THE ORIENTAL INSURANCE COMPANY LIMITED
Regd. Office: Oriental House, A-25/27, Asaf Ali Road, New Delhi-110002.
CIN No.U66010DL1947GOI007158

# ORIENTAL SAMPOORNA SWASTHYA SURAKSHA

**WE VALUE YOUR HEALTH & YOUR WEALTH. BUILD A PRODUCTIVE NATION**

## POLICY WORDINGS

WHEREAS the insured named in the Schedule hereto has by a proposal and declaration (which shall be the basis of this Contract and is deemed to be incorporated herein) has applied to THE ORIENTALINSURANCE COMPANY LIMITED (hereinafter called the Company) for the insurance hereinafter set forth in respect of person(s) named in the Schedule hereto (herein after called the INSURED PERSON(S)and has paid premium to the Company as consideration for such insurance to be serviced by Third Party Administrator (herein after called the TPA)or the Company as the case may be.

## 1. PREAMBLE

Now this Policy witnesses that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the Company undertakes that, if during the period of insurance stated in the Schedule any Insured Person(s) shall contract or suffer from any Illness / ailment

/ disease (hereinafter called 'DISEASE') or sustain any bodily Injury through accident (hereinafter called 'INJURY') and if such disease or Injury shall require any such Insured Person(s) upon the advice of a duly qualified Physician /Medical Specialist/Medical Practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called 'SURGEON') to incur expenses on (a) Hospitalization(as defined hereinafter) for medical/surgical treatment at any Nursing Home/Hospital in India as herein defined (hereinafter called 'HOSPITAL') as an In-patient OR (b) on Domiciliary treatment in India under Domiciliary Hospitalization Benefits as hereinafter defined, the Company/TPA will pay to the Hospital(s) (only if treatment is taken at Network Hospital(s) with prior written approval of Company / TPA) or reimburse to the Insured Person, as the case may be, the amount of such admissible expenses as specified hereunder. It is a condition precedent that the expenses incurred in respect of medically necessary treatment, are reasonable and customary; and in any case, the liability of the Company, in respect of one or all the Insured Persons stated in the schedule, shall be up to the limit specified in the Policy and/or schedule of the Policy, but not exceeding the Sum Insured as stated in the schedule, for all claims arising during the Policy Period mentioned in the schedule.

## 2. DEFINITIONS
### STANDARD DEFINITIONS

**2.1 ACCIDENT** is a sudden, unforeseen, and involuntary event caused by external, visible, and violent means.

**2.2 AMBULANCE SERVICES** means ambulance service charges reasonably and necessarily incurred in shifting the Insured Person from residence to Hospital for admission in the

emergency ward / ICU or from one Hospital / Nursing Home to another Hospital / Nursing Home, by registered ambulance only. The ambulance service charges are payable only if the Hospitalization expenses are admissible under the Policy.

**2.3 ANY ONE ILLNESS** Any one illness means a 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.

**2.4 CASHLESS FACILITY** 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.

**2.5 CONGENITAL ANOMALY** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure, or position.

A. Internal Congenital Anomaly which is not in the visible and accessible parts of the body.
B. External Congenital Anomaly which is in the visible and accessible parts of the body.

**2.6 CONDITION PRECEDENT** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

**2.7 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.

**2.8 CONTRIBUTION** is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rate able proportion of the Sum Insured. If two or more policies are taken by the insured during a period from one or more insurers, the contribution clause shall not be applicable where the cover/benefit offered:

A. is fixed in nature;
B. does not have any relation to the treatment costs;

**2.9 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 the supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under: -

A. has qualified nursing staff under its employment;
B. has qualified medical practitioner/s in charge;
C. has a fully equipped operation theatre of its own where surgical procedures are carried out;
D. Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

**2.10 DAY CARE TREATMENT** means medical treatment, and/or surgical procedure which is:

A. Undertaken under General or Local Anesthesia in a hospital/daycare center in less than 24 hrs. because Of technological advancement, and
B. Which would have otherwise required hospitalization of more than 24 hours. Treatment normally taken on an outpatient basis is not included in the scope of this definition. (Insurers may, in addition, restrict coverage to a specified list)

**2.11 DENTAL TREATMENT** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

**2.12 DOMICILIARYHOSPITALISATION**meansmedicaltreatmentforanillness/disease/injurywhichi n the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

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

**2.13 HOME CARE TREATMENT** means receiving medical treatment at home that would normally require hospitalization, but is instead provided at home under specific conditions. These conditions include a medical practitioner's recommendation for home treatment, continuous monitoring of the patient's health status by a medical professional, and a daily monitoring chart maintained by the treating practitioner.

**2.14 FAMILY** consists of the Insured and/or anyone or more of the family members as per the table mentioned below:

A. Legally wedded spouse.
B. Dependent Children (i.e. natural or legally adopted) between the ages of day one to 18 years. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals. Physical Dependent disabled child without any age limit
C. Parents /Parents-in-law
D. Unmarried dependent siblings, (brothers up to 25 years of age, and sisters including divorced or widowed).
E. Grandparents/ Grandparents in law

**2.15 GRACE PERIOD** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as sum insured, No Claim Bonus, Specific waiting periods, coverage of pre-existing diseases and Moratorium period, etc.

Grace Period for payment of premium:

a) The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium.
b) If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.

Availability of insurance coverage during grace period:

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

**2.16 FLOATER OPTION** means that a single Sum Insured is available for use by any or all insured family members covered under the policy.

**2.17 FLOATER-FLOATER OPTION** This option allows multiple floater groups, each with its own separate Sum Insured, to be covered under a single policy. Each floater group should have minimum of 2 members. For example, a policyholder may opt for a floater cover of ₹10 lakhs for self and spouse, and an additional floater cover of ₹5 lakhs for the children—both included within the same policy. For each floater group, the benefits payable will be limited to the respective Sum Insured chosen for that group, and the applicable policy terms and conditions will apply separately to each group.

**2.18 HOSPITAL/NURSING HOME** A hospital means any institution established for in-patient care and daycare treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act Or complies with all minimum criteria as under:

A. has qualified nursing staff under its employment round the clock;
B. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least15in-patient beds in all other places;
C. has qualified medical practitioner(s) in charge round the clock;
D. has a fully equipped operation theatre of its own where surgical procedures are carried out;
E. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

*Following are the enactments specified under the schedule of Section 56 of Clinical Establishment (Registration and Regulation) Act, 2010 as of October 2013. Please refer to the Act for amendments, if any:

- The Andhra Pradesh Private Medical Care Establishments(Registration and Regulations)Act,2002
- The Bombay Nursing Homes Registration Act, 1949
- The Delhi Nursing Home RegistrationAct,1953
- The Madhya Pradesh Upcharya Griha Tatha Rujopchar Sanbadhu Sthapamaue (RagistrikaranTathaAnugyapan) Adhiniyam, 1973.
- TheManipurHomesandClinicsRegistrationAct,1992
- TheNagalandHealthCareEstablishmentsAct,1997
- The Orissa Clinical Establishments (Control and Regulations) Act, 1990
- The Punjab State Nursing Home Registration Act, 1991
- The West Bengal Clinical Establishment Act,1950

**2.19 AYUSH HOSPITAL** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practioner (s) comprising of any of the following:

A. Central or State Government AYUSH Hospital; or
B. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/Central Council for Homeopathy ;or
C. AYUSH Hospital, standalone or co-located with an in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
   i. Having at least five in-patient beds;
   ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
   iii. Having dedicated AYUSH therapy sections as required and/or having equipped operation theatre where surgical procedures are to be carried out;
   iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

**2.20 AYUSH DAY CARE CENTRE** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic, or any such health center which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without inpatient services and must comply with all the following criterion:

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

b. Having dedicated AYUSH therapy sections as required and/or having equipped operation theatre where surgical procedures are to be carried out;
c. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

**2.21 HOSPITALISATION** 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 24consecutivehours.

**2.22 INSURED PERSON** means person(s) named as Insured Person(s) in the schedule of the Policy.

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

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

**2.24 I.D. CARD** means the card issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital.

**2.25 INDIVIDUAL OPTION** under this option, each insured member is covered with a separate Sum Insured. For example, if multiple family members are covered under the same policy, each person will have their own individual Sum Insured, which cannot be shared with others. For each member, the benefits payable will be limited to the individual Sum Insured selected for them, and will be governed by the policy terms and conditions applicable to that chosen Sum Insured.

**2.26 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.

**2.27 INTENSIVE CARE UNIT** means an identified section, ward, or wing of a hospital that 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.

**2.28 IN-PATIENT** means an Insured Person who is admitted to the Hospital and stays for at least 24 hours for the sole purpose of receiving treatment for suffered ailment / Illness/disease / Injury/accident during the currency of the Policy.

**2.29 IN-PATIENT CARE** means treatment for which the Insured Person has to stay in a Hospital formorethan24 hours for a covered event.

**2.30 ICU (INTENSIVE CARE UNIT) CHARGES** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices ,critical care nursing, and intensivist charges.

**2.31 MATERNITYEXPENSES** shall include

A. Medical treatment expenses traceable to childbirth (including complicated deliveries and cesarean sections)incurred during Hospitalization
B. Expenses towards lawful medical termination of pregnancy during the Policy Period.

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

**2.33 MEDICAL EXPENSES** 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.

**2.34 MEDICAL PRACTITIONER** 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; is acting within its scope and jurisdiction of license.

**2.35 MEDICALLY NECESSARY TREATMENT** means any treatment, tests, medication, or stay in hospital or part of a staying hospital which:

A. is required for the medical management of the illness or injury suffered by the insured;
B. must not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity;
C. must have been prescribed by medical practitioner;
D. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

**2.36 NEW BORN BABY** means baby born during the Policy Period.

**2.37 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.

**2.38 NON-NETWORK** means any hospital, day care centre or other provider that is not part of the network.

**2.39 NOTIFICATION OF CLAIM** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

**2.40 OPHTHALMIC COVER** It covers ophthalmic ailments arising out of trauma/ infection/age-related diseases/ foreign body removals and excludes cosmetic eye surgeries, Lasik, cost of spectacles and contact lenses.

**2.41 OUT-PATIENT TREATMENT** is one in which the Insured visits a clinic/Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner .The Insured is not admitted as a day care or in-patient.

