassionate visit) or B.23(Sub-limit on specified Illness / conditions), if applicable.

iv. Annual Aggregate Deductible shall not reduce the Sum Insured.

For the purpose of this benefit Deductible applicable under this Benefit is Annual Aggregate Deductible. For a claim to become payable, the sum of all admissible claims under the Policy, subject to Policy terms and conditions, in a given Policy Period has to exceed the Aggregate Deductible as mentioned in the Policy Schedule/Certificate of Insurance

SECTION F: HOSPITAL DAILY CASH

During the Hospitalisation of the Insured Person for Medically Necessary treatment required due to an Illness or Injury, We will pay the per day amount / benefit up to maximum number of days as opted and specified in the Policy Schedule/Certificate of Insurance,

Conditions:

i. Our maximum liability to pay the claim under this benefit shall be limited to the limits specified in Policy Schedule/Certificate of Insurance.

ii. The Deductible under this benefit shall be applicable on no. of days of Hospitalization, if opted and as specified in the Policy Schedule/Certificate of Insurance.

iii. The benefit shall become payable only after the completion number of days of Deductible, as opted and specified in the Policy Schedule/Certificate of Insurance.

iv. Benefits under this Section shall be available on an individual basis up to the limits specified in the Policy Schedule/Certificate of Insurance.

v. This cover is available on reimbursement basis only.

Note:

i. It is Condition Precedent if Section 2 is opted under the Policy, then Claim under this benefit shall be payable if we have accepted the claim under Section 2.A.1 (In-patient Care)

ii. This benefit is over and above Sum Insured for Base Cover.

SECTION G: CRITICAL ILLNESS COVER

If an Insured Person is diagnosed with any of the below listed Critical Illness, during the Policy Period, then We will pay the Critical Illness Sum Insured specified in the Policy Schedule/Certificate of Insurance provided that:

i. The Critical Illness must have occurred or has manifested for the first time for that particular Insured Person during the Policy Period, as a first incidence; and

ii. The Insured Person survives a default Survival Period of at least 28 days or as opted and Specified under Policy Schedule/Certificate of Insurance, from the date of Diagnosis of such Critical Illness; and

iii. Upon Our admission of the first claim under this Section, in respect of an Insured Person in any Policy Period, the cover under this benefit shall automatically terminate in respect of that Insured Person;

iv. Irrespective of Individual or Floater Policy, this cover will be available on individual basis.

v. Our total liability for an Insured Person under this Benefit will be limited to the Critical Illness Sum Insured as specified in the Policy Schedule/ Certificate of Insurance

vi. For the purpose of this Policy, Critical Illness means an Illness, sickness or a disease or a corrective measure as specifically defined below, that first commence at least 90 days after the commencement of the Policy Period, or as opted and as Specified in the Policy Schedule/Certificate of Insurance.

STANDARD DEFINITION

1. Cancer of specified severity:

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

The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, premalignant, borderline malignant, low malignant potential, neoplasm of unknown behavior or noninvasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN 2 and CIN-3.

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

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

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Myocardial Infarction (First Heart Attack of specific severity)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins, or other specific biochemical markers

The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. Open Chest CABG

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

The following are excluded:

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

4. Open Heart Replacement Or Repair of Heart Valves

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

5. Coma of Specified Severity

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

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

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

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

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

6. Kidney failure requiring regular dialysis Kidney failure requiring regular dialysis

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

7. Stroke Resulting In Permanent Symptoms

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

The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic Injury of the brain

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

8. Major Organ / Bone Marrow Transplant

The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

9. Permanent Paralysis of Limbs

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

10. Motor Neuron Disease with Permanent Symptoms

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

11. Multiple Sclerosis with Persisting Symptoms

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

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

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

Other causes of neurological damage such as SLE are excluded.

12. Benign Brain Tumor

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

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

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

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

iii. The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitar tumors, tumors of skull bones and tumors of the spinal cord.

13. Blindness

Total, permanent and irreversible loss of all vision in both eyes as a result of Illness or Accident. The Blindness is evidenced by:

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

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

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

14. Deafness

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

15. End Stage Lung Failure

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

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

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

iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and

iv. Dyspnea at rest.

16. End Stage Liver Failure

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

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy. Liver failure secondary to drug or alcohol abuse is excluded.

17. Loss of Speech

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

18. Loss of Limbs

The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of Injury or disease. This will include medically necessary amputation necessitated by Injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self- inflicted Injury, alcohol or drug abuse is excluded

19. Major head Trauma

Accidental head Injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the Accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The Accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

The Accidental Head Injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

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

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

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

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

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

The following is excluded: Spinal cord Injury

20. Primary (Idiopathic) Pulmonary Hypertension

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

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

i. Class III: Marked limitation of physical activity.

Comfortable at rest, but less than ordinary activity causes symptoms.

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

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

21. Third Degree Burns

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

22. Alzheimer's Disease

Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain, characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.

Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a Neurologist and supported by Our appointed Medical Practitioner.

The disease must result in a permanent inability to perform three or more Activities of daily living with Loss of Independent Living" or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days

The following conditions are however not covered:

i. neurosis or neuropsychiatric symptoms without imaging evidence of Alzheimer's Disease;

ii. alcohol related brain damage; and

iii. any other type of irreversible organic disorder/ dementia not associated with Alzheimer's Disease.

The Activities of Daily Living are:

a. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

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

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

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

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

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

23. Parkinson's Disease

The unequivocal diagnosis of progressive degenerative primary idiopathic Parkinson's disease by Neurologist acceptable to us. The diagnosis must be supported by all the following conditions:

i. The disease cannot be controlled with medication; and

ii. Signs of progressive impairment; and Inability of the Insured Person to perform at least 3 of the 6 activities of daily as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means;

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

iii. Transferring: The ability to move from bed to a upright chair or wheelchair and vice versa;

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

v. Feeding: The ability to feed oneself once the food has prepared and made available;

vi. Mobility: The ability to move indoors from room to room on level surfaces.

The following is excluded:

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

24. Aorta Graft Surgery

The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.

The Insured Person understands and agrees that we will not cover:

i. Surgery performed using only minimally invasive or intraarterial techniques.

ii. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.

Aorta graft Surgery benefit covers Surgery to the aorta wherein part of it is removed and replaced with a graft.

25. Amputation of Feet due to Complications from Diabetes

Diabetic neuropathy and vasculitis resulting in the amputation of both feet at or above ankle as advised by a Registered Doctor who is a specialist as the only means to maintain life. Amputation of toe or toes, or any other causes for amputation shall not be covered.

26. Myasthenia Gravis

An acquired autoimmune disorder of neuromuscular transmission leading to fluctuating muscle weakness and fatigability, where all of the following criteria are met:

Presence of permanent muscle weakness categorized as Class IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification given below; and

The Diagnosis of Myasthenia Gravis and categorization are confirmed by a Registered Doctor who is a neurologist.

Myasthenia Gravis Foundation of America Clinical Classification:

Class I: Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere.

Class II: Eye muscle weakness of any severity, mild weakness of other muscles.

Class III: Eye muscle weakness of any severity, moderate weakness of other muscles.

Class IV: Eye muscle weakness of any severity, severe weakness of other muscles.

Class V: Intubation needed to maintain airway.

27. Elephantiasis

Massive swelling in the tissues of the body as a result of destroyed regional lymphatic circulation by chronic filariasis infection. The unequivocal diagnosis of elephantiasis must be confirmed by a Registered Doctor who is a specialist physician. There must be clinical evidence of permanent massive swelling of legs, arms, scrotum, vulva, or breasts. There must also be laboratory confirmation of microfilariae infection.

Swelling or lymphedema caused by infection with a sexually transmitted disease, trauma, post-operative scarring, congestive heart failure, or congenital lymphatic system abnormalities is excluded.

28. Aplastic Anaemia

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

i. Blood product transfusion;

ii. Marrow stimulating Agents;

iii. Immunosuppressive Agents; or

iv. Bone marrow transplantation.

The diagnosis must be confirmed by a haematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following:

i. Absolute neutrophil count of less than 500/mm^3 or

less

ii. Platelets count less than 20,000/mm³ or less

iii. Reticulocyte count of less than 20,000/mm³ or less Temporary or reversible Aplastic Anaemia is excluded.

29. Loss of Independent Existence

The Insured Person is physically incapable of performing at least three (3) of the "Activities of Daily Living" as defined below (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months signifying a permanent and irreversible inability to perform the same.

For the purpose of this definition, the word "permanent" shall mean beyond the hope of recovery with current medical knowledge and technology. The Diagnosis of Loss of Independent Existence must be confirmed by a Registered Doctor.

Insured Person Age between 18 and 74 on first diagnosis is eligible to receive a benefit under this Illness.

Activities of daily living:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means;

ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances; Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

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

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

v. Mobility: The ability to move indoors from room to room on level surfaces.

30. Dissecting Aortic Aneurysm

A condition where the inner lining of the aorta (intima layer) is interrupted so that blood enters the wall of the aorta and separates its layers. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The diagnosis must be made by a Registered Doctor who is a specialist with computed tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiograph (MRA) or angiogram. Emergency surgical repair is required.

31. Progressive Scleroderma

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

The following are excluded:

i. Localized scleroderma (linear scleroderma or morphea)

ii. Eosinophilic fasciitis; and

iii. Crest Syndrome

32. Chronic Adrenal Insufficiency (Addison's Disease)

An autoimmune disorder causing a gradual destruction of the adrenal gland resulting in the need for life long glucocorticoid and mineral corticoid replacement therapy. The disorder must be confirmed by a Registered Doctor who is a specialist in endocrinology through one of the following:

i. ACTH simulation tests;

ii. insulin-induced hypoglycemia test;

iii. plasma ACTH level measurement;

iv. Plasma Renin Activity (PRA) level measurement.

Only autoimmune cause of primary adrenal insufficiency is included. All other causes of adrenal insufficiency are excluded

33. Other Serious Coronary Artery Disease

The narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, as proven by coronary angiography, regardless of whether or not any form of coronary artery intervention or Surgery has been performed.