**2.42 PRE-HOSPITALISATION MEDICALEXPENSES** means medical expenses incurred during the period up to 30 days for the **PREMIUM** Plan, 45 days for the **ELITE** Plan, and 90 days for

the **ROYAL** Plan before the date of admission in the Hospital ,provided that:

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

B. The in-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

**2.43 POST-HOSPITALISATION EXPENSES** means medical expenses incurred for a period upto60 days for the **PREMIUM** Plan, 90 days for the **ELITE** Plan, and 180 days for the **ROYAL** Plan from the date of discharge from the Hospital, provided that:

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

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

**2.44PRE-EXISTINGDISEASE (PED)**

A pre-existing disease refers to any condition, ailment, injury, or disease that meets either of the following criteria:

A. It was diagnosed by a physician within:

- 36 months for **PREMIUM** coverage,
- 24 months for **ELITE** coverage, or
- 12 months for **ROYAL** coverage (for insured individuals up to 45 years of age) / 24 months (for insured individuals over 45 years of age), prior to the effective date of the policy issued by the insurer, or its reinstatement.

B. Medical advice or treatment was recommended by or received from a physician within:

- 36 months for **PREMIUM** coverage,
- 24 months for **ELITE** coverage, or
- 12 months for **ROYAL** coverage (for insured individuals up to 45 years of age) / 24 months (for insured individuals over 45 years of age), prior to the effective date of the policy issued by the insurer, or its reinstatement.

**2.45 POLICYPERIOD** means the period of coverage as mentioned in the schedule.

**2.46 QUALIFIED NURSE** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India

**2.47 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.

**2.48 RENEWAL** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of a grace period for treating the renewal continuous to gain credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

**2.49 ROOM RENT** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

**2.50 SURGERY/ SURGICAL OPERATION** 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 daycare centre

by a medical practitioner.

**2.51 THIRD PARTY ADMINISTRATOR (TPA)** means any person who is licensed under the IRDAI (Third Party Administrators – Health Service) Regulations, 2016 & its amendments by the Authority and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

**2.52 UNPROVEN/EXPERIMENTAL TREATMENT** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

**2.53 MIGRATION** means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time-bound exclusions, with the same insurer.

**2.54 PORTABILITY** means, the right accorded to individual health insurance policy holders (including all members under family cover), to transfer the credit gained for preexisting conditions and time-bound exclusions, from one insurer to another insurer.

**SPECIFICDEFINITIONS**

**2.55 MENTAL ILLNESS** means a substantial disorder of thinking, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize 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 characterized by sub normality of intelligence.

**2.56 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, organization or any other entity or person, where persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence, and rehabilitation, either temporarily or otherwise; and includes any general hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person; but does not include a family residential place where a person with mental illness resides with his relatives or friends.

**2.57 MENTAL HEALTH PROFESSIONAL**

A. A psychiatrist or
B. A professional registered with the concerned State Authority under section55; or
C. a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post- graduate degree (Siddha)in Sirappu Maruthuvam;

## 3 BENEFITS COVERED UNDER THE POLICY

3.1 **COVERAGE** The benefits under this Policy are available under three plans, viz **PREMIUM**, **ELITE**, and **ROYAL** as opted by the Insured in the proposal form. The Policy covers reasonable and customary charges in respect of Hospitalization and/or Domiciliary Hospitalization for medically necessary treatment only for Illnesses/ diseases contracted/ suffered or Injury sustained by the Insured Person(s) during the Policy Period, up to the limit of Sum Insured or mentioned sub-limits, as detailed below:

| FAMILY COMPOSITION | PREMIUM | ELITE | ROYAL |
|---|---|---|---|
| Family composition | Self + Spouse +Dependent Children+ Parents (Maximum of 6 members in case of a fresh policy only). Member limit is not applicable in case of migration from an existing Individual or Family Floater Policy | Self + Spouse+ Dep. Children + unmarried Dependent Siblings (brothers up to 25 years of age, and sisters including divorced or widowed) + Parents (2) + Parents-in-law (2). Cross-combination of parents is allowed. For **new policies**, a maximum of **10 members** can be included. For **migration from existing individual or family floater policies**, there is **no limit** on the number of members. | Grand Parents (2) +Grand Parents-in-law (2) + Parents (2) + Parents in law (2) + Self +Spouse +unmarried Children + unmarried dependent siblings (Brother upto age of 25 yrs and sisters /divorced and widowed sisters.) Cross-combination of parents is allowed. |

| Clause | COVERAGE / EXPENSES COVERED | PREMIUM | ELITE | ROYAL |
|---|---|---|---|---|
| | | Limits of covered Expenses | Limits of covered Expenses | Limits of covered Expenses |
| **A.** | **BENEFIT TABLE** | | | |
| i(a) | Sum Insured Available | **Individual Plan**: Coverage options of ₹ 2, 3, 4, 5, 6, 7, 8, 9 and 10 lakhs for fresh Policyholders. **Floater Plan**: Coverage options of ₹ 3,4,5,6,7,8,9 and 10 lakhs for fresh policyholders. **Options for Current HFF Policyholders on migration and subsequent renewal:** ₹ 2, 3, 4, 5, 6, 7, 8, 9and10 lakhs only. **Options for Current Individual Policyholders on migration and subsequent renewal**: ₹ 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 lakhs only. | **Individual Plan**: Coverage options of ₹ 3, 5, 7, 10, 12, 15, 18,20, 25,30,40 and 50 lakhs. **Floater Plan**: Coverage options of ₹ 5,7,10,12,15,18, 20,25,30,40 and 50 lakhs. **Options for current HFF Policyholders on migration and subsequent renewal:** ₹5, 7, 10, 12, 15, 18, 20, 25, 30, 40 and 50 lakhs only. **Options for Current Diamond and Platinum Individual Policyholders on migration and subsequent renewal**: ₹ 3,5,7,10,12, 15,18, 20, 25,30,40 and 50 lakhs only | **Individual Plan**: Coverage options of ₹ 7, 10, 15, 20, 25, 50, 75, 100, 150, 200, 250, and 500 lakhs. **Floater Plan**: Coverage options of ₹ 10, 15, 20, 25, 50, 75, 100, 150, 200, 250, and 500 lakhs. |

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|---|---|---|---|---|
| i(b) | Options | Individual, Floater, Floater - Floater basis | Individual, Floater, Floater - Floater basis | Individual, Floater, Floater - Floater basis |
| ii | Room, Boarding ,and Nursing Expenses as provided by the Hospital/Nursing Home. | 1 % of the Sum Insured per day | Upto 10 lakhs : - 1% of the Sum Insured per day<br>Above 10 lakhs :<br>actual expenses incurred for the Sum Insured per day | Actual expenses incurred per day |
| iii | Intensive Care Unit(ICU) Expenses as provided by the Hospital/Nursing Home. * | 2% of the Sum Insured per day. | Upto 10 lakhs: - 2%of the Sum Insured per day<br>Above 10 lakhs :<br>actual expenses incurred for the Sum Insured per day | Actual expenses incurred per day |
| iv | Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees | As per the limits of Sum Insured subject to "ii" and "iii" below | As per the limits of Sum Insured subject to "ii" and" iii" below | As per the Limits of Sum Insured subject to" ii" and "iii" below |
| v | Expenses related to Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines and Drugs, , Dialysis, Chemotherapy, Radiotherapy, as well as the cost of Pacemakers implanted during surgical procedures relevant laboratory/diagnostic test x- rays, Artificial Limbs, and similar items. | As per the limits of Sum Insured subject to "ii" and "iii" below | As per the limits of Sum Insured subject to "ii" and "iii" below | As per the limits of Sum Insured subject to "ii" and "iii" below |
| | **a.** The number of days of stay under sections 'ii' and 'iii' must not exceed the total duration of hospitalization. All associated expenses, including those mentioned in sections 'iv' and 'v,' shall be payable in accordance with the entitled room category, subject to the room rent limit stated above. However, this condition does not apply to pharmaceuticals, consumables, diagnostics, medical devices, or body implants.<br>**b.** The insurer will not cover any expenses that exceed the reasonable and customary charges as defined in the policy or, in the case of network hospitals, exceed the negotiated prices. | | | |

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|---|---|---|---|---|
| vi | Cataract Limit | Upto 4 Lakhs Sum Insured: Upto ₹ 30,000/- (PER EYE) or actuals whichever is less.<br><br>5 Lakhs to 10 Lakhs Sum Insured: Upto ₹ 40000/- **(**PER EYE) or actuals whichever is less. | Upto 7 Lakhs Sum Insured: up to₹ 50000 (PER EYE) or actual expenses whichever is less.<br><br>For 10 Lakhs and above Sum Insured: up to ₹100000 (PER EYE) or actual expenses whichever is less. | (PER EYE LIMIT upto ₹ 150000 or Actual expenses incurred, whichever is lesser for ROYAL PLAN) |
| | | **Note: -**The above-mentioned cataract limits represent the total liability/indemnity, including the cost of the procedure, implant/lens, pre-and post-operative expenses, operation theatre charges, surgeon fees, nursing expenses, ICU charges, room charges, RMO, consumables, medication costs, and any other related expenses. | | |
| vii | Road Ambulance service charges as hereinafter defined. | Subject to an admissible hospitalization claim, emergency road ambulance expenses incurred are payable as per the following limits for Individual and Family plans:<br><br>• Up to ₹ 3,000 per illness<br>• Up to ₹ 5,000 per Policy Year | Subject to an admissible hospitalization claim, emergency road ambulance expenses incurred are payable as follows for Individual and Family plans:<br><br>• Up to ₹ 5,000 per illness<br>• Up to ₹ 10,000 per Policy Year | Subject to an admissible hospitalization claim, emergency road ambulance expenses incurred are payable for Individual and Family plans. |
| viii | Daily Hospital Cash Allowance as herein after defined.<br><br>(Provided only to Insured person directly.)<br><br>**(Refer to clause3.1.2)** | Upto 0.1**% of the Sum Insured** per day of hospitalization, up to a maximum of ₹ 500/- per day.<br>**Maximum compensation:** 10 days per illness.<br>**Overall liability:** The Company's total liability per policy yearis limited to ₹5,000/-.<br>**Deductible:** 5 days (i.e., no benefit will be paid for the first 5 days of hospitalization per illness). | Upto 0.1**% of the Sum Insured** per day of hospitalization, up to a maximum of ₹ 1,000/- per day.<br>**Maximum compensation:** 10 days per illness.<br>**Overall liability:** The Company's total liability per policy yearis limited to ₹10,000/-.<br>**Deductible:** 5 days (i.e., no benefit will be paid for the first 5 days of hospitalization per illness). | Upto 0.1**% of the Sum Insured** per day of hospitalization, up to a maximum of ₹ 2,000/- per day.<br>**Maximum compensation:** 10 days per illness.<br><br>**Overall liability:** The Company's total liability per policy yearis limited to ₹20,000/-.<br><br>**Deductible:** 5 days (i.e., no benefit will be paid for the first 5 days of hospitalization per illness). |