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery (but not including their branches).

34. Severe Rheumatoid Arthritis

Unequivocal Diagnosis of systemic immune disorder of rheumatoid arthritis where all of the following criteria are met:

i. Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis;

ii. Permanent inability to perform at least two (2) "Activities of Daily Living";

iii. Widespread joint destruction and major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet; and

iv. The foregoing conditions have been present for at least six (6) months.

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

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

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

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

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

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

35. Cardiomyopathy

An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Doctor who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association classification Class IV, or its equivalent, for at least six (6) months based on the following classification criteria:

NYHA Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced.

The Diagnosis of Cardiomyopathy has to be supported by echocardiographic findings of compromised ventricular performance.

Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

36. Infective Endocarditis

Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:

i. Positive result of the blood culture proving presence of the infectious organism(s);

ii. Presence of at least moderate heart valve incompetence (meaning regurgitant fraction of 20% or above) or moderate heart valve stenosis (resulting in heart valve area of 30% or less of normal value) attributable to Infective Endocarditis; and

iii. The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a Registered Doctor who is a cardiologist.

37. Medullary Cystic Disease

Medullary Cystic Disease where the following criteria are met:

i. the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;

ii. clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and

iii. the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

Isolated or benign kidney cysts are specifically excluded from this benefit.

38. Apallic Syndrome

Apallic Syndrome or Persistent vegetative state (PVS) or unresponsive wakefulness syndrome (UWS) is a Universal necrosis of the brain cortex with the brainstem remaining intact. The diagnosis must be confirmed by a Neurologist acceptable to us and the patient should be documented to be in a vegetative state for a minimum of at least one month in order to be classified as UWS, PVS, Apallic Syndrome.

39. Creutzfeldt-Jacob Disease (CJD)

Creutzfeldt-Jacob disease is an incurable brain infection that causes rapidly progressive deterioration of mental function and movement. A Registered Doctor who is a neurologist must make a definite diagnosis of Creutzfeldt-Jacob disease based on clinical assessment, EEG and imaging. There must be objective neurological abnormalities on exam along with severe progressive dementia

40. Ebola

Infection with the Ebola virus where the following conditions are met:

i. Presence of the Ebola virus has been confirmed by laboratory testing;

ii. there are ongoing complications of the infection persisting beyond thirty (30) days from the onset of symptoms; and

iii. the infection does not result in death.

41. Pneumonectomy

The undergoing of Surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic Injury suffered by the life insured. The following conditions are excluded:

a. Removal of a lobe of lungs (lobectomy)

b. Lung resection or incision

42. Brain Surgery

The actual undergoing of Surgery to the brain under general anesthesia during which a craniotomy is performed. Keyhole Surgery is included however, minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolizations, thrombolysis and stereotactic biopsy are all excluded. Brain Surgery as a result of an Accident is also excluded. The procedure must be considered medically necessary by a Registered Doctor who is a qualified specialist.

43. Severe Ulcerative Colitis

Acute fulminant ulcerative colitis with life threatening electrolyte disturbances. All of the following criteria must be met:

i. the entire colon is affected, with severe bloody diarrhoea and

ii. the necessary treatment is total colectomy and ileostomy; and

iii. the diagnosis must be based on histopathological features and confirmed by a Registered Doctor who is a specialist in gastroenterology.

44. Chronic Relapsing Pancreatitis

An unequivocal diagnosis of Chronic Relapsing Pancreatitis, made by a Registered Doctor who is a specialist in gastroenterology and confirmed as a

continuing inflammatory disease of the pancreas characterized by irreversible morphological change and typically causing pain and/or permanent impairment of function. The condition must be confirmed by pancreatic function tests and radiographic and imaging evidence.

Relapsing Pancreatitis caused directly or indirectly, wholly or partly, by alcohol is excluded.

45. Progressive Supranuclear Palsy

Confirmed by a Registered Doctor who is a specialist in neurology of a definite diagnosis of progressive supranuclear palsy. There must be permanent clinical impairment of motor function, eye movement disorder and postural instability.

46. Terminal Illness

The conclusive diagnosis of an Illness, which in the opinion of a Registered Doctor who is an attending Consultant and agreed by our appointed Registered Doctor, life expectancy is no greater than twelve (12) months from the date of Notification of Claim, regardless of any treatment that might be undertaken.

47. Fulminant Hepatitis

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

i. Rapid decreasing of liver size;

ii. Necrosis involving entire lobules, leaving only a collapsed reticular framework;

iii. Rapid deterioration of liver function tests;

iv. Deepening jaundice; and

v. Hepatic encephalopathy.

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

48. Severe Crohn's Disease

Crohn's Disease is a chronic, transmural inflammatory disorder of the bowel. To be considered as severe, there must be evidence of continued inflammation in spite of optimal therapy, with all of the following having occurred:

i. Stricture formation causing intestinal obstruction requiring admission to Hospital, and

ii. Fistula formation between loops of bowel, and

iii. At least one bowel segment resection.

The diagnosis must be made by a Registered Doctor who is a specialist Gastroenterologist and be proven histologically on a pathology report and/or the results of sigmoidoscopy or colonoscopy.

49. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks resulting in permanent inability to perform three or more Activities of daily Living.

This diagnosis must be confirmed by:

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

ii. A consultant neurologist.

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

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

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

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

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

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

50. Loss of One Limb and One Eye

Total, permanent and irrecoverable loss of sight of one eye and loss by severance of one limb at or above the elbow or knee. A loss of sight of one eye must be clinically confirmed by a Registered Doctor who is an eye specialist, and must not be correctable by aides or Surgical Procedures

51. Necrotising Fasciitis

Necrotizing fasciitis is a progressive, rapidly spreading, infection located in the deep fascia causing necrosis of the subcutaneous tissues. An unequivocal diagnosis of necrotizing fasciitis must be made by a Registered Doctor who is a specialist and the diagnosis must be supported with laboratory evidence of the presence of bacteria that is a known cause of necrotizing fasciitis. There must also be widespread destruction of muscle and other soft tissues that results in a total and permanent loss or function of the affected body part.

52. Muscular Dystrophy

A group of hereditary degenerative diseases of muscle characterized by weakness and atrophy of muscle. The diagnosis of muscular dystrophy must be unequivocal and made by a Registered Doctor who is a consultant neurologist. The condition must result in the inability of the Life Insured to perform (whether aided or unaided) at least 3 of the 6 "Activities of Daily Living" for a continuous period of at least 6 months.

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any

braces, artificial limbs or other surgical appliances;

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

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

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

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

53. Hemiplegia

The total and permanent loss of the use of one side of the body through paralysis persisting for a period of at least 6 weeks and with no foreseeable possibility of recovery caused by Illness or Injury, except when such Injury is self-inflicted.

54. Poliomyelitis

The occurrence of Poliomyelitis where the following conditions are met:

i. Poliovirus is identified as the cause,

ii. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months

55. Tuberculosis Meningitis

Meningitis caused by tubercle bacilli, resulting in permanent neurological deficit persisting for at least 180 consecutive days. Such a diagnosis must be confirmed by a Registered Doctor who is a specialist in neurology. Permanent neurological deficit with persisting clinical symptoms means symptoms of dysfunction in the nervous system that are not present on clinical examination and expected to last throughout the lifetime of life insured.

56. Encephalitis

Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection and resulting in permanent neurological deficit. This diagnosis must be certified by a Registered Doctor who is a consultant neurologist and the permanent neurological deficit must be documented for at least 6 weeks. The permanent deficit should result in permanent inability to perform three or more Activities for Daily Living (listed below).

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

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

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

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

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

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

57. Myelofibrosis

A disorder which can cause fibrous tissue to replace the normal bone marrow and results in anaemia, low levels of white blood cells and platelets and enlargement of the spleen. The condition must have progressed to the point that it is permanent and the severity is such that the Life Insured requires a blood transfusion at least monthly.

The diagnosis of myelofibrosis must be supported by bone marrow biopsy and confirmed by a Registered Doctor who is a specialist.

58. Pheochromocytoma

Presence of a neuroendocrine tumour of the adrenal or extra- chromaffin tissue that secretes excess catecholamines requiring the actual undergoing of Surgery to remove the tumour.

The Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who is an endocrinologist.

59. Systemic Lupus Erythematosus with Lupus Nephritis

A multi-system autoimmune disorder characterized by the development of autoantibodies directed against various self- antigens. In respect of this Policy, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V Lupus Nephritis, established by renal biopsy, and in accordance with the WHO Classification). The final diagnosis must be confirmed by a Registered Doctor specializing in Rheumatology and Immunology.

The WHO Classification of Lupus Nephritis: ClassI Minimal Change Lupus Glomerulonephritis Class II Mesangial Lupus Glomerulonephritis Class III Focal Segmental Proliferative Lupus Glomerulonephritis Class IV Diffuse Proliferative Lupus Glomerulonephritis Class V Membranous Lupus Glomerulonephritis

60. Eisenmenger's Syndrome

Development of severe pulmonary hypertension and shunt reversal resulting from heart condition. The diagnosis must be made by a Registered Doctor who is a specialist with echocardiography and cardiac catheterization and supported by the following criteria: i. Mean pulmonary artery pressure > 40 mm Hg; ii. Pulmonary vascular resistance > 3mm/L/min (Wood units); and iii. Normal pulmonary wedge pressure < 15 mm Hg.

SECTION H: PERSONAL ACCIDENT

We will provide the Covers as detailed below and as shown in the Policy Schedule/Certificate of Insurance to be operative for an event or occurrence described below that occurs during the Policy Year. All the Covers under this Section are optional however H.4 Repatriation & Funeral Expenses, 2.5 Child Education,

H.6 Adaptation Allowance (Home & Vehicle), H.7 Ambulance Cover cannot be opted on standalone basis. However, they can be opted in accordance with terms and conditions mentioned within each of these Covers.

The Policy Holder must opt H.1 Accidental Death Cover under this section.

H.1 Accidental Death (AD)

We will pay the Personal Accident Sum Insured, as mentioned in the Policy Schedule/Certificate of Insurance, for any Injury that is caused due to an Accident that immediately or eventually results in Insured Person's loss of life, provided that such loss occurs under the circumstances described in the Policy within 365 Days from the date of the Accident which caused the Injury.

We will pay the Personal Accident Sum Insured less any other amount paid or payable under Permanent Total Disability, Permanent Partial Disability of this Policy, if these coverages are offered under this Policy, as a result of the same Accident.

Exposure: For the purposes of the Accidental Death Cover above, a loss resulting from Insured Person being unavoidably exposed to the elements due to an Accident occurring under the circumstances described in the Policy will be payable as if resulting from an Injury. Loss must occur within 365 days of the date of the Accident.

Specific Exclusions: In addition to the Exclusions listed in this Policy the coverage under this section will not cover any loss caused directly or indirectly, wholly or partly by:

i. Infections (except pyogenic infections which shall occur through an Accidental cut or wound) or any other kind of Disease;

ii. Medical or surgical treatment except as may be necessary solely as a result of Injury.

H.2 Permanent Total Disability (PTD) (Including Loss of Sight and Hearing)

We will pay a percentage of the Personal Accident Sum Insured towards Permanent Total Disability as specified in the Policy Schedule/Certificate of Insurance if Injury to Insured Person results in one of the losses shown in the Table of Losses below. The loss must occur under the circumstances described under the Policy within 365 days from the date of the Accident which caused Injury.

We will pay, provided such disability has continued for a period of 365 days from the date of the Accident which caused Injury and is total, continuous and Permanent at the end of this period, the Personal Accident Sum Insured less any other amount paid or payable under: Permanent Partial Disability Cover, if these coverages are offered under this Policy, as the result of the same Accident.

If more than one loss results from any one Accident, the largest of the amount that becomes payable will be paid.

Table of Losses

Loss of	% of Sum Insured
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
Either Hand or Foot and Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
Either Hand or Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Hearing in One Ear	25%
Thumb and Index Finger of Same Hand	25%

"Loss" with regard to:

i. hand or foot means actual severance through or above the wrist or ankle joints respectively;

ii. eye means entire and irrecoverable loss of sight;

iii. thumb and index finger means actual severance through or above the joint that meets the hand at the palm;

iv. speech or hearing means entire and irrecoverable loss of speech or hearing of both ears;

Exposure:

For the purposes of the Accidental Disability Cover above, a loss resulting from Insured Person being unavoidably exposed to the elements due to an Accident occurring under the circumstances described in a Hazard will be payable as if resulting from an Injury. Loss must occur within 365 Days of the date of the Accident.

Specific Exclusion:

In addition to the Exclusions listed in this Policy this coverage section shall not cover loss caused directly or indirectly, wholly or partly by:

i. Infections (except pyogenic infections which shall occur through an Accidental cut or wound) or any other kind of Disease.

ii. Medical or surgical treatment except as may be necessary solely as a result of Injury.

H.3 Permanent Partial Disability (PPD)

When as the result of Injury occurring during the Policy Period and commencing within 365 Days from the date of the Accident, Insured Person suffer a Permanent Partial Disability, We will pay, provided such disability has continued for a period of 365 days and is continuous and Permanent, at the end of this period, a percentage of the Personal Accident Sum Insured shown in the Policy Schedule if Injury to Insured Person results in one of the losses shown in the Scale below

less any other amount paid or payable under the Accidental Death, or Permanent Total Disability as the result of the same Accident.

Loss of	% of Sum Insured
Loss of toes – all (both feet)	20%
Great toe	5%
Other than great toe, if more than one toe lost, each	1%
Loss of four fingers and thumb of one hand	40%
Loss of four fingers	25%
Loss of thumb	15%
Loss of index finger	10%
Loss of middle finger	6%
Loss of ring finger	5%
Loss of little finger	4%

"Loss" with regard to:

i. Toe, finger, thumb means actual complete severance from the foot or hand;

ii. Hearing means entire and irrecoverable loss of hearing.

When more than one form of disability results from one Accident, We add the percentages from each together. However, We will not pay more than 100% of the Personal Accident Sum Insured shown in the Policy Schedule.

If the Insured Person has an existing medical condition and suffers Injury, We will assess whether the Insured Person's medical condition has contributed to his/her disability; and whether the disability makes the Insured Person's medical condition worse. In either case, We will assess the difference between the Insured Person's medical condition before, and their disability after the Accident. Any payment We make will be based on the difference, expressed as a percentage, and applied to the appropriate Cover above or in the scale.

Specific Exclusion: In addition to the Exclusions listed in this Policy this coverage section shall not cover loss caused directly or indirectly, wholly or partly by:

i. Infections (except pyogenic infections which shall occur through an Accidental cut or wound) or any other kind of Disease.

ii. Medical or surgical treatment except as may be necessary solely as a result of Injury.

H.4 Repatriation & Funeral Expenses

In the event of Accidental Death, We will pay towards the expenses incurred for preparing Insured Person's body for burial or cremation and/or transportation of mortal remains to city of residence, provided

i. We have accepted a claim under H.1 Accidental Death (AD)

ii. We shall provide reimbursement under this Cover up to a limit as specified in the Policy Schedule/ Certificate of Insurance.

iii. The claim payment under this Cover is over and above the Personal Accident Sum Insured.

H.5 Child Education

In the event of Accidental Death or Permanent Total Disability of the Insured Person, We will pay towards the education support of Insured Person's child(ren), to the extent of limit specified in the Policy Schedule/ Certificate of Insurance towards this Cover per child per year, minimum of - till the 25th birthday of Insured Person's child or four continuous years or till the time Insured Person's child ceases to be enrolled in any regular education programme provided we have accepted a claim under H.1 Accidental Death and/ or H.2 Permanent Total Disability. This Cover shall be provided to first and second child who may or may not be an Insured Person under the Policy.

The claim payment under this Cover is over and above the Personal Accident Sum Insured.

H.6 Adaptation Allowance (Home & Vehicle)

If Insured Person is required to modify his/her vehicle or make some changes in his/her house as necessitated by Insured Person's Permanent Total Disability or Permanent Partial Disability which resulted from an Accident covered under this Policy in that case We shall pay for such expenses up to a limit as specified in Policy Schedule/Certificate of Insurance provided We have accepted a Claim either under H.2 Permanent Total Disability and/or H.3 Permanent Partial Disability.

The claim payment under this Cover is over and above the Personal Accident Sum Insured.

H.7 Ambulance Cover

In the event of Accidental Death or Permanent Total Disability or Permanent Partial Disability of the Insured Person, We will indemnify the Insured Person upto the limit specified in the Policy Schedule/Certificate of Insurance towards expenses incurred for availing an Ambulance Service to transfer the Insured Person to a Hospital from the location of Accident or Injury during the Policy Year provided we have accepted a claim under H.1 Accidental Death or H.2 Permanent Total Disability or H.3 Permanent Partial Disability.

SECTION I: WELLNESS CARE

Under this benefit, The Insured Person may avail wellness services as opted. The services may include any or all programs/services intended to maintain, improve, promote health and fitness of the Insured Person. The wellness services offered shall be in compliance to the guidelines issued from IRDAI from time to time.

The Wellness care program includes but not limited to Health Assistance (A.I. Personal Fitness Coaching), Dietician and Nutrition E- consultation, Weight Loss Management Programs etc as provided by our Network Providers.

The Insured can avail the Wellness Care benefits

as specified in the Policy Schedule/Certificate of Insurance,

Condition:

i. The services will be provided through an empanelled Service Provider. It is entirely for the Insured Person to decide whether to obtain these services.

ii. We shall not be responsible for any disputes arising between the Insured Person and the Service Provider.

iii. The services provided under this benefit, does not constitute Medical Advice of any kind and it is not intended to be, and should not be, used to diagnose or identify treatment for a medical or mental health condition.

SECTION NO. 3 WAITING PERIOD AND EXCLUSIONS

The Company is not liable to make any payment under the Policy in connection with or in respect of the following expenses till the expiry of the waiting period and any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or any way attributable to any of the following unless expressly stated to the contrary in this Policy;

A. Waiting Periods

1. Pre-Existing Diseases (Code- Excl01)

a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of number of months (as Specified in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy with insurer.

b) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

c) If the Insured Person is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the Policy after the expiry of number of months (as Specified in Policy Schedule/ Certificate of Insurance) for any Pre-Existing Disease is subject to the same being declared at the time of application and accepted by Us.

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

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of number of months (as Specified in Policy Schedule/Certificate of Insurance) of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident

b) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

c) If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on Portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures

- Cataract
- Benign Prostatic Hypertrophy
- Hysterectomy / myomectomy for menorrhagia or fibromyoma or prolapse of uterus
- Non-infective Arthritis, Treatment of Spondylosis / Spondylitis, Gout & Rheumatism
- Surgery of Genitourinary tract
- Calculus Diseases of any etiology
- Sinusitis and related disorders
- Surgery for prolapsed intervertebral disc unless arising from Accident
- Surgery of varicose veins and varicose ulcer
- Chronic Renal failure including dialysis
- Gastric/ Duodenal Ulcer
- Gout and Rheumatism
- Treatment for joint replacement unless arising from Accident
- Age-related Osteoarthritis & Osteoporosis

3. Initial waiting period- Code- Excl03

a) Expenses related to the treatment of any Illness within 30 days from the first Policy Commencement Date shall be excluded except claims arising due to an Accident, provided the same are covered.

b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

4. Global Cover

A Waiting Period of 0/12/24/36 months (as opted) as specified in Policy Schedule/Certificate of Insurance shall be applicable to all Claims falling under the benefit B.47 Global Cover.

B. Standard Exclusions

1. Investigation & Evaluation- Code- Excl04

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

b) Any diagnostic expenses which are not related or not

incidental to the current diagnosis and treatment are excluded.