<table>
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<td>ix</td>
<td>Attendant allowance as herein after defined. (Refer to clause3.1.3)</td>
<td>₹ 500/- per day of hospitalization,<br><br>Subject to a maximum compensation of 10 days per illness.<br><br>Overall liability: The Company's liability is limited to a maximum of fifteen (15) days per policy year.<br><br>Deductible: 5 days (i.e., no benefit will be paid for the first 5 days of hospitalization per illness).</td>
<td>₹ 750/- per day of hospitalization,<br><br>Subject to a maximum compensation of 10 days per illness.<br><br>Overall liability: The Company's liability is limited to a maximum of fifteen (15) days per policy year.<br><br>Deductible: 5 days (i.e., no benefit will be paid for the first 5 days of hospitalization per illness).</td>
<td>Sum Insured (SI) less than 100 Lakhs: ₹ 2,000/- per day of hospitalization, subject to a maximum compensation of 10 days per illness.<br><br>Sum Insured (SI) 100 Lakhs and above: ₹5,000/- per day of hospitalization, subject to a maximum compensation of 10 days per illness.<br><br>Overall liability: The Company's liability is limited to a maximum of fifteen (15) days per policy year.<br><br>Deductible: 5 days (i.e., no benefit will be paid for the first 5 days of hospitalization per illness).</td>
</tr>
<tr>
<td>x</td>
<td>Maternity &new born Baby expenses as here in after defined. (Refer to clause 3.1.4 A& special conditions mentioned therein)</td>
<td>Not Available</td>
<td>The Insurance Company will cover medical expenses for inpatient delivery (including cesarean sections) or lawful medical termination of pregnancy during the policy period. This coverage is limited to two deliveries or terminations, or either, during the lifetime of the insured person. A waiting period of 24 months applies.
<table>
<tr><th>Sum Insured Slabs</th><th>Benefit</th></tr>
<tr><td>For all slabs</td><td>Upto 5% of Sum Insured and maximum upto ₹ 50,000/-</td></tr>
</table>
</td>
<td>The Insurance Company will cover medical expenses for inpatient delivery (including caesarean sections) or lawful medical termination of pregnancy during the policy period. This coverage is limited to two deliveries or terminations, or either, during the lifetime of the insured person. A waiting period of 24 months applies.
<table>
<tr><th>Sum Insured Slabs</th><th>Benefit</th></tr>
<tr><td>For all slabs</td><td>Upto 10% of Sum Insured and maximum upto ₹ 2,00,000/-</td></tr>
</table>
</td>
</tr>
<tr>
<td></td>
<td></td>
<td colspan="3">Note: -The maternity limits mentioned above represent the total liability/indemnity, which includes the cost of the procedure, pre-and post-operative expenses, operation theatre charges, surgeon fees, nursing expenses, ICU charges, room charges, RMO, consumables, medication costs, and any other related expenses.</td>
</tr>
</table>

<table>
<tr><td>xi</td><td>New Born Baby cover.<br><br>(Refer to clause 3.1.4B & special conditions mentioned therein)</td><td colspan="3">Medical expenses incurred on treatment taken in Hospital as an In-patient in respect of the new born baby from day one upto SI subject to declaration and payment of premium.</td></tr>
<tr><td>xii</td><td>Assisted Reproduction Treatment<br>(Once in a lifetime)<br>(Refer to clause 3.1.5)</td><td>Not available</td><td>Coverage is available up to ₹ 1 Lakh (once in a lifetime), subject to a waiting period of 36 months.<br><br>Coverage will be as per ACT only.</td><td>Coverage is available up to ₹2 lakhs (once in a lifetime), subject to a waiting period of 36 months.<br><br>Coverage will be as per ACT only.</td></tr>
<tr><td>xiii(a)</td><td>Donor Expenses when Insured Person is Donor.<br><br>(Refer to clause3.1.7)</td><td>Maximum<br>up to 10% of Sum Insured</td><td>Up to 10% of the Sum Insured and max ₹ 1 Lakh</td><td>Up to 10% of the Sum Insured and max ₹ 2 Lakhs.</td></tr>
<tr><td>xiii(b)</td><td>Donor Expenses when Insured Person is Recipient.<br><br>(Refer to clause 3.1.8)</td><td>100% of the Sum Insured</td><td>100% of the Sum Insured</td><td>100% of the Sum Insured</td></tr>
<tr><td>xiv</td><td>Restoration of the Sum Insured<br>(Refer to clause3.1.17)</td><td>Upto 3 times</td><td>Upto 5 times</td><td>Infinite/Unlimited</td></tr>
<tr><td>xv</td><td>Medical Second Opinion for 11 specified critical Illnesses - taken from anywhere in the world.<br><br>(Refer to clause 3.1.6)<br><br>*The benefit limit applies separately to each floater group</td><td>NO</td><td>Yes<br>For Individual (per policy year):<br><table><tr><th>Sum Insured Slabs</th><th>Benefit</th></tr><tr><td>Across all Sum Insured slabs</td><td>5,000</td></tr></table><br>For floater/floater-floater(per policy year):<br><table><tr><th>Sum Insured Slabs</th><th>Benefit</th></tr><tr><td>Across all Sum Insured slabs</td><td>10,000</td></tr></table></td><td>Yes<br>For Individual(per policy year):<br><table><tr><th>Sum Insured Slabs</th><th>Benefit</th></tr><tr><td>Upto 50 lakhs</td><td>7,500</td></tr><tr><td>Above 50 lakhs</td><td>15,000</td></tr></table><br>For floater/floater-floater (per policy year):<br><table><tr><th>Sum Insured Slabs</th><th>Benefit</th></tr><tr><td>Upto 50 lakhs</td><td>15,000</td></tr><tr><td>Above 50 lakhs</td><td>30,000</td></tr></table></td></tr>
<tr><td>xvi</td><td>Air Ambulance Cover(Refer</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
</table>

| | | | | |
|---|---|---|---|---|
| | **to clause3.1.9)** | Upto ₹1 lakh Subject to in case of specific illness &life-threatening condition only | Upto ₹2.5 lakhs Subject to expenses incurred in case of specific illness &life-threatening condition only | Upto ₹5 lakhs: Applicable for Sum Insured bracket of ₹7 to ₹25 lakhs<br>Upto ₹7.5 lakhs: Applicable for Sum Insured above ₹25 lakhs (Subject to actual in case of specific illness &life-threatening condition only) |
| xvii | Inbuilt Accidental coverage (Benefit plan)<br>In case of Accidental Death/Permanent Total Disability cover **(Refer to clause 3.1.10)** | No | YES,<br><br>10% of Sum Insured Only when Sum Insured opted is ₹15 Lakhs and above. | 10% of Sum Insured |

| | | | | |
|---|---|---|---|---|
| xviii | OPD benefit for Dental and Ophthalmic cover **(Refer toclause3.1.11)**<br><br>The policy will reimburse OPD expenses in a block of every three continuous claim-free years (two years for the Royal Plan) for Dental and Ophthalmic care with respect to<br>i. Out-patient consultations by a medical practitioner.<br>ii. Diagnostic tests prescribed by a medical practitioner.<br>iii. Medicines/drugs prescribed by a medical practitioner.<br><br>*The benefit limit applies separately to each floater group | No | Yes<br><br>**Category** / **Limit(in ₹**<br>Individual (Sum Insured *20 & 25 lakhs only*) — 2,000/- per policy period<br>*For Floater/ Floater-Floater* * (Sum Insured *20 & 25 lakhs only*) — 5,000/- per policy period | Yes<br>For individual-:<br>**Sum Insured** / **Limit (in ₹)**<br>20 -25 lakhs — 3,000/- per policy period<br>50-100 lakhs — 5,000/- per policy period<br>Above 100 lakhs — 10,000/- per policy period<br>*For Floater/Floater-Floater**-:<br>**Sum Insured** / **Limit (in ₹)**<br>20-25 lakhs — 5,000/- per policy period<br>50-100 lakhs — 10,000/- per policy period<br>Above 100 lakhs — 20,000/- per policy period |
| xix | Additional Sum Insured for critical illnesses **(Refer to clause3.1.12)** | Not available | YES<br>For policies with a Sum Insured of ₹20 Lakhs or above, an additional upto 10% of the Sum Insured | YES<br>An additional upto 10% of Sum Insured(without Cumulative Bonus) will be provided |

<table>
<tr><td></td><td></td><td></td><td>(excluding any Cumulative Bonus) will be provided exclusively for the treatment of Critical Illnesses</td><td>exclusively for the treatment of Critical Illnesses</td></tr>
<tr><td>xx</td><td>Age group</td><td colspan="3">Age-Based Premium Loading for Fresh and Ported Policyholders:<br><br>• Up to 65 years: No loading.<br>• 66 to 70 years: 10% loading on the base premium for each member in this age bracket, applicable for life. If the member remains claim-free for 3 years, the loading will be reduced to 5% for life.<br>• 71 to 80 years: 25% loading on the base premium for each member in this age bracket, applicable for life. If the member remains claim-free for 3 years, the loading will be reduced to 15% for life.<br>• 80 years and above 50% loading on the base premium for each member in this age bracket, applicable for life.</td></tr>
<tr><td>xxi</td><td>Pre and Post Hospitalization expenses</td><td>Medical expenses incurred up to 30 days hospitalization and up to 60 days after hospitalization will be covered</td><td>Medical expenses incurred up to 45 days before hospitalization and up to 90 days after hospitalization will be covered</td><td>Medical expenses incurred up to 90 days before hospitalization and up to 180 days after hospitalization will be covered</td></tr>
<tr><td>xxii</td><td>Specialised Oncology Test/ Investigation (Outside India) (Once in a lifetime for each member)(Refer to clause 3.1.19)</td><td>No</td><td>No</td><td>For Individual &Floater/Floater-floater option(per policy period):<table><tr><th>Sum Insured Slabs</th><th>Benefit</th></tr><tr><td>20-25 lakhs</td><td>50,000</td></tr><tr><td>50-75 lakhs</td><td>1,00,000</td></tr><tr><td>Above 75 lakhs</td><td>1,50,000</td></tr></table></td></tr>
<tr><td>xxiii</td><td>Plan Movement (Refer to clause 5.33)</td><td colspan="3">Lower to Upper plan only (no downgrade of plan)</td></tr>
<tr><td>xxiv</td><td>Specific coverage limit</td><td>Yes(See Table for Specific Coverage Limit)</td><td>No</td><td>No</td></tr>
<tr><td>xxv</td><td>zone</td><td colspan="3">Zone I: Gujarat, Mumbai, Greater Mumbai, Chennai, Bengaluru, Pune, and Delhi NCR (including Ghaziabad, Faridabad, Noida, Greater Noida & Gurugram)<br>Zone II: Rest of India</td></tr>
</table>

<table>
<tr><td>xxvi</td><td>Limit on Modern Treatment & Mental Illness (Including Pre- and Post-Treatment)<br>This represents the overall limit for modern treatments and mental illness</td><td>Upto 20% of Sum Insured</td><td>Upto 50% of Sum Insured</td><td>Upto 100% of Sum Insured</td></tr>
<tr><td>xxvii</td><td>Health Check-Up<br><br>(A claim-free year is defined as a year during which no claims has been made by any family member throughout the entire policy year)<br><br>*The benefit limit applies separately to each floater group</td><td>NO</td><td>Reimbursements of expenses incurred towards the Cost of medical health checkups up to the limits (per policy year) mentioned below on completion of two continuous claim-free years-:<br><br>For Individual:<table><tr><th>Sum Insured Slabs</th><th>Benefit</th></tr><tr><td>Upto 5 lakhs</td><td>Upto 1,000</td></tr><tr><td>7- 10 lakhs</td><td>Upto 1,500</td></tr><tr><td>12-50 lakhs</td><td>Upto 2,000</td></tr></table>*For Floater/Floater-floater:<table><tr><th>Sum Insured Slabs</th><th>Benefit</th></tr><tr><td>Upto 5lakhs</td><td>Upto 2,000</td></tr><tr><td>7- 10 lakhs</td><td>Upto 3,000</td></tr><tr><td>12-50 lakhs</td><td>Upto 4,000</td></tr></table>(Subject to submission of original receipts, bills, reports, and related documents only)</td><td>Reimbursement of expenses incurred for medical health check-ups will be provided up to the limits (per policy period) specified below, upon completion of two continuous claim-free years<br><br>For Individual:<table><tr><th>Sum Insured Slabs</th><th>Benefit</th></tr><tr><td>Upto 25 lakhs</td><td>Upto 2000</td></tr><tr><td>Above 25 lakhs</td><td>Upto 4,000</td></tr></table>*For Floater/Floater-floater:<table><tr><th>Sum Insured Slabs</th><th>Benefit</th></tr><tr><td>Upto 25 lakhs</td><td>Upto 5,000</td></tr><tr><td>Above 25 lakhs</td><td>Upto 10,000</td></tr></table>(Subject to submission of original receipts, bills, reports, and related documents only)</td></tr>
<tr><td>xxviii</td><td>NCB (Refer to clause 3.1.20)<br>Option 1: Cumulative Bonus</td><td>Cumulative Bonus:<br>10% per annum upto 100% of Sum insured</td><td>Cumulative Bonus:<br>20% per annum upto 100% of Sum insured</td><td>Cumulative Bonus:<br>• Upto 25 Lacs Sum Insured<br>25% per annum upto</td></tr>
</table>

| | | | | |
|---|---|---|---|---|
| | **Option 2: Discount in renewal Premium:** In the event that the aforementioned feature is not availed, a discount of 2% shall be applied to the renewal premium. This facility will be available each time while renewing the policy. | | | 200% of Sum insured<br>• Above 25 lacs Sum Insured<br>50% per annum upto 200% of Sum insured |
| xxix | Pre-existing waiting Limit **(Refer to clause 4.1)** | 3 years | 2 years | 1 year for Insured upto age of 45 Years & 2 Yrs for age above 45 Yrs |
| xxx | Enhancement of Sum Insured on Renewal **(Refer to clause 5.33)** | The policyholder may opt to increase the Sum Insured at the time of policy renewal. However, the enhanced portion of the Sum Insured will be subject to the standard Pre-Existing Disease (PED) waiting period, as applicable based on the plan chosen and the insured's age.<br>Please note that the option to reduce or waive the PED waiting period will **not** be available for the enhanced Sum Insured.<br>**Example:**<br>If a policyholder currently has a Sum Insured of ₹5 lakhs and chooses to increase it to ₹10 lakhs at renewal, the additional ₹5 lakhs will be treated as an enhancement. This enhanced ₹5 lakhs will be subject to the standard PED waiting period, and **the policyholder will not be permitted to buy back or reduce the PED waiting period for this additional coverage.** | | |
| xxxi | Merger/ Portability of two or more policies into a single policy | Policyholders may choose to port or merge one or more individual/ floater policies into a single-family floater policy<br><br>When porting or merging policies, the policyholder will be offered the nearest available sum insured based on the combined sum insured of the individual/floater Policies<br><br>If a policyholder is migrating from an individual or floater sum-insured plan to a family floater plan, the combined sum insured of all individual or floater policies will be rounded, and the nearest available sum insured under the family floater plan will be offered | | |
| xxxii | Premium frequency **(Refer to clause 3.1.21)** | Monthly/Quarterly, half yearly/ Annual/Biennial/Trien nial | Monthly/Quarterly, half yearly/ Annual/Biennial/Trien nial | Monthly/Quarterly, half yearly/ Annual/Biennial/Trienni al |
| xxxiii | Long Term Policy **(Refer to clause 3.1.21)** | 1, 2, & 3 yrs | 1, 2, & 3 yrs | 1, 2, & 3 yrs |
| xxxiv | Teleconsultation / Telemedicine **(For the policy year)** | Individual: One consultation max ₹ 500/- per person | Individual: Two consultations max ₹ 1000/- | Individual: Three consultations max ₹ 2500/- |

| | | | | |
|---|---|---|---|---|
| | | *Floater/Floater-floater: One consultation max Upto ₹ 1000/- per floater group<br>*the limit applies separately to each floater group | *Floater/Floater-floater: Two consultations max Upto ₹ 2000/- per floater group<br>*the limit applies separately to each floater group | *Floater/Floater-floater: Three consultations max Upto ₹ 5000/- per floater group<br><br>*the limit applies separately to each floater group |
| xxxv | AYUSH Coverage | Upto 100% of the Sum Insured | Upto 100% of the Sum Insured | Upto 100% of the Sum Insured |
| xxxvi | Treatment in Non-Network Hospitals<br>(The deduction will apply only if the insured chooses to be hospitalized in a facility that is outside the network of the insurance company and the Third-Party Administrator (TPA)<br><br>However, if there is no hospital within the insurance company's and TPA's network in village /towns/cities where the insured can be hospitalized or admission is affected on account of an emergency, the deduction will not be applicable) | 10% Co-Payment | 5% Co-Payment | Not Applicable |

xxxvii Co-Pay Option and discount **(Refer to clause3.2.2)**

| **Sum Insured (in ₹)** | **Option 1** | **Option 2** | **Discount 1** | **Discount 2** |
|---|---|---|---|---|
| **100000** | 7500 | 15000 | 7.5% | 15% |
| **200000** | 10000 | 20000 | 7.5% | 15% |
| **300000** | 10000 | 20000 | 7.5% | 15% |
| **400000** | 15000 | 30000 | 7.5% | 15% |
| **500000** | 15000 | 30000 | 7.5% | 15% |
| **600000** | 15000 | 30000 | 7.5% | 15% |
| **700000** | 20000 | 30000 | 7.5% | 15% |
| **800000** | 20000 | 30000 | 7.5% | 15% |
| **900000** | 20000 | 30000 | 7.5% | 15% |
| **1000000** | 20000 | 30000 | 7.5% | 15% |
| **1200000** | 20000 | 40000 | 7.5% | 15% |
| **1500000** | 20000 | 40000 | 7.5% | 15% |
| **1800000** | 20000 | 40000 | 7.5% | 15% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | **2000000** | 20000 | 40000 | 7.5% | 15% |
| | | | **2500000** | 25000 | 50000 | 7.5% | 15% |
| | | | **3000000** | 25000 | 50000 | 7.5% | 15% |
| | | | **4000000** | 25000 | 50000 | 7.5% | 15% |
| | | | **5000000** | 25000 | 50000 | 7.5% | 15% |
| xxxviii | PERSONAL ACCIDENT (add-on Cover) **(Refer to clause3.2.1)** | For individuals aged 18 and above, coverage is available up to ₹10 lakhs, while below 18 years, coverage is capped at ₹5 lakhs | | For individuals aged 18 and above, coverage is available up to ₹20 lakhs, while below 18 years, coverage is capped at ₹10 lakhs | | For individuals aged 18 and above, coverage is available up to ₹50 lakhs, while below 18 years,, coverage is capped at ₹20 lakhs | |
| xxxix | Room Rent Up gradation Clause **(Refer to clause3.2.3)** | Option of increment of 50% and 100% is available | | Option of increment of 50% and 100% is available for Sum insured upto ₹10 lakhs only | | Not Applicable | |
| xxxx | Pre-Existing Disease (PED) Waiting Period Buyback Option **(Only for fresh proposals**.) **(Refer to clause3.2.4)** | 3 Years<br>2 Years<br>1 Year | | 2Years<br>1Years | | 2Years<br>1Years | |
| | ***The PED buyback option will not be applicable to the specified diseases listed in clause 4.2. The waiting period will be applicable as mentioned in the table*** | | | | | | |
| | 1 The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital | | | | | | |
| | 2. Relaxation to 24 hours minimum duration for Hospitalization is allowed in<br>a. Day care procedures/surgeries (Appendix I) where such treatment is taken by an Insured Person in a Hospital/ day care center (but not the Outpatient department of a Hospital), Or<br>b. Any other daycare treatment as mentioned and for which prior approval from Company/ TPA is obtained in writing | | | | | | |
| **B** | **DOMICILIARYHOSPITALISATIONBENEFITS** (Refer to clause 3.1.1 below) | | | | | | |
| i | Surgeon, Medical Practitioner, Consultants, Specialists Fees, Blood, Oxygen, Surgical Appliances, Medicines & Drugs, Diagnostic Material and Dialysis, Chemotherapy, Nursing expenses | Upto 10%ofSumInsured, Maximum ₹25000/- per policy year. | | Maximum ₹50,000/- per policy year. | | Maximum ₹1,00,000 per policy year. | |