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

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

i. Custodial care either at Home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

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

3. Obesity/ Weight Control: Code- Excl06

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

1) Surgery to be conducted is upon the advice of the Doctor

2) The Surgery/Procedure conducted should be supported by clinical protocols

3) The member has to be 18 years of Age or older and

4) Body Mass Index (BMI);

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

4. Change of Gender Treatments (Code- Excl 07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex. However, such exclusion shall not be applicable to respective Insured Person to comply with Transgender Persons (Protection of Rights) Act, 2019.

5. Cosmetic or plastic Surgery: Code- Excl08

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

6. Hazardous or Adventure sports: Code- Excl09

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

7. Breach of law: Code- Excl10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

8. Excluded Providers: Code- Excl11

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

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

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

11.Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure. Code- Excl14

12. Refractive Error: Code- Excl15

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

13. Unproven Treatments: Code- Excl16

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

14. Sterility and Infertility: Code- Excl17

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

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

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

15. Maternity: Code Excl18

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

ii. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the Policy Period.

C. Specific Exclusions

C.1 Specific Exclusion applicable to all Sections

1. Any medical treatment taken outside India, unless otherwise agreed by Us as Specified in the Policy Schedule/Certificate of Insurance.

2. Hospitalization for donation of any body organs by an Insured including complications arising from the donation of organs.
3. Nuclear damage caused by, contributed to, by or arising from ionising radiation or contamination by radioactivity from:

a. any nuclear fuel or from any nuclear waste; or

b. from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission);

c. nuclear weapons material;

d. nuclear equipment or any part of that equipment;

4. 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.
5. Injury or Disease caused by or contributed to by nuclear weapons/materials.
6. Circumcision unless necessary for treatment of a disease, Illness or Injury not excluded hereunder, or, as may be necessitated due to an Accident.
7. Prostheses, corrective devices, medical appliances, external medical equipment of any kind used at Home as post Hospitalization care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition, unless agree by Us and as Specified in the Policy Schedule/Certificate of Insurance.
9. Treatment with alternative medicines like acupuncture, acupressure, osteopath, chiropractic, reflexology and aromatherapy.
10. Intentional self-Injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation o law or participation in an event/activity that is against law with a criminal intent.
11. Vaccination or inoculation except as post bite treatment for animal bite.
12. Convalescence, general debility, "Run-down" condition, rest cure, Congenital external Illness/disease/defect, unless agreed by Us and as Specified in the Policy Schedule/Certificate of Insurance.
14. Outpatient diagnostic, medical and Surgical Procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy, unless agreed by Us and as Specified in the Policy Schedule/ Certificate of Insurance
15. Dental Treatment or Surgery of any kind unless requiring Hospitalisation as a result of accidental Bodily Injury, unless agreed by Us and as Specified in the Policy Schedule/Certificate of Insurance
16. Venereal/ Sexually Transmitted disease other than HIV/ AIDS.
17. Stem cell storage/preservation unless agreed by Us and as Specified in the Policy Schedule/Certificate of Insurance.
18. Any kind of service charge, surcharge levied by the Hospital.
19. Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.
20. Standard list of excluded items as Specified in the Annexure II, unless agreed by Us and as Specified in the Policy Schedule/Certificate of Insurance
21. Any medical procedure or treatment, which is not medically necessary or not performed by a Doctor/ Treating Medical Practitioner.

C.2 Specific Exclusion applicable to Personal Accident

1. Persons serving in any branch of the Military, Navy or Air-force or any branch of Armed Forces or any paramilitary forces except during peace time.
2. Participation in an actual or attempted felony, riot, crime, misdemeanor, or civil commotion.
3. Operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft apart from a Scheduled Airline; or whilst engaged in aviation or ballooning, or whilst mounting into, dismounting from or travelling in any balloon or aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world.
4. Death or disability resulting directly or indirectly, contributed or aggravated or prolonged by childbirth or from pregnancy.

SECTION NO. 4 GENERAL TERMS AND CLAUSES

4.1 Condition Precedent to the contract

4.1 (a). Disclosure of Information

The Policy shall be void and all premiums paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description, or non-disclosure of any Material Fact by the Policyholder.

(Explanation: "Material facts" for the purpose of this Policy shall mean all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk).

4.1 (b) Condition Precedent to Admission of Liability

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

4.1 (c) Withdrawal of the Product

Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as Cumulative Bonus, waiver of Waiting Period as per IRDAI guidelines, provided the Policy has been maintained without a break.

4.1 (d) Premium Payment in Instalment

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

i. Grace Period would be given to pay the instalment premium due for the Policy.

In case of monthly instalment option, a Grace Period of 15 days is applicable. Whereas, in case of Single, Half Yearly, Quarterly instalment options, a Grace Period of 30 days is applicable.

ii. During such Grace Period, coverage will be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. The Insured Person will get the accrued continuity benefit in respect of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Periods for Pre-existing Diseases, Moratorium period etc in the event of payment of premium within the stipulated Grace Period

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

v. In case of instalment premium due not received within the Grace Period, the Policy will get cancelled.

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

vii. The Company has the right to recover and deduct all the pending instalments from the Claim amount due under the Policy.

4.1 (e) Possibility of Revision of terms of the Policy including the Premium Rates

i. The Company, with prior approval of Product Management Committee may revise or modify the terms of the Policy including the premium rates.

ii. Existing Policy will continue to remain in force till its expiry, and revision will be applicable only from the date of next Renewal. Credit of continuity/waiting periods for all the previous Policy Years would be extended in the new Policy on Renewal with Us.

4.1 (f) Nomination

The Policyholder is required at the inception of the Policy to make a nomination for the purpose of payment of Claims under the Policy in the event of death of Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Policyholder, the Company will pay the Nominee (as named in the Policy Schedule) and in case there is no subsisting Nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

4.1 (g) Currency

The monetary limits applicable to this Policy will be in Indian Rupees (INR).

4.1 (h) Premium

The premium payable under this Policy shall be paid in accordance with the schedule of payments in the Policy Schedule agreed between the Policyholder and Us in writing. No receipt for premium shall be valid except on Our official form signed by Our duly authorized official. The due payment of premium and realization thereof by Us and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied ith by the Insured Person shall be a Condition Precedent to Our liability to make any payment under this Policy.

4.1 (g) Territorial Jurisdiction

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

Geographical Coverage/ applicability of each Section (except B.47 Global Cover, H.1 Accidental Death, H.2 Permanent Total Disability, H.3 Permanent Partial Disability, H.4 Repatriation and Funeral Expenses, H.5 Child Education) under this Policy is within the territorial boundaries of India and Claims under the Policy will be paid in accordance with the same.

4.1 (h) Terms and conditions of the Policy

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

4.1 (i) Arbitration clause

i. If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independent of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties thereto, 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 three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two Arbitrators who shall act as the presiding arbitrator and Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996) as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

iii. It is hereby 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 expenses shall be first obtained.

4.2 Condition Applicable During the Contract

4.2 (a) Fraud

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the Hospital/doctor/ any other party acting on behalf of the Insured Person, with intent to deceive the Insurer or to induce the Insurer to issue an Insurance Policy:

i. The suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

ii. The active concealment of a fact by the Insured Person having knowledge or belief of the fact;

iii. Any other act fitted to deceive; and

iv. Any such act or omission as the law specially declares to be fraudulent.

The Company shall not repudiate the Claim and/or forfeit the Policy benefits on the ground of Fraud, if the Insured Person/beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer

4.2 (b) Moratorium Period

After completion of sixty continuous months of coverage (including Portability and Migration) in health insurance Policy, no Policy and Claim shall be contestable by the Insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period.

The moratorium would be applicable for the Sums Insured of the first Policy. Wherever, the Sum Insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of Sums Insured only on the enhanced limits.

4.2 (c) Free Look Period

i. Every Policyholder of new individual health insurance policies except those with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of Policy document, whether received electronically or otherwise, to review the terms and conditions of such Policy.

ii. In the event a Policyholder disagrees to any of the Policy terms or conditions, or otherwise and has not made any Claim, he shall have the option to return the Policy to the Insurer for cancellation, stating the reasons for the same.

iii. Irrespective of the reasons mentioned, the Policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the Insurer on medical examination of the proposer and stamp duty charges.

iv. A request received by Insurer for cancellation of the Policy during free look period shall be processed and premium shall be refunded within 7 days of receipt of such request, as stated at sub regulation (iii) above.

4.2 (d) Addition of Insured during the Policy Period

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

Option of Mid-term inclusion of a person in the Policy as an Insured will be only upon marriage or childbirth (inclusion of child only if less than 1 year of age), additional differential Premium will be calculated on a pro rata basis. Otherwise, child addition can happen only in next enewal or at the start of next Policy Year in multi-year policies.

4.2 (e)Change of Sum Insured

Base Sum Insured or Plan can be changed (increase / decrease) only at the time of Renewal/ or at any time subject to underwriting by the Us. For any increase in Base Sum Insured, the Waiting Period shall start afresh only for the enhance portion of the Sum Insured.

4.2 (f) Notice and Communication

Any notice, direction, instruction, or any other communication related to the Policy should be made in writing.

i. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule/Certificate of Insurance.

ii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the Policy Schedule/Certificate of Insurance.

4.2 (g) Automatic change in Coverage under the Policy

i. The coverage for the Insured Person(s) shall

automatically terminate: In the case of his/ her (Insured Person) demise. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other Insured Persons may also apply to renew the Policy. In case, the other Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardians appointed by court. All relevant particulars in respect of such person (including his/her relationship with the Insured Person) must be submitted to the Company along with the application. Provided no Claim has been made, and termination takes place on account of death of the Insured Person, pro-rata refund of premium of the deceased Insured Person for the balance period of the Policy will be effective.

ii. Upon exhaustion of Sum Insured and Cumulative Bonus, for the Policy year. However, the Policy is subject to Renewal on the due date as per the applicable terms and conditions.