| | | | | |
|---|---|---|---|---|
| ii | Treatment for a Dog bite (or bite of another rabid animal like monkey, cat, snake bite etc.) | Maximum ₹5,000 /- incurred on immunization injections in anyone Policy year This will be part of Domiciliary Hospitalization limits as specified for this clause the conditions for Domiciliary Hospitalization benefit shall not apply | Maximum ₹10,000 /- incurred on immunization injections in anyone Policy year. This will be part of Domiciliary Hospitalization limits as specified for this clause the conditions for Domiciliary Hospitalization benefit shall not apply | |
| iii | Home Care Treatment | NA | Yes<br>Limit: Maximum ₹50,000/- per year only | Yes<br>Limit: Maximum ₹ 1,00,000 per year only |
| **C** | HIV/AIDS cover | Covered | | |

**Table for Specific Coverage Limit:**

| SR NO | NAME OF THE DISEASE / PROCEDURE | LIMIT OF INDEMNITY (INR) Sum Insured UPTO ₹ 5 LAKHS | LIMIT OF INDEMNITY (INR) Sum Insured ABOVE 5 LAKHS |
|---|---|---|---|
| 1 | Unilateral Total Knee Replacement (excluding implant) | ₹ 1,35,000 | ₹ 1,65,000 |
| 2 | Bilateral Total Knee Replacement (excluding implant) | ₹ 1,75,000 | ₹ 2,00,000 |
| 3 | Unilateral Total Hip Replacement (excluding implant) | ₹ 1,35,000 | ₹ 1,65,000 |
| 4 | Bilateral Total Hip Replacement (excluding implant) | ₹ 1,75,000 | ₹ 2,00,000 |
| 5 | Piles, Fistula, Fissure, Tonsillitis, Sinusitis | ₹ 20,000 | ₹ 30,000 |
| 6 | Benign Prostatic hypertrophy, Hernia (all types of Hernia) | ₹ 40,000 | ₹ 50,000 |
| 7 | Appendicitis, Cholecystectomy | ₹ 30,000 | ₹ 40,000 |
| 8 | Hysterectomy | ₹ 40,000 | ₹ 50,000 |
| 9 | Internal congenital diseases, genetic diseases or disorders | Per policy period 10% of Sum Insured, subject to a maximum of ₹ 50,000 | Per policy period 10% of Sum Insured, subject to a maximum of ₹ 1,00,000 |
| 10 | Age-related macular degeneration (ARMD) | Per policy period 10% of Sum Insured, subject | Per policy period 10% of Sum Insured, subject to a |

| | | | |
|---|---|---|---|
| | | to a maximum of ₹ 50,000 | maximum of ₹ 1,00,000 |

**Note: Package / Procedure rates agreed with the Network Provider or the ailment capping mentioned in the policy documents whichever is lesser will be the limit of indemnity for that package/procedure under the policy**

**3.1.1 DOMICILIARY HOSPITALIZATION** benefit shall, however, not cover expenses in any of the following cases:

A. If the treatment lasts for three days or less

B. incurred on treatment of any of the following diseases:

i. Asthma

ii. Bronchitis

iii. Chronic Nephritis and Nephritic Syndrome

iv. Diarrhea and all types of Dysenteries including Gastro-enteritis Diabetes Mellitus and Insipidus

v. Epilepsy

vi. Hypertension

vii. Influenza ,Cough ,and Cold

viii. Pyrexia of unknown origin for less than 10 days

ix. Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis

x. Arthritis, Gout, and Rheumatism

**Note: Liability** of the Company under Domiciliary Hospitalization Benefit is restricted as stated above

**3.1.2 DAILY HOSPITAL CASH ALLOWANCE** When an Insured Person is hospitalized and a claim is admitted under the Policy, then the Insured Person shall be eligible for a Daily Cash Allowance for every continuous and completed period o f24 hours of Hospitalization, as mentioned above

**3.1.3 ATTENDANT ALLOWANCE** When an Insured Person upto the age of10 years is Hospitalized and a claims admitted under the PREMIUM or ELITE or ROYAL plan of the Policy, a sum as mentioned above will become payable under the Policy

**3.1.4 MATERNITY EXPENSES AND NEWBORN BABY COVER UNDER ELITE AND ROYAL PLAN**

A. **MATERNITY EXPENSES:** The Company shall pay the Medical Expenses incurred as an In-patient for delivery (including cesarean section) or lawful medical termination of pregnancy during the Policy Period limited to two deliveries or terminations or either during the lifetime of the Insured Person This benefit is applicable only in ELITE and ROYAL Plan ,and available only to the Insured or his spouse, provided that:

i. ELITE /ROYAL Plan has been continuously in force for a period of a minimum of 24 months in respect of both the Insured and his /her spouse

ii. Those Insured Persons who already have two or more living children will not be eligible for this benefit

iii. The Company's maximum liability per delivery or termination shall be limited to upto 10%

of the Sum Insured max 2 lakhs as stated in the Schedule and no cases hall the Company's liability under this clause exceed10%oftheSum Insured, in anyone Policy Period

**Special conditions applicable to Maternity Expenses**

i. These benefits are admissible only if the expenses are incurred in Hospital/Nursing Homes as in-patients in India

ii. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered

**NEWBORN BABY:** New born Baby shall be covered from day one and Medical expenses incurred for treatment taken in Hospital as in patient shall be payable, subject to terms and conditions of the policy.

Special conditions applicable to New Born Baby Cover

1. These benefits are admissible only if the expenses are incurred in Hospital/Nursing Homes as in- patients in India.
2. The Policy covers New Born Baby from day 1 only on payment of requisite premium.
3. In case claim is spread over two Policy Periods, the aggregate liability of the Company, for all claims in respect of the New Born Baby, shall be limited to the Sum Insured of the Policy under which claim was reported

**3.1.5 ASSISTED REPRODUCTION TREATMENT (ART)** Assisted Reproduction Treatment is defined as these to techniques and medical treatments that allow couples to start a family when it cannot be achieved naturally due to infertility problems It should be proven by the specialized doctor that it Is not possible to conceive through natural process due to established sub-fertility /infertility problems of the couple For the scope of this policy, ART will be covering any treatment or procedure that involves the in-vitro handling of human oocytes and sperm or embryos to establish a pregnancy The Company will reimburse expenses incurred on Assisted Reproduction Treatment, where indicated as mentioned above, for sub-fertility/infertility subject to:

i. A waiting period of 36 months from the date of first inception of this policy with the Company for the insured persons (both spouses) The benefit is only payable if the treatment has been initiated after the specified waiting period

ii. The maximum liability of the Company for such treatment shall be limited upto ₹1, 00,000/- for **ELITE**& upto₹ 2, 00,000/- for **ROYAL.** This benefit (1 Lakh or 2Lakhs) will be a part of the basic Sum Insured, not in addition to it

iii. to claim under this benefit ,in-patient treatment is not mandatory

iv. Automatic Restoration of Basic Sum Insured, Recharge benefit shall not be applicable for this benefit

v. If this benefit is opted for by the insured, then exclusion under4.17 will be deleted

**Note:** To be eligible for this benefit both partners should stay insured continuously without break under this policy for every block **This coverage is available for ELITE and ROYAL Plan only** This cover is limited to one child once in a lifetime only If the couple has one living child this benefit will not be available This benefit of₹1, 00,000/- or 2, 00,000/-will only be give nonce in a lifetime

**3.1.6 MEDICAL SECOND OPINION:** If the Insured Person is diagnosed with one of the specified major illnesses listed below and obtains a Medical Second Opinion (including an opinion from

overseas), either before starting treatment or during treatment, the Policy will cover the Medical Expert's fees up to the amount as per benefit table:

**Conditions for Payment:**

- The Hospitalization claim associated with the major illness must be admissible under the policy.
- This expense is payable only once per major illness per Insured Person during their lifetime.

Major Illnesses covered:

I. Cancer
II. Renal Disease
III. Stroke resulting in permanent symptoms
IV. Coma
V. All Cardiac conditions/surgeries
VI. Major Organ / Bone Marrow transplantation
VII. Paralysis of limbs
VIII. Motor Neuron disease
IX. All Brain related conditions /surgeries
X. Multiple Sclerosis
XI. Liver failure

**3.1.7 ORGAN DONOR BENEFIT- WHEN INSURED PERSON IS THE DONOR:** A lump sum payment of 10% of the Sum Insured in Premium plan, upto 10% of sum insured maximum ₹1 lakh for the ELITE Plan & upto ₹2 lakhs for the ROYAL Plan, to take care of medical and other incidental expenses is payable to the Insured Person donating an organ provided that the donation conforms to the Transplantation of Human Organs Act 1994 (amended) and any other extant Act, Central / State Rules/regulations, as applicable, in respect of transplantation of human organs This benefit is subject to the Policy (NEW PRODUCT) having been continuously in force for at least 12 (twelve) months in respect of that Insured Person.

**3.1.8 ORGAN DONOR EXPENSES- WHEN INSURED PERSON IS THE RECIPIENT:** The Policy covers inpatient Hospitalization Medical expenses including the donor expenses provided that the donation conforms to the Transplantation of Human Organs Act 1994(amended) and/or any other extant Act, Central / State Rules/regulations, as applicable, in respect of transplantation of human organs. Further provided that:

The medical expenses will include the following:

- Compatibility Test: The organ of the donor undergoes evaluation for compatibility with the receiver's anatomy.
- Pre-hospitalization expenses: If the organ of the donor is found compatible, he/she usually goes through rigorous medication and treatment before he is hospitalized.
- Hospitalization Expenses: The hospitalization cost includes room rent, nurse's fees, and other charges.
- Organ transplantation surgery: The surgeon's fees and the cost of the procedure for harvesting the organ are covered.

- Post-surgery care & recovery: It is common for complications to arise after an organ has been surgically removed from someone's body. Hence, the donor may need to stay in the hospital for an extended period. He/she may also need post-operative therapy for a full recovery.
- Post-Hospitalization Expenses: Medication may still continue after the donor has been discharged from the hospital. Frequent Health Checkups are a must for the donor.

All the benefits will be limited to the Sum Insured of the Policyholders and any applicable pre and post- hospitalization limit
The Policy does not cover:

- Cost directly or indirectly associated with the acquisition of the organ and/or cost of the organ
- Policyholders must not engage in any form of organ-selling

**NOTE: -ORGAN DONOR EXPENSES- WHEN BOTH ORGAN DONOR AND RECIPIENT ARE COVERED UNDER TWOSEPARATE POLICY OF THIS PRODUCT/OPTED FOR INDIVIDUAL SUM INSURED IN CASE OF INDIVIDUAL OR FLOATER-FLOATER PLAN**
The following terms shall apply:

- The donor may claim hospitalization, pre-surgery, and post-surgery expenses incurred under their respective policy or the available sum insured under the individual or floater-floater option, as applicable.
- The total benefit payable will be limited to the sum insured under the respective policy or the individual or floater-floater option of this product, whichever applies.

This clause ensures that the maximum benefit is availed by the organ donor.

**3.1.9 AIR AMBULANCE COVER:**The policy provides coverage for air ambulance costs, subject to the following conditions:

1. This coverage is available only for medical emergencies that require immediate and rapid transportation to a hospital or medical center due to the severity of the condition and the limitations of ground transportation.
2. The necessary medical treatment must not be available at the location where the Insured Person is situated at the time of the emergency.
3. The air ambulance transportation must be prescribed by a Medical Practitioner and deemed medically necessary.
4. The Insured Person must be located within India at the time of the emergency.
5. The coverage will be available for the following medical conditions:
    - Cardiovascular diseases
    - Central nervous system-related conditions
    - Accidental trauma cases
6. This air ambulance coverage can only be availed once during the entire lifetime of the policyholder.
7. The air ambulance service provider must be duly licensed and authorized by the Competent Authorities of the relevant Government(s) to operate as such.

8. This policy does not provide cover for the return transportation of insured Person's to his home by air ambulance

**3.1.10 ACCIDENTAL DEATH BENEFITAND PERMANENT TOTAL DISABILITY:** This benefit is available only for ELITE and ROYAL Plans. The benefit will be payable if an Insured Person sustains an Accident during the Policy Period, and such Accident is the sole and direct cause of either:

- Death, or
- Permanent Total Disability

occuring within 365 days from the date of the Accident, the Policy will pay a fixed benefit amount.

This benefit is provided in addition to any optional Personal Accident (PA) coverage, if such coverage has been selected by the Insured.

**3.1.11 OPD BENEFIT FOR DENTAL AND OPHTHALMIC COVER**: Refractive Error- Code- Excl15 shall not apply for this benefit).The policy will reimburse OPD Expenses Reimbursement of expenses on completion of 3 continuous claim-free years for Dental and Ophthalmic care with respect of

i. Out-patient consultations by a medical practitioner
ii. Diagnostic tests prescribed by a medical practitioner
iii. Medicines/drugs prescribed by a medical practitioner

**3.1.12 ADDITIONAL SUM INSURED FOR CRITICAL IILLNESS (Available for ELITE and ROYAL PLAN only):** If the policyholder is diagnosed with a Critical Illness as defined by the Insurance Regulatory and Development Authority of India (IRDAI) during the policy period, they may utilize the additional Critical Sum Insured (if available) before making any claims under the selected base Sum Insured. This additional benefit will be payable on an indemnity basis exclusively for the treatment of the diagnosed Critical Illness, provided that the diagnosis is supported by clinical, radiological, histological, and laboratory evidence acceptable to the company.

If the policyholder exhausts the available additional Critical Sum Insured in a policy year under a Floater or Floater-Floater plan, this benefit will not be available to other members covered under this policy for the remaining duration of the policy

Any cumulative bonuses added to sum insured will not be considered for amount calculation

**3.1.13TELEMEDICINE:** Expenses incurred by the insured on telemedicine/Tele-consultation with a registered medical practitioner for Diagnosis & treatment of a disease/illness covered under the Policy Such reasonably incurred expenses will be reimbursable wherever consultation with a registered medical practitioner is allowed in the terms and conditions of policy contract and shall be subject to Limits/Sublimits prescribed in Policy Schedule Telemedicine offered shall comply with the Telemedicine Practice Guidelines dated 25th of March 2020 by MCI and as amended from time to time "The amount benefit payable for telemedicine services will be subject to the limit specified in the benefit table.".

**3.1.14HIV/ AIDS COVER:** The Company shall indemnify the Hospital or the Insured the Medical Expenses for In-Patient Care ,Pre and Post Hospitalization Expenses related to HIV infection

**3.1.15MENTAL ILLNESS COVER MENTAL ILLNESS COVER:** The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalization Expenses)

only under certain conditions as: -

i. Illness covered under the definition of mental illness mentioned under definitions clause*

ii. Hospitalization in Mental Health Establishment as defined under definitions clause*

iii. HospitalizationasadvisedbyMentalHealthProfessionalasdefinedunderdefinitionsclause*

iv. Mental Conditions associated with the abuse of alcohol and drugs are excluded

v. Mental Retardation and associated complications arising therein are excluded

vi. Anykindofpsychologicalcounseling,cognitive/family/group/behavior/palliativetherapy,orotherkindsofpsychotherapyforwhichHospitalizationisnotnecessaryshallnotbecovered

*For starred items, please refer to Specific Definitions

**3.1.16 ADVANCED TREATMENTS:** The following advanced medical procedures are covered under the policy, provided they are performed as in-patient care, domiciliary hospitalization, or daycare treatment, subject to the limits specified in the benefits table:

- Uterine Artery Embolization and High-Intensity Focused Ultrasound (HIFU)
- Balloon Sinuplasty
- Deep Brain Stimulation
- Oral Chemotherapy
- Immunotherapy – Monoclonal Antibody administered via injection
- Intra-vitreal Injections
- Robotic Surgeries
- Stereotactic Radiosurgery
- Bronchial Thermoplasty
- Vaporization of the Prostate (using Green Laser or Holmium Laser treatment)
- Intra-Operative Neuro Monitoring (IONM)
- Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions

**3.1.17 RESTORATION OF SUM INSURED:** If during the Policy Period, the Selected Sum Insured is reduced or exhausted due to a claim under the Policy, this benefit will restore the Basic sum insured to its original limit

Under the Premium Plan, the opted Sum Insured (excluding any cumulative bonus) will be automatically restored if any single claim—other than the first—during the policy period is equal to or exceeds the total of the Sum Insured and the cumulative bonus accrued under the policy. The following conditions apply:

**Conditions:**

1. The Sum Insured will only be restored if any single incidence of a claim (except the first), exceeds/equal to the total of Sum Insured and any cumulative bonus accrued under the policy.
2. Restoration will not occur if the first incidence claim fully exhausts the total of Sum Insured and any cumulative bonus or if multiple smaller claims together exhaust the opted Sum Insured and any cumulative bonus accrued under the policy.
3. **Eligibility for restored sum insured:**

a. **Individual Sum Insured:** For policies where each member has a separate Sum Insured, the restored Sum Insured can only be utilized for future claims arising from different illnesses, injuries, or surgical procedures than those that initially exceeded the opted Sum Insured and any cumulative bonus accrued under the policy for the same member.
b. **Floater/Floater-Floater Option:** For policies where the Sum Insured is shared among family members, the restored Sum Insured will be available exclusively to the same member for future claims arising from illnesses, injuries, or surgical procedures **that are different from** those that initially exhausted the opted Sum Insured and any cumulative bonus accrued under the policy. The restored Sum Insured will also be available to other insured family members.

4. **Policy Period Limitation:** The restored Sum Insured is available only for the same policy period and cannot be carried forward to the next policy term.
5. Restoration of the Basic Sum Insured, subject to the above conditions, is allowed up to a maximum of **three** times during the policy period.

**Examples:**

1. Mr. X purchases a policy with a Sum Insured of ₹5 lakhs If his first incidence of claim fully utilizes the entire sum insured, the restoration benefit will not apply.
2. Mr. Y purchases a policy with a Sum Insured of ₹5 lakhs His first incidence of claim amounts to ₹1 lakh, and later, his second incidence of hospitalization incurs ₹5.5 lakhs in expenses, which exceeds the Sum Insured. In this case, the policy will restore the full ₹5 lakhs for any future hospitalisations within the same policy period that are unrelated to the illnesses, injuries, or surgical procedures that exceeded the basic Sum Insured.

Under the **ELITE Plan**, Under the Elite Plan, opted Sum Insured (excluding any cumulative bonus) will automatically be restored if any single incidence of a claim during the policy period exceeds/equal to the total of the Sum Insured and any cumulative bonus accrued under the policy. The following conditions apply:

**Conditions:**

1. The restoration benefit is triggered only if any single incidence of a claim exceeds/equal tothe total of Sum Insured and any cumulative bonus accrued under the policy.
2. Restoration will not occur multiple smaller incidents of claims together exhaust the total of Sum Insured and the cumulative bonus accrued under the policy.
3. **Eligibility for restored sum insured:**
    a. **Individual Sum Insured:** For policies where each member has a separate Sum Insured, the restored Sum Insured can only be utilized for future claims arising from different illnesses, injuries, or surgical procedures than those that initially exceeded the total Sum Insured and any cumulative bonus accrued under the policy for the same member.
    b. **Floater/Floater-Floater Option:** For policies where the Sum Insured is shared among family members, the restored Sum Insured will be available exclusively to the same member for future claims arising from illnesses, injuries, or surgical procedures **that are different from** those that initially exhausted the total Sum Insured and any cumulative bonus accrued under the policy. The restored Sum Insuredwill also be available to other insured family members.
4. **Policy Period Limitation:** The restored Sum Insured is available only for the same policy period and cannot be carried forward to the next policy term.