4.2 (h)Alterations in the Policy

The Proposal Form, Certificate, and Policy Schedule constitute the complete contract of insurance. This Policy constitutes the complete contract of insurance between the Policyholder and Us. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed, and stamped by Us. All endorsement requests will be made by the Policy Holder and/or the Insured Person only. This Policy cannot be changed by anyone (including an insurance agent or broker) except Us.

4.2 (i) Implants, Medicines & Medical Devices – Statutory Price Compliance

The liability of the Company towards the cost of medicines, implants, stents, surgical devices or consumables shall be limited to the ceiling prices notified by the National Pharmaceutical Pricing Authority (NPPA) - https://nppa.gov.in/medicaldevices-2 or any other competent statutory authority, wherever applicable, along with applicable taxes. Any amount charged by the Hospital in excess of such notified ceiling prices shall not be payable by the Company.

4.3 Condition When a Claim Arises

Compliance with Policy Provisions Failure by You or the Insured Person to comply with any of the provisions in this Policy shall invalidate all claims hereunder.

4.3 (a) Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a Claim, as the case may be, within 15 days from the date of receipt of Claim intimation.

ii. In case the Claim is not settled within the specified timelines, then the claimant is entitled for interest at bank rate plus 2 percent from the date of receipt of intimation to till the date of payment. Such interest shall be suo-moto paid by the Company.

(Explanation: Bank Rate means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the Claim has fallen due)

4.3 (b) Complete Discharge

Any payment to the Policyholder, Insured Person or his/her Nominees or his/her legal representative or assignee or to the Hospital, as the case maybe, for any benefit under the Policy shall be a valid discharge towards payment of Claim by the Company to the extent of that amount for the particular Claim.

4.3 (c) Multiple Policies (applicable for Indemnity Section only)

i. Indemnity Policies:

A Policyholder can file for Claim settlement as per his/her choice under any Policy. The Insurer of that chosen Policy shall be treated as the primary Insurer.

In case the available coverage under the said Policy is less than the admissible Claim amount, the primary Insurer shall seek the details of other available policies of the Policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the Policy conditions, without causing any hassles to the Policyholder.

ii. Benefit based Policies:

On occurrence of the Insured event, the Policyholders can Claim from all Insurers under all policies.

4.3 (d) Records to be Maintained

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

4.3 (e) Notification of Claim

In the event of any Accidental Injury or Illness or condition which has resulted in a claim or may result in a claim covered under the Policy, the Policy Holder/Insured Person/ Legal Heir must notify Us either at the call center or in writing immediately.

The following details are to be provided to Us at the time of intimation of claim:

i. Policy Number

ii. Name of the Policy Holder

iii. Name of the Insured Person in whose relation the claim is being lodged

iv. Nature of Accident/Injury/Illness

v. Name and Address of the attending Medical Practitioner and Hospital

vi. Date of Accident

vii. Any other information as requested by Us.

4.3 (f) Conditions when a Claim arises

Claims procedure:

If Insured meet with any accidental Bodily Injury or suffer an Illness that may result in a claim, then as a Condition Precedent to Our liability, Insured must comply with the following:

Procedures	Cashless Hospitalization	Reimbursement Claims
Claim Intimation	You shall intimate the Claims to us through any available mode of communication as specified in the Policy, Health Card or our Website.	
Claim Intimation timelines	Within 24 hours of the Emergency Hospitalization At least 72 hours prior to the planned Hospitalization	Within 48 hours of admission or before discharge from the Hospital, whichever is earlier
Particulars to be provided to us for Claim notification	1.Policy Number 2.Name of the Insured Person(s) named in the Policy Schedule / Certificate of Insurance availing treatment, 3.Nature of disease/Illness/Injury, 4.Name and address of the attending Medical Practitioner Hospital 5.Date and time of event if applicable 6. Date of admission	

Procedures	Cashless Hospitalization	Reimbursement Claims
Particulars to be provided for preauthorization	1.Policy Number 2.Name of the Insured Person(s) named in the Policy Schedule availing treatment 3.Nature of disease/Illness/Injury 4.Name and address of the attending 5.Medical Practitioner/ Hospital 6.Date of admission & probable date of discharge 7.Approximate Claim Expenses 8.Treatment Details 9.Claim Form / Pre-Authorization Request form 10. Any other relevant information as required 11. KYC Form and KYC Documents	Not Applicable

Procedures	Cashless Hospitalization	Reimbursement Claims
Process for obtaining Pre-Authorization	I. If the particulars are not provided in full or are insufficient for us to consider the request in Pre- defined Claim Form, We will request additional information or documentation II. On receipt of duly filled pre authorization form from the Network Provider along with other sufficient details to assess the request, We may;· • Issue the authorization letter specifying the sanctioned amount any specific limitation on the • claim and non-payable items, if applicable or Reject the request for preauthorization specifying reasons for the rejection	Not Applicable

Procedures	Cashless Hospitalization	Reimbursement Claims
Procedure for Cashless Claims in case of Home Health Care	On receipt of duly filled pre-authorization form with other sufficient details to assess a cashless request, the Company will inform the Home Healthcare service provider or Network Provider, who will share the care plan and treatment cost estimation with the Company. On receipt of the complete documents the Company may: a. issue the authorization letter specifying the sanctioned amount, any specific limitation on b. the claim and non-payable items, if applicable, or reject the request for pre-authorization specifying reasons for the rejection.	Not Applicable

List of necessary claim documents/information to be submitted for reimbursement claims

- Duly filled and signed claim form
- Certified copy of Hospital discharge Summary
- Certified copy of final Hospital bill, pharmacy bills, Investigation labs bills
- All original reports of Investigations done
- Self-attested Copy of PAN card & masked Aadhar card, photo ID & address Proof of the nominee / beneficiary (Driving license / Passport / Election Card, etc) for address Specified in claim form
- Beneficiary bank account / NEFT details: Cancelled cheque or copy of first page of bank passbook showing

account holder's name, Account number, IFSC code, Branch name etc.

- Certified copy of Death certificate issued by municipal authority (in case of death of insured)
- Any additional documents may be called as required based on the circumstances of the claim.
- Claim documents submission address

All claim related documents need to be sent to below address within 30 days of date of discharge from Hospital. Please do mention appropriate claim number on claim documents dispatched.

Accident & Health claims team

SBI General Insurance Company Limited

9th Floor, Westport, Pan Card Club Road, Baner

Pune, Maharashtra – 411 045

Note:

1. Case specific additional documents may be requested if required for justified Claim decision & processing.
2. The Company at its discretion may revise the list of documents mentioned above.
3. Certified copies of document meaning documents attested by any vested authority (e.g. Notarized Documents, attested from Gazetted officer, SBI Branch Manager, Special Executive officer, any officer who is having authority of attestation of documents).

- Conditions for obtaining Cashless Facility:

i. Cashless Facility can be availed only at Our Network Providers. The complete list of Network Providers and empaneled Service providers are available on Our Website.

ii. We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities at Our sole discretion. The same shall be duly updated on Our website. You shall check the updated list of Network Providers before applying for Cashless Claim.

iii. Pre-authorization is valid for 15 days from date of issuance and if all the details of the Hospitalization/ treatment, including dates, Hospital and locations match with the details as per Cashless authorized.

iv. We will make payment for the Cashless authorized amount directly to the Network Provider.

v. If the claim is not notified to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

- Claim documents submission:

In case of any Claim, the list of documents as Specified above shall be provided by the Policy holder/ Insured Person to Company within 30 days of date of discharge from Hospital.

- Claim Assessment

We will pay fixed amounts as specified in the applicable Sections in accordance with the terms of this Policy.

We are not liable to make any payments that are not specified in the Policy.

- Condonation of delay

If the claim is not notified/ or submitted to Us within the specified time limits, then We shall be provided the

reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to

be for reasons beyond the claimant's control.

4.3 (g) Payment of Claim

i. Claims shall not be admissible under this Policy unless We have been provided with the complete documentation/ information which We have requested to establish its liability for the claim, its circumstances and its quantum unless the Policy Holder/ Insured Person have complied with the obligations under this Policy.

ii. The Sum Insured, if any, of the Insured Person shall be reduced by the amount payable/paid under the Benefit(s) and the balance Sum Insured shall be available for the unexpired Policy Period.

iii. We will pay the Policy Holder/Insured Person or the Nominee/ Legal Heir as the case may be and a discharge by them shall discharge Us of all its liability under the Policy for that claim.

iv. We will only be liable to pay for such Benefits for which the Policy Holder has specifically claimed in the claim form.

v. The maximum liability of Us to pay the claims under the Policy is limited to Sum Insured, Cumulative Bonus (if applicable), Sum Insured Escalation (if applicable) and Reinstatement of Sum Insured (if applicable).

vi. All claims under the Policy shall be payable in Indian currency only.

4.4 Conditions For Renewal of The Contract

4.4 (a) Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company by applying for Migration of the Policy at least 30 days before the Policy Renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Period for Pre-existing Diseases, Moratorium Period etc. in the previous Policy to the Migrated Policy.

For Detailed Guidelines on Migration, kindly refer the link-

https://content.sbigeneral.in/uploads/c6a2844dd65446019b130ffbae1fa20f.pdf

4.4 (b) Portability

The Insured Person will have the option to port the Policy to other Insurers by applying to such Insurer to port the entire Policy along with all the members of the Family, if any, at least 30 days before, but not earlier than 60 days from the Policy Renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance Policy with an Indian General/Health Insurer, the proposed Insured Person is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Period for Pre-existing Diseases, Moratorium Period, etc. from the existing Insurer to the acquiring Insurer in the previous Policy.

For Detailed Guidelines on Portability, kindly refer the link

https://content.sbigeneral.in/uploads/c6a2844dd65446019b130ffbae1fa20f.pdf

4.4 (c) Renewal Conditions:

i. The Policy shall ordinarily be renewable provided the product is not withdrawn, except on grounds of established fraud or non-disclosure or misrepresentation by the Insured Person.

ii. The Company shall endeavor to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.

iii. Renewal shall not be denied on the ground that the Insured Person had made a Claim or Claims in the preceding Policy years.

iv. Request for Renewal along with the requisite premium shall be received by the Company before the end of the Policy Period

v. At the end of the Policy Period, the Policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.

vi. No loading shall apply on Renewals based on individual Claims experience.