5. Restoration of the Basic Sum Insured, subject to the above conditions, is allowed up to a maximum of **five** times during the policy period.

**Examples:**

1. If Mr. X's policy with a ₹5 lakhs Sum Insured is fully used by his first hospitalisation claim, the restoration benefit will restore the full ₹5 lakhs. This restored amount can only be used for future claims in the same policy period, as long as they are for different illnesses, injuries, or surgical procedures than the one that exhausted/exceeded the basic Sum Insured.
2. Mr. Y also has a policy with a Sum Insured of ₹5 lakhs. His first hospitalisation claim is ₹1 lakh, and his second claim is ₹4.5 lakhs Since no single claim exceeds the Sum Insured, the restoration benefit will not be triggered.

Restoration Benefit for **ROYAL Plan (₹10** lakhs**, ₹15** lakhs**, ₹20** lakhs**, ₹25** lakhs). This benefit automatically restores the Sum Insured to its opted Sum Insured (excluding any cumulative bonus) amount if a single member or policyholder fully exhausts the total of the Sum Insured and the cumulative bonus accrued under the policy due to multiple incidences of claim within the policy period.

**Conditions:**

1. **Full Exhaustion:** The restoration benefit is applicable only when the total of the Opted Sum Insured and any cumulative bonus has been completely utilized by a single member or policyholder during the policy period.
2. **Eligibility for New Claims:**
    a. **Individual Sum Insured:** When each member holds a separate Sum Insured, the restored Sum Insured can only be utilized for future claims arising from illnesses, injuries, or surgical procedures that are different from the conditions that led to the initial depletion.
    b. **Floater or Floater-Floater Option:** In cases where the Sum Insured is shared among members, the restored Sum Insured will be available exclusively to the same member for future claims arising from illnesses, injuries, or surgical procedures **that are different from** those that initially exhausted the total of the Sum Insured and the cumulative bonus. The restored Sum Insured will also be available to other insured family members.
3. **Policy Period Limitation:** The restored Sum Insured is available only for the same policy period and cannot be carried forward to the next policy term.
4. There is no restriction on the number of times the opted Sum Insured can be restored within the same policy period, provided the above conditions are met.

**Example:**

1. **Individual Policy:** Mr. X purchases a policy with a Sum Insured of ₹10 lakhs. Mr. X incurred ₹5 lakhs for the first incidence of hospitalization claim and subsequently for the second hospitalization incurred ₹7 lakhs, which resulted in full utilization of the Sum Insured. In this case, the Sum Insured will automatically be restored to ₹10 lakhs for any subsequent hospitalization within the same policy period for different illnesses, injuries, or surgical procedures than those led to exhausted the basic Sum Insured.
2. **Floater Policy:** Mr. Y purchased a floater policy with a Sum Insured of ₹10 lakhs for himself and his spouse. Mr. Y incurred ₹5 lakhs for his hospitalisation claim, afterwards his wife also got hospitalised and incurred ₹7 lakhs which resulted in full utilization of the Sum

Insured. In this scenario, the Sum Insured will **not** be restored as per the floater policy conditions.

Restoration Benefit for the **ROYAL Plan (₹50** lakhs **and above).** The benefit will automatically be restored to opted Sum Insured (excluding any cumulative bonus) after full utilization the total of the Sum Insured and any cumulative bonus accrued under the policy during the policy period. Below are the conditions for availing the restoration benefit:

**Conditions:**

1. **Full Exhaustion:** The Sum Insured and any cumulative bonus must be fully utilized before the restoration benefit is applied.
2. **Eligibility for New Claims:**

    a. **Individual Sum Insured:** If each member has a separate Sum Insured, the restored Sum Insured can only be used for future claims.
    b. **Floater or Floater-Floater Option:** For policies where the Sum Insured is shared, the restored Sum Insured will be available to all members, regardless of individual usage. The restored Sum Insured can only be used for future claims.

3. **Policy Period Limitation:** The restored Sum Insured is applicable only for the same policy period and cannot be carried forward to the next policy term.
4. There is no restriction on the number of times the basic Sum Insured can be restored within the same policy period, provided that the above conditions are met.

**Example:**

1. **Individual Policy:** Mr. X purchases a policy with a Sum Insured of ₹50 lacs. After hospitalization, he incurs ₹51 lacs for a kidney transplant and ₹26 lacs for a second claim, fully exhausting the Sum Insured. In this case, the policy will automatically restore ₹50 lacs for any future claims during the same policy period, including for kidney transplantation.
2. **Floater Policy:** Mr. X purchases a floater policy with a Sum Insured of ₹50 lakhs, shared with his spouse. Mr. X incurs ₹30 lakhs for one claim, and his spouse incurs ₹25 lakhs for another, fully exhausting the total Sum Insured. In this scenario, the policy will restore the original Sum Insured of ₹50 lakhs, available for future claims by either member within the same policy period.

**Note: -**

1. An incidence of claim refers to the total medical expenses incurred as a result of a single medical event, such as an illness, injury, or surgical procedure. This includes costs associated with hospitalization, pre-hospitalization treatment, and post-hospitalization care.
2. The Basic Sum Insured refers to the amount chosen by the policyholder, which determines the coverage limit for medical insurance benefits.

**3.1.18 GEOGRAPHICAL EXTENSION TO SAARC COUNTRIES:** The Policy will cover Insured Persons visiting other SAARC (South Asian Association for Regional Cooperation) countries, including Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan, and Sri Lanka. No additional premium will be charged for this extension. However, the Insured Person must request this extension in writing before leaving the country, providing details of the duration,

purpose, and country (ies) of the visit. An endorsement for such an extension will be issued by the Company.

Please note that cashless services will not be available for treatment received in countries outside India. Claims for such treatments will be processed on a reimbursement basis only.

**3.1.19 Specialized Oncology Test/ Investigation (Outside India):** The Policy will cover the cost of Specialized Oncology Test/Investigation as specified in the Benefit Table. The Insurer will reimburse the claim amount, subject to the limits prescribed, provided the following conditions are met:

- **Prescribing Physician:** The test must be prescribed by the treating oncologist and test sample must be collected in a medical facility located in India.
- **Medical Necessity:** The test must be necessary for assisting diagnosis, treatment and monitoring of cancer by the treating oncologist.
- **Recognized Facility:** The test must be performed in a recognised foreign medical facility.

The coverage for Specialized Oncology Test/Investigation may include the cost of the test itself, as well as any associated consultation fees.

**3.1.20 NCB (NO CLAIM BONUS):** The Policyholder will be eligible for a No Claim Bonus (NCB) if no claims have been made against the Policy during the previous Policy Year. Such NCB shall be paid as per the choice/express consent of the policyholder in **eithe**r of the following forms at the time of renewal.

**Cumulative Bonus (CB):** Enhancement of the Sum Insured (SI)
**Discount on Premium:** Reduction in renewal premium

a) **Cumulative Bonus:** The NCB will be calculated as [x%] of the Opted Sum Insured for each claim-free Policy Year. The maximum NCB shall be as specified in the Benefit Table.

If the Policyholder claims during the Policy Year, the accrued NCB will be reduced by [x%] of the Opted Sum Insured at the time of Policy Renewal.

**Note:** The NCB cannot be less than zero. If a claim is made, the NCB will be reduced to zero, but it will not become negative.

**NCB Benefit accrual:**

**Individual Option:** For the Individual Option, each Policyholder will accrue NCB benefits separately, regardless of claims made by other Policyholders under the same Policy.

**Floater Option:** Under the Floater Option, NCB will only accrue if none of the members are covered under the policy claim during the previous policy year.

**Floater-Floater Option:** For the Floater-Floater Option, each floater group will accrue NCB benefits separately, regardless of claims made by members of other floater groups.

b) **Discount in Premium:** If a Policyholder is eligible for NCB, then he/she is required to choose either a cumulative bonus or discount on the premium option. This facility will be available each time while renewing the policy.

**How Cumulative Bonus/ Discount of Premium are operated:**

**Example Scenarios:**

**Scenario 1:**

**Original Sum Insured (SI): ₹5,00,000**
The policyholder has the option to choose between a Cumulative Bonus (CB) that increases their sum insured, or a Discount on Premium, at the time of renewal.

| Original Sum Insured | Fresh/ Renewal | Selected Option | CB Amount | Premium Discount | Claim Status |
|---|---|---|---|---|---|
| ₹ 5,00,000 | Fresh Policy | - | - | - | No |
| ₹ 5,00,000 | Renewal | CB | ₹ 50,000 | - | No |
| ₹ 5,00,000 | Renewal | Discount | - | 2% of Premium | No |
| ₹ 5,00,000 | Renewal | CB | ₹ 1,00,000 | - | Yes |
| ₹ 5,00,000 | Renewal | No CB/Discount | ₹ 50,000 | - | No |
| ₹ 5,00,000 | Renewal | CB | ₹ 1,00,000 | - | No |
| ₹ 5,00,000 | Renewal | Discount | ₹ 1,00,000 | 2% of Premium | No |

- **No Claim Year**: In years when no claim is filed, the policyholder can either opt for a Cumulative Bonus (CB), which increases the sum insured by a certain amount (e.g., ₹50,000 or ₹1,00,000 based on the policy terms) or receive a discount on their renewal premium (e.g., 2% of the premium).
- **Claim Impact**: When a claim is filed, the policyholder is not eligible for a CB or premium discount at renewal. In this scenario, the Cumulative Bonus is reduced by a step (in this case, ₹50,000 or 10% of the original sum insured). The policyholder can still choose between a CB or premium discount in future renewals, provided no claim is filed that year.