4.4 (d) Material Change

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

4.5 Conditions for Cancellation of the Contract

4.5 (a) Cancellation by you:

The Policyholder may cancel his/her Policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall

i. refund proportionate premium for unexpired Policy Period, if the term of Policy upto one year and there is no Claim (s) made during the Policy Period.

ii. refund premium for the unexpired Policy Period, in respect of policies with term more than 1 year and risk coverage for such Policy years has not commenced.

4.5 (b) Cancellation by Us:

We may cancel the Policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the Insured Person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

4.6 Conditions For Grievance Redressal

Stage 1

If you wish to register your grievances directly with us, you may write to us at head.customercare@sbigeneral.in or gro@sbigeneral.in or call our toll free number- 1800 102 1111. After examining the matter, final response would be conveyed within a period of 14 days from the date of receipt of your complaint. In our initial acknowledgement of receipt letter, we will provide the name and title of the person who is handling your Grievance. This person will have the authority necessary to investigate and resolve the Grievance. For Senior Citizens: Senior citizens can reach us through the following dedicated channels: Email: Seniorcitizengrievances@SBIGeneral.in

Toll-Free Number: 1800 102 1111 (Available 24/7)

Details of our Grievance Redressal Officer is mentioned on our website at

https://www.sbigeneral.in/grievance-redressal

Note: The Company shall endeavour to maintain the regulatory TAT of 14 days in resolving your grievances. Alternatively, you may Register your grievance with the regulator through Bima Bharosa which is a grievance redressal platform provided by the Insurance Regulatory and Development Authority of India (IRDAI). You may access the Bima Bharosa Portal using the following link:https://bimabharosa.irdai.gov.in/Home/Home

Stage 2 : Escalation to Insurance Ombudsman

If you feel that the response to your Grievance was unsatisfactory, or if you believe your concerns have not been adequately addressed by the company, you may escalate the matter to the Insurance Ombudsman.

Submit your Grievance online: https://www.cioins.co.in/

Ombudsman We will offer other benefits besides those Specified in Section A,B,C,D,E, F, and G as given below:

- Any Cover / benefit available in expiring Policy as specifically agreed by us to be covered and Specified in

the Policy Schedule/Certificate of Insurance.

- Cover beyond Indian Geographical jurisdiction available in expiring Policy, if specifically agreed by us to be covered and Specified in the Policy Schedule/ Certificate of Insurance.

ANNEXURE I – LIST OF OMBUDSMEN OFFICES

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel. Nos: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh, Chhattisgarh	Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Odhisa	62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh	S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).	Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.	2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry	6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email- Bimalokpal.jaipur@ecoi.co.in

Areas of Jurisdiction	Office of the Insurance Ombudsman
Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.	Shri P.K.Vijayakumar, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, ERNAKULAM-682 015. Tel : 0484-2358759/2359338 Fax : 0484-2359336 Email: bimalokpal.ernakulam@gbic.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands	Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).	3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in.
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email- bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand.	1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email- bimalokpal.patna@ecoi.co.in
Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).	Smt. Ramma Bhasin, Secretary General, Shri Y.R. Raigar, Secretary 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), MUMBAI – 400054 Tel : 022-26106889/6671 Fax : 022-26106949 Email- inscoun@gbic.co.in

The updated details of Insurance Ombudsman are available on IRDA website: www.irdai.gov.in, on the website of General Insurance Council: www.gicouncil.in, our website www.sbigeneral.inss

Source: - CIO (cioins.co.in)

ANNEXURE II – NON-MEDICAL EXPENSES

List 1 - Items for which coverage is not available in the Policy

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS

Sl No	Item
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Char es
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER FOR USAGE OUTSIDE THE HOSPITAL
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOTWEAR
45	KNEE BRACES LONG/ SHORT/ HINGED
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT

Sl No	Item
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS SPECIFIED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List 2- Items that are to be subsumed into Room charges

No.	Item
1	BABY CHARGES UNLESS SPECIFIED/INDICATED
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH-PASTE
13	TOOTH-BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES

No.	Item
23	AIR CONDITIONER CHARGES
24	1M IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/VVARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES NOT EXPLAINED
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List 3- Items that are to be subsumed into Procedure Charges

No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	CAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List 4 - Items that are to be subsumed into costs of treatment

No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALIZATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP- COST
8	HYDROGEN PEROXIDE/SPIRIT/DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer & Strips
18	URINE BAG

ANNEXURE III – INDICATIVE LIST OF DAY CARE PROCEDURES

SR	Procedure Name
1	Coronary Angiography
2	Suturing Oral Mucosa
3	Myringotomy With Grommet Insertion
4	Tymanoplasty (closure Of An Eardrum Perforation reconstruction Of The Auditory Ossicles)
5	Removal Of A Tympanic Drain
6	Keratosis Removal Under Ga
7	Operations On The Turbinates (nasal Concha)
8	Removal Of Keratosis Obturans
9	Stapedotomy To Treat Various Lesions In Middle Ear
10	Revision Of A Stapedectomy
11	Other Operations On The Auditory Ossicles

SR	Procedure Name
12	Myringoplasty (post-aura/endaural Approach As Well As Simple Type-i Tympanoplasty)
13	Fenestration Of The Inner Ear
14	Revision Of A Fenestration Of The Inner Ear
15	Palatoplasty
16	Transoral Incision And DrainAge Of A Pharyngeal Abscess
17	Tonsillectomy Without Adenoidecto-my
18	Tonsillectomy With Adenoidectomy
19	Excision And Destruction Of A Lingual Tonsil
20	Revision Of A Tympanoplasty
21	Other Microsurgical Operations On The Middle Ear
22	Incision Of The Mastoid Process And Middle Ear
23	Mastoidectomy
24	Reconstruction Of The Middle Ear
25	Other Excisions Of The Middle And Inner Ear
26	Incision (opening) And Destruction (elimination) Of The Inner Ear
27	Other Operations On The Middle And Inner Ear
28	Excision And Destruction Of Diseased Tissue Of The Nose
29	Other Operations On The Nose – (other operation of the nose is very broad if any drainAge of local pus will be considered as OPD)
30	Nasal Sinus Aspiration
31	Foreign Body Removal From Nose (if same is removed without using any anesthesia at OPD)
32	Other Operations On The Tonsils And Adenoids
33	Adenoidectomy
34	Labyrinthectomy For Severe Vertigo
35	Stapedectomy Under Ga
36	Stapedectomy Under La
37	Tympanoplasty (Type IV)

SR	Procedure Name
38	Endolymphatic Sac Surgery For Me-niere's Disease
39	Turbinectomy
40	Endoscopic Stapedectomy
41	Incision And DrainAge Of Perichondri-tis
42	Septoplasty
43	Vestibular Nerve Section
44	Thyroplasty Type I
45	Pseudocyst Of The Pinna - Excision
46	Incision And DrainAge - Haematoma Auricle
47	Tympanoplasty (Type II)
48	Reduction Of Fracture Of Nasal Bone
49	Thyroplasty (Type II)
50	Tracheostomy
51	Excision Of Angioma Septum
52	Turbinoplasty
53	Incision & DrainAge Of Retro Pharyn-geal Abscess
54	UvuloPalatoPharyngoPlasty
55	Adenoidectomy With Grommet Inser-tion
56	Adenoidectomy Without Grommet Insertion
57	Vocal Cord Lateralisation Procedure
58	Incision & DrainAge Of Para Pharynge-al Abscess
59	Tracheoplasty
60	Cholecystectomy
61	Choledocho-jejunostomy
62	Duodenostomy
63	Gastrostomy
64	Exploration Common Bile Duct
65	Esophagoscopy.
66	Gastroscopy
67	Duodenoscopy with Polypectomy
68	Removal of Foreign Body
69	Diathery Of Bleeding Lesions
70	Pancreatic PseudocystEus& DrainAge
71	Rf Ablation For Barrett's Oesophagus
72	Ercp And Papillotomy
73	Esophagoscope And Sclerosant Injec-tion

SR	Procedure Name
74	Eus + Submucosal Resection
75	Construction Of Gastrostomy Tube
76	Eus + Aspiration Pancreatic Cyst
77	Small Bowel Endoscopy (therapeutic)
78	Colonoscopy ,lesion Removal –(only for investigation purpose is considered under investigation purpose)
79	ERCP
80	Colonscopy Stenting Of Stricture
81	Percutaneous Endoscopic Gastrostomy
82	Eus And Pancreatic Pseudo Cyst DrainAge
83	ERCP And Choledochoscopy
84	Proctosigmoidoscopy Volvulus Detorsion
85	ERCP And Sphincterotomy
86	EsophAgeal Stent Placement
87	ERCP + Placement Of Biliary Stents
88	Sigmoidoscopy W / Stent
89	Eus + Coeliac Node Biopsy
90	UgiScopy And Injection Of Adrenaline, Sclerosants Bleeding Ulcers
91	Incision Of A Pilonidal Sinus / Abscess
92	Fissure In AnoSphincterotomy
93	Surgical Treatment Of A Varicocele And A Hydrocele Of the Spermatic Cord
94	Orchidopexy
95	Abdominal Exploration In Cryptorchidism
96	Surgical Treatment Of Anal Fistulas
97	Division Of The Anal Sphincter (sphincterotomy)
98	Epididymectomy
99	Incision Of The Breast Abscess
100	Operations On The Nipple
101	Excision Of Single Breast Lump
102	Incision And Excision Of Tissue In The Perianal Region
103	Surgical Treatment Of Hemorrhoids
104	Other Operations On The Anus
105	Ultrasound Guided Aspirations
106	Sclerotherapy, Etc

SR	Procedure Name
107	Laparotomy For Grading Lymphoma With Splenectomy.
108	Laparotomy For Grading Lymphoma with Liver Biopsy
109	Laparotomy For Grading Lymphoma with Lymph Node Biopsy
110	Therapeutic Laparoscopy With Laser
111	Appendicectomy With DrainAge
112	Appendicectomy without DrainAge
113	Infected Keloid Excision
114	Axillary Lymphadenectomy
115	Wound Debridement And Cover
116	Abscess-decompression
117	Cervical Lymphadenectomy
118	Infected Sebaceous Cyst
119	Inguinal Lymphadenectomy
120	Infected Lipoma Excision
121	Maximal Anal Dilatation
122	Piles
123	A) Injection Sclerotherapy
124	B) Piles Banding
125	Liver Abscess- Catheter DrainAge
126	Fissure In Ano- Fissurectomy
127	Fibroadenoma Breast Excision
128	OesophAgealVaricesSclerotherapy
129	ERCP - Pancreatic Duct Stone Removal
130	Perianal Abscess I&d
131	Perianal Hematoma Evacuation
132	UgiScopy And PolypectomyOesophagus
133	Breast Abscess I& D
134	Feeding Gastrostomy
135	Oesophagoscopy And Biopsy Of Growth Oesophagus
136	ERCP - Bile Duct Stone Removal
137	Ileostomy Closure
138	Polypectomy Colon
139	Splenic Abscesses Laparoscopic DrainAge
140	UgiScopy And Polypectomy Stomach
141	Rigid Oesophagoscopy For Fb Removal
142	Feeding Jejunostomy
143	Colostomy

SR	Procedure Name
144	Ileostomy
145	Colostomy Closure
146	Submandibular Salivary Duct Stone Removal –
147	Pneumatic Reduction Of Intussusception
148	Varicose Veins Legs - Injection Sclerotherapy
149	Rigid Oesophagoscopy For Plummer Vinson Syndrome
150	Pancreatic Pseudocysts Endoscopic DrainAge
151	Zadek's Nail Bed Excision
152	Subcutaneous Mastectomy
153	Excision Of Ranula Under Ga
154	Rigid Oesophagoscopy For Dilation Of Benign Strictures
155	Eversion Of Sac
156	Unilateral
157	Bilateral
158	Lord's Plication
159	Jaboulay's Procedure
160	Scrotoplasty
161	Circumcision For Trauma
162	Meatoplasty
163	Intersphincteric Abscess Incision And DrainAge
164	Psoas Abscess Incision And DrainAge
165	Thyroid Abscess Incision And DrainAge
166	Tips Procedure For Portal Hypertension
167	EsophAgeal Growth Stent
168	Pair Procedure Of Hydatid Cyst Liver
169	Tru Cut Liver Biopsy
170	Photodynamic Therapy Or EsophAgeal Tumour And Lung Tumour
171	Excision Of Cervical Rib
172	Laparoscopic Reduction Of Intussusception
173	Microdochectomy Breast
174	Surgery For Fracture Penis
175	Parastomal Hernia
176	Revision Colostomy

SR	Procedure Name
177	Prolapsed Colostomy- Correction
178	Laparoscopic Cardiomyotomy(Hellers)
179	Laparoscopic Pyloromyotomy(Ramstedt)
180	Operations On Bartholin's Glands (cyst)
181	Incision Of The Ovary
182	Insufflations Of The Fallopian Tubes
183	Other Operations On The Fallopian Tube
184	Conisation Of The Uterine Cervix
185	Therapeutic CurettAge With Colposcopy.
186	Therapeutic CurettAge With Biopsy
187	Therapeutic CurettAge With Diathermy
188	Therapeutic CurettAge With CryoSurgery
189	Laser Therapy Of Cervix For Various Lesions Of Uterus
190	Other Operations On The Uterine Cervix
191	Incision Of The Uterus (hysterectomy)
192	Local Excision And Destruction Of Diseased Tissue Of The Vagina And The Pouch Of Douglas
193	Incision Of Vagina
194	Incision Of Vulva
195	Culdotomy
196	Salpingo-oophorectomy Via Laparotomy
197	Endoscopic Polypectomy
198	Hysteroscopic Removal Of Myoma
199	D&C –
200	Hysteroscopic Resection Of Septum
201	Thermal Cauterisation Of Cervix
202	Hysteroscopic Adhesiolysis
203	Polypectomy Endometrium
204	Hysteroscopic Resection Of Fibroid
205	Lletz
206	Conization
207	Polypectomy Cervix

SR	Procedure Name
208	Hysteroscopic Resection Of Endometrial Polyp
209	Vulval Wart Excision
210	Laparoscopic Paraovarian Cyst Excision
211	Uterine Artery Embolization
212	Laparoscopic Cystectomy
213	Hymenectomy (Imperforate Hymen)
214	Endometrial Ablation
215	Vaginal Wall Cyst Excision
216	Vulval Cyst Excision
217	Laparoscopic Paratubal Cyst Excision
218	Repair of Vagina (Vaginal Atresia)
219	Hysteroscopy, Removal Of Myoma
220	Turbt
221	Ureterocoele Repair - Congenital Internal
222	Vaginal Mesh For Pop
223	Laparoscopic Myomectomy
224	Surgery For Sui
225	Repair Recto- Vagina Fistula
226	Pelvic Floor Repair (Excluding Fistula Repair)
227	URS + LL
228	Laparoscopic Oophorectomy
229	Percutaneous Cordotomy
230	Intrathecal Baclofen Therapy
231	Entrapment Neuropathy Release
232	Diagnostic Cerebral Angiography
233	Vp Shunt
234	Ventriculoatrial Shunt
235	Radiotherapy For Cancer
236	Cancer Chemotherapy
237	IV Push Chemotherapy
238	HBI - Hemibody Radiotherapy
239	Infusional Targeted Therapy
240	SRT - Stereotactic Arc Therapy
241	Sc Administration Of Growth Factors
242	Continuous Infusional Chemotherapy
243	Infusional Chemotherapy
244	CCRT - Concurrent Chemo + Rt
245	2D Radiotherapy
246	3D Conformal Radiotherapy

SR	Procedure Name
247	IGRT - ImAge Guided Radiotherapy
248	IMRT - Step & Shoot
249	IMRT – DMLC
250	Rotational Arc Therapy
251	Tele Gamma Therapy
252	FSRT - Fractionated Srt
253	VMAT - Volumetric Modulated Arc Therapy
254	SBRT - Stereotactic Body Radiotherapy
255	Helical Tomotherapy
256	SRS - Stereotactic RadioSurgery
257	X - Knife Srs
258	GammaknifeSrs
259	TBI - Total Body Radiotherapy
260	Intraluminal Brachytherapy
261	TSET - Total Electron Skin Therapy
262	Extracorporeal Irradiation Of Blood Products
263	Telecobalt Therapy
264	Teleseism Therapy
265	External Mould Brachytherapy
266	Interstitial Brachytherapy
267	Intracavity Brachytherapy
268	3D Brachytherapy
269	Implant Brachytherapy
SR	Procedure Name
270	Intravesical Brachytherapy
271	Adjuvant Radiotherapy
272	After loading Catheter Brachytherapy
273	Conditioning Radiothearpy For Bmt
274	Extracorporeal Irradiation To The Homologous Bone Grafts
275	Radical Chemotherapy
276	Neoadjuvant Radiotherapy
277	LDR Brachytherapy
278	Palliative Radiotherapy
279	Radical Radiotherapy
280	Palliative Chemotherapy
281	Template Brachytherapy
282	Neoadjuvant Chemotherapy
283	Induction Chemotherapy
284	Consolidation Chemotherapy

SR	Procedure Name
285	Maintenance Chemotherapy
286	HDR Brachytherapy
287	Incision And Lancing Of A Salivary Gland And A Salivary Duct
288	Excision Of Diseased Tissue Of A Salivary Gland And A Salivary Duct
289	Resection Of A Salivary Gland
290	Reconstruction Of A Salivary Gland And A Salivary Duct
291	Other Operations On The Salivary Glands And Salivary Ducts
292	Other Incisions Of The Skin And Subcutaneous Tissues
293	Surgical Wound Toilet (wound Debridement) And Removal Of Diseased Tissue Of The Skin And Subcutaneous Tissues
294	Local Excision Of Diseased Tissue Of The Skin And Subcutaneous Tissues
295	Other Excisions Of The Skin And Subcutaneous Tissues
296	Simple Restoration Of Surface Continuity Of The Skin And Subcutaneous Tissues
297	Free Skin Transplantation, Donor Site
298	Free Skin Transplantation, Recipient Site
299	Revision Of Skin Plasty
300	Other Restoration And Reconstruction Of The Skin And Subcutaneous Tissues
301	ChemoSurgery To The Skin
302	Destruction Of Diseased Tissue In The Skin And Subcutaneous Tissues
303	Reconstruction Of Deformity/defect In Nail Bed
304	Excision Of Bursirtis
305	Tennis Elbow Release
306	Incision, Excision And Destruction Of Diseased Tissue Of The Tongue
307	Partial Glossectomy
308	Glossectomy
309	Reconstruction Of The Tongue
310	Other Operations On The Tongue

SR	Procedure Name
311	Surgery For Cataract
312	Incision Of Tear Glands
313	Other Operations On The Tear Ducts
314	Incision Of Diseased Eyelids
315	Excision And Destruction Of Diseased Tissue Of The Eyelid
316	Operations On The Canthus And Epicanthus
317	Corrective Surgery For Entropion And Ectropion
318	Corrective Surgery For Blepharoptosis
319	Removal Of A Foreign Body From The Conjunctiva
320	Removal Of A Foreign Body From The Cornea
321	Incision Of The Cornea
322	Operations For Pterygium
323	Other Operations On The Cornea
324	Removal Of A Foreign Body From The Lens Of The Eye
325	Removal Of A Foreign Body From The Posterior Chamber Of The Eye
326	Removal Of A Foreign Body From The Orbit And Eyeball
327	Correction Of Eyelid Ptosis By LevatorPalpebraeSuperioris Resection (bilateral)
328	Correction Of Eyelid Ptosis By Fascia Lata Graft (bilateral)
329	Diathermy/cryotherapy To Treat Retinal Tear
330	Anterior Chamber Paracentesis.
331	Anterior Chamber Cyclodiathermy
332	Anterior Chamber Cyclocyrotherapy
333	Anterior Chamber Goniotomy
334	Anterior Chamber Trabeculotomy
335	Anterior Chamber Filtering
336	Allied Operations to Treat Glaucoma
337	Enucleation Of Eye Without Implant
338	Dacryocystorhinostomy For Various Lesions Of Lacrimal Gland
339	Laser Photocoagulation To Treat Retinal Tear
340	Biopsy Of Tear Gland

SR	Procedure Name
341	Treatment Of Retinal Lesion
342	Surgery For Meniscus Tear
343	Incision On Bone, Septic And Aseptic
344	Closed Reduction On Fracture, Luxation Or Epiphyseolysis With Osteosynthesis
345	Suture And Other Operations On Tendons And Tendon Sheath
346	Reduction Of Dislocation Under Ga
347	Arthroscopic Knee Aspiration
348	Surgery For Ligament Tear
349	Surgery For Hemoarthrosis/pyoarthrosis
350	Removal Of Fracture Pins/nails
351	Removal Of Metal Wire
352	Closed Reduction On Fracture, Luxation
353	Reduction Of Dislocation Under Ga
354	Epiphyseolysis With Osteosynthesis
355	Excision Of Various Lesions In Coccyx
356	Arthroscopic Repair Of Acl Tear Knee
357	Arthroscopic Repair Of Pcl Tear Knee
358	Tendon Shortening
359	Arthroscopic Meniscectomy - Knee
360	Treatment Of Clavicle Dislocation
361	Haemarthrosis Knee- LavAge
362	Abscess Knee Joint DrainAge
363	Carpal Tunnel Release
364	Closed Reduction Of Minor Dislocation
365	Repair Of Knee Cap Tendon
366	Orif With K Wire Fixation- Small Bones
367	Release Of Midfoot Joint
368	Orif With Plating- Small Long Bones
369	Implant Removal Minor
370	Closed Reduction And External Fixation
371	Arthrotomy Hip Joint
372	Syme's Amputation
373	Arthroplasty
374	Partial Removal Of Rib
375	Treatment Of Sesamoid Bone Fracture
376	Shoulder Arthroscopy / Surgery

SR	Procedure Name
377	Elbow Arthroscopy
378	Amputation Of Metacarpal Bone
379	Release Of Thumb Contracture
380	Incision Of Foot Fascia
381	Partial Removal Of Metatarsal
382	Repair / Graft Of Foot Tendon
383	Revision/removal Of Knee Cap
384	Exploration Of Ankle Joint
385	Remove/graft Leg Bone Lesion
386	Repair/graft Achilles Tendon
387	Remove Of Tissue Expander
388	Biopsy Elbow Joint Lining
389	Removal Of Wrist Prosthesis
390	Biopsy Finger Joint Lining
391	Tendon Lengthening
392	Treatment Of Shoulder Dislocation
393	Lengthening Of Hand Tendon
394	Removal Of Elbow Bursa
395	Fixation Of Knee Joint
396	Treatment Of Foot Dislocation
397	Surgery Of Bunion
398	Tendon Transfer Procedure
399	Removal Of Knee Cap Bursa
400	Treatment Of Fracture Of Ulna
401	Treatment Of Scapula Fracture
402	Removal Of Tumor Of Arm Under GA
403	Removal of Tumor of Arm under RA
404	Removal of Tumor Of Elbow Under GA
405	Removal of Tumor Of Elbow Under RA
406	Repair Of Ruptured Tendon
407	Decompress Forearm Space
408	Revision Of Neck Muscle (torticollis Release)
409	Lengthening Of Thigh Tendons
410	Treatment Fracture Of Radius & Ulna
411	Repair Of Knee Joint
412	External Incision And DrainAge In The Region Of The Mouth.
413	External Incision And DrainAge in the Region Of the Jaw.
414	External Incision And DrainAge in the Region Of the Face.

SR	Procedure Name
415	Incision Of The Hard And Soft Palate
416	Excision And Destruction Of Diseased Hard Palate
417	Excision And Destruction of Diseased Soft Palate
418	Incision, Excision And Destruction In The Mouth
419	Other Operations In The Mouth
420	Excision Of Fistula-in-ano
421	Excision Juvenile Polyps Rectum
422	Vaginoplasty
423	Dilatation Of Accidental Caustic Stricture OesophAgeal
424	Presacral Teratomas Excision
425	Removal Of Vesical Stone
426	Excision Sigmoid Polyp
427	Sternomastoid Tenotomy
428	Infantile Hypertrophic Pyloric Stenosis Pyloromyotomy
429	Excision Of Soft Tissue Rhabdomyosarcoma
430	High Orchidectomy For Testis Tumours
431	Excision Of Cervical Teratoma
432	Rectal-myomectomy
433	Rectal Prolapse (delorme's Procedure)
434	Detorsion Of Torsion Testis
435	Eua + Biopsy Multiple Fistula In Ano
436	Construction Skin Pedicle Flap
437	Gluteal Pressure Ulcer-excision
438	Muscle-skin Graft, Leg
439	Removal Of Bone For Graft
440	Muscle-skin Graft Duct Fistula
441	Removal CartilAge Graft
442	Myocutaneous Flap
443	Fibro Myocutaneous Flap
444	Breast Reconstruction Surgery After Mastectomy
445	Sling Operation For Facial Palsy
446	Split Skin Grafting Under Ra
447	Wolfe Skin Graft
448	Plastic Surgery To The Floor Of The Mouth Under Ga

SR	Procedure Name
449	Thoracoscopy And Lung Biopsy
450	Excision Of Cervical Sympathetic Chain Thoracoscopic
451	Laser Ablation Of Barrett's Oesophagus
452	Pleurodesis
453	Thoracoscopy And Pleural Biopsy
454	Ebus + Biopsy
455	Thoracoscopy Ligation Thoracic Duct
456	Thoracoscopy Assisted Empyema DrainAge
457	Haemodialysis
458	Lithotripsy/nephrolithotomy For Renal Calculus
459	Excision Of Renal Cyst
460	DrainAge Of Pyonephrosis Abscess
461	DrainAge Of Perinephric Abscess
462	Incision Of The Prostate
463	Transurethral Excision And Destruction Of Prostate Tissue
464	Transurethral And Percutaneous Destruction Of Prostate Tissue
465	Open Surgical Excision And Destruction Of Prostate Tissue
466	Radical Prostatovesiculectomy
467	Other Excision And Destruction Of Prostate Tissue
468	Operations On The Seminal Vesicles
469	Incision And Excision Of Periprostatic Tissue
470	Other Operations On The Prostate
471	Incision Of The Scrotum And Tunica Vaginalis Testis
472	Operation On A Testicular Hydrocele
473	Excision And Destruction Of Diseased Scrotal Tissue
474	Other Operations On The Scrotum And Tunica Vaginalis Testis
475	Incision Of The Testes
476	Excision And Destruction Of Diseased Tissue Of The Testes
477	Unilateral Orchidectomy
478	Bilateral Orchidectomy

SR	Procedure Name
479	Surgical Repositioning Of An Abdominal Testis
480	Reconstruction Of The Testis
481	Implantation, Exchange And Removal Of A Testicular Prosthesis
482	Other Operations On The Testis
483	Excision In The Area Of The Epididymis
484	Operations On The Foreskin
485	Local Excision And Destruction Of Diseased Tissue Of The Penis
486	Amputation Of The Penis
487	Other Operations On The Penis
488	Cystoscopical Removal Of Stones
489	Lithotripsy
490	Biopsy Oftemporal Artery For Various Lesions
491	External Arterio-venous Shunt
492	Av Fistula - Wrist
493	Ursl With Stenting
494	Ursl With Lithotripsy
495	CystoscopicLitholapaxy
496	Eswl
497	Bladder Neck Incision
498	Cystoscopy & Biopsy
499	Cystoscopy And Removal Of Polyp
500	SuprapubicCystostomy
501	Percutaneous Nephrostomy
502	Cystoscopy And "sling" Procedure
503	Tuna- Prostate
504	Excision Of Urethral Diverticulum
505	Removal Of Urethral Stone
506	Excision Of Urethral Prolapse
507	Mega-ureter Reconstruction
508	Kidney Renoscopy And Biopsy
509	Ureter Endoscopy And Treatment
510	Vesical Ureteric Reflux Correction
511	Surgery For Pelvic Ureteric Junction Obstruction
512	Anderson Hynes Operation
513	Kidney Endoscopy And Biopsy
514	Paraphimosis Surgery

SR	Procedure Name
515	Injury Prepuce- Circumcision
516	Frenula Tear Repair
517	Meatotomy For Meatal Stenosis
518	Surgery For Fournier's Gangrene Scrotum
519	Surgery Filarial Scrotum
520	Surgery For Watering Can Perineum
521	Repair Of Penile Torsion
522	DrainAge Of Prostate Abscess
523	Orchiectomy
524	Cystoscopy And Removal Of Fb
525	RF Ablation Heart
526	RF Ablation Uterus
527	RF Ablation Varicose Veins
528	Percutaneous nephrolithotomy (PCNL)
529	Laryngoscopy Direct Operative with Biopsy
530	Treatment of Fracture of Long Bones
531	Treatment of Fracture of Short Bones
532	Treatment of Fracture of Foot
533	Treatment of Fracture of Hand
534	Treatment of Fracture of Wrist
535	Treatment of Fracture of Ankle
536	Treatment of Fracture of Clavicle
537	Chalazion Surgery

The list of Day Care Treatment is an indicative list and any other treatment which may get included in future shall be covered by the virtue of standard definition of "Day Care Treatment"