**Scenario 2:**

**Original Sum Insured (SI): ₹5,00,000**
The policyholder opted for an enhanced Sum Insured of ₹10,00,000.

| Original Sum Insured | Renewal Sum Insured | Selected Option | CB Amount | Premium Discount | Claim Status |
|---|---|---|---|---|---|
| ₹ 5,00,000 | Fresh Policy | - | - | - | No |
| ₹ 10,00,000 | Renewal | CB | ₹ 50,000 | - | No |
| ₹ 10,00,000 | Renewal | CB | ₹ 1,50,000 | - | No |
| ₹ 10,00,000 | Renewal | CB | ₹ 2,50,000 | - | Yes |
| ₹ 10,00,000 | Renewal | No CB/Discount | ₹ 1,50,000 | - | Yes |
| ₹ 10,00,000 | Renewal | No CB/Discount | ₹ 50,000 | - | Yes |
| ₹ 10,00,000 | Renewal | No CB/Discount | - | - | No |
| ₹ 10,00,000 | Renewal | Discount | - | 2% of Premium | No |
| ₹ 10,00,000 | Renewal | CB | ₹ 1,00,000 | - | No |
| ₹ 10,00,000 | Renewal | CB | ₹ 2,00,000 | - | No |

- **No Claim Year**: If no claims are made, the policyholder can accumulate a significant Cumulative Bonus, potentially increasing their sum insured by a substantial amount (up to ₹2,50,000 in this example). This enhances the policyholder's coverage over time.
- **Claim Impact**: When a claim is filed, the policyholder is not eligible for a CB or premium discount at renewal. The Cumulative Bonus (CB) is reduced by a specified percentage of the original Sum Insured (SI). For instance, if a claim is made when the CB is ₹2,50,000 and the reduction is 10%

of the Sum Insured, the CB will decrease by ₹1,00,000 (10% of ₹10,00,000). However, the reduction will be limited to the available CB amount, meaning the CB will decrease by the smaller of either the percentage of the Sum Insured or the remaining CB balance (i.e., min (x% of Sum Insured, Balance CB)). In future renewals, the policyholder can once again choose between the CB and a premium discount, provided no claim is made during the previous policy year.

### 3.1.21 TERM OF POLICY/ PREMIUM FREQUENCY:

- **1-Year Policy:** The policyholder has the option to pay the premium Monthly, Quarterly, Half-Yearly, or Annually.
- **2-Year Policy:** The policyholder has the option to pay the premium Monthly, Quarterly, Half-Yearly, Annually, or Biennially.
- **3-Year Policy:** The policyholder has the option to pay the premium Monthly, Quarterly, Half-Yearly, Annually, or Triennially.

### 3.2 OPTIONAL COVERS

**The following coverage can be taken on payment of an additional premium. The amount payable under this section will be in addition to selected health Insurance benefits**

**3.2.1PERSONAL ACCIDENT COVER: (WORLDWIDE):** If, during the currency of the Policy, the Insured Person sustains bodily injury resulting solely and directly from a sudden, unforeseen, and involuntary event caused by external, visible, and violent means anywhere in the world, and if such injury, within 12 months of its occurrence, is the sole and direct cause of death or disability covered under the Policy, the Company undertakes to pay to the Insured or their nominee, or in the absence of a nominee, the legal heir, the following sums:

| No | Coverage | Amount payable |
|---|---|---|
| 1 | Accidental Death only | 100% of CSI |
| 2 | Loss of two entire limbs ,or sight of two eyes ,or one entire Limb and sight of one eye | 100% of CSI |
| 3 | Loss of one entire limb or Sight of one eye | 50 % of CSI |
| 4 | Permanent Total Disablement resulting in totally and absolutely disabling the person insured from engaging and Employment or occupation whatsoever | 100% of CSI |

- Overallliabilityintheeventofoneormoreoftheeventualities(listedabove)occurringshallberestrictedto the CSI of the Insured Person
- CSImeansCapitalSumInsuredoptedunderthePersonalAccidentsectionandmentionedintheschedule
- Family Discount of10% if more than one member is covered with individual sum insured under this section

| Features | Premium | Elite | Royal |
|---|---|---|---|

| | | | |
|---|---|---|---|
| PED(Refer3.22(B)) | The Coverage Sum Insured (CSI) is available in multiples of ₹1,00,000, up to a maximum of ₹10,00,000 per Insured Person aged 18 years and above. For Insured Persons below 18 years of age, the maximum CSI allowed is ₹5,00,000, provided that this amount does not exceed the CSI of the Insured Person. | The Coverage Sum Insured (CSI) is available in multiples of ₹1,00,000, up to a maximum of ₹20,00,000 per Insured Person aged 18 years and above. For Insured Persons below 18 years of age, the maximum CSI allowed is ₹10,00,000, provided that this amount does not exceed the CSI of the Insured Person. | The Coverage Sum Insured (CSI) is available in multiples of ₹1,00,000, up to a maximum of ₹50,00,000 per Insured Person aged 18 years and above. For Insured Persons below 18 years of age, the maximum CSI allowed is ₹20,00,000, provided that this amount does not exceed the CSI of the Insured Person. |

**EXCLUSIONS:** The Company shall not be liable under the Personal Accident section for injuries/ death on account of

- Intentional self-injury, suicide, or attempted suicide
- Whilst under the influence of intoxicating liquor
- Engagement in aviation or ballooning ,speed contests or racing of any kind (other than on foot),bungee jumping, parasailing, parachuting, ski-diving, BASE jumping, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, solo climbing ,ice climbing, ice canoeing,scubadiving,Caving,cavediving,potholing,abseiling,snowboarding,wave ski surfing, deep sea diving using a hard helmet and breathing apparatus, polo, snow and ice sports and similar other hazardous activities or involving military, air force or naval operations, or whilst mounting into, dismounting from or traveling in any aircraft other than as a passenger (fare paying or otherwise), in any duly licensed standard type of aircraft ,any wherein the world, unless specifically covered and endorsed on the Policy
- Caused by venereal disease(s)
- Arising or resulting from the insured committing a breach of law with criminal intent
- War, invasion, the act of a foreign enemy, hostilities (whether war be declared or not), civil war ,rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrest ,restraints ,and detainments of people
- Caused by or arising from ionizing radiations or contamination by radioactivity from any nuclear fuel, nuclear weapon material, or from any nuclear waste from the combustion of nuclear fuel
- Caused by, contributed to, aggravated or prolonged by childbirth or from pregnancy or in consequence thereof

**3.2.2 OPTION FOR CO-PAY WITH FIXED AMOUNT:** This is an optional benefit in this policy given to policyholders. The benefit of this option for the Policyholders are

- Predictability: Policyholders know exactly how much they will have to pay upfront for each claim.
- Any claim amount exceeding the Sum Insured, even after deducting the fixed co-pay, will not be covered.

- Example: A policyholder bought a policy with a fixed co-pay of ₹ 10,000 and a Sum Insured of ₹ 2,00,000.

- Scenario 1: The policyholder claims₹ 50,000. After the claim assessment, the valid claim amount is determined to be ₹ 50,000. The insurance company is liable to pay ₹ 40,000 (₹ 50,000 claim - ₹ 10,000 co-pay).

- Scenario 2: The policyholder claims₹ 2,00,000. After the claim assessment, the valid claim amount is determined to be ₹ 2,00,000. The insurance company is liable to pay ₹ 1,90,000 (₹ 2,00,000 claim - ₹ 10,000 co-pay).

- Scenario 3: The policyholder claims₹ 2,50,000. After the claim assessment, the valid claim amount is determined to be ₹ 2,50,000. The insurance company is liable to pay only ₹ 2,00,000 (₹ 2,50,000 claim -₹ 10,000 co-pays limited to the Sum Insured of ₹ 2,00,000 only).

- Scenario 4: The policyholder claims₹ 2,20,000. After the claim assessment, the valid claim amount is determined to be ₹ 2,00,000. The insurance company is liable to pay ₹ 1,90,000 (₹ 2,00,000 claim - ₹ 10,000 co-pay).

**3.2.3 ROOM RENT UPGRADATION CLAUSE:** In the event of hospitalization, all related medical expenses, including charges for the surgeon, anesthetist, medical practitioners, consultants, blood, anesthesia, OT, and other services, will be payable according to the entitled room category, based on the room rent/ICU limit as specified in Benefit Table A. If the actual room rent charges exceed the limit prescribed in the benefit table, the policyholder will be required to bear a proportionate share of expenses, calculated as the ratio of the admissible charges to the actual room rent charges. By paying an additional premium, policyholders have the option to enhance their room rent and associated charges by either 50% or 100%. This option is available under the PREMIUM and ELITE Plans, up to a sum insured of ₹10 **lakhs** only.

For example, if a policyholder with a sum insured of ₹5 **lakhs** opts for a 50% enhancement, they will be eligible for 150% of the admissible room rent. Once this option is selected, the policyholder cannot opt out of this clause unless.

- Increases the sum insured to 12 lakhs or more in the ELITE Plan.
- Migrates to the ROYAL Plan

**3.2.4PRE EXISTING DISEASE (PED) WAITING PERIOD BUYBACK OPTION:** The Pre-Existing Disease (PED) Waiting Period Buyback Option allows policyholders to accelerate coverage for medical conditions that existed prior to the start of a **fresh policy**. By paying an additional premium, policyholders can reduce or eliminate the standard waiting period for each individual covered under this policy.

**Eligibility**: The policyholder must declare the pre-existing conditions for each member covered in the policy, as the PED buyback option exists only at policy level..

**Waiting Period Adjustment:** The default PED waiting periods are as follows: 3 years for the PREMIUM Plan, 2 years for the ELITE Plan, and 2 years for the ROYAL Plan (for those over 45 years of age) or 1 year for others. The policyholder may choose to reduce or fully remove the waiting period at policy level. Both full and partial PED waiting period buyback are available.

1. **Premium Plan**
   - **Default PED Waiting Period:** 3 years (fixed)
   - **Buyback Options Available:**
     - **Reduce to 2 years** → PED waiting period becomes 2 years and the additional premium loading will be for **1 year only**.
     - **Reduce to 1 year** → PED waiting period becomes 1 year and the additional premium loading will be for 2 **years only**.
     - **Reduce to 0 years** → No PED waiting period; claims related to PEDs are payable from day one and the additional premium loading will be for 3 **years only**.

**Example:**

i.If the policyholder chooses the “Reduce to 1 Year” option, the Pre-Existing Disease (PED) waiting period will be reduced to 1 year. An additional premium will be charged for two years

only.

ii. If the policyholder chooses the “Reduce to 0 Years” option, the PED waiting period will be completely waived. An additional premium will be charged for three years only.

2. **Elite Plan**

- **Default PED Waiting Period:** 2 years (fixed)
- **Buyback Options Available:**

  - **Reduce to 1 year** → PED waiting period becomes 1 year and the additional premium loading will be for 1 **year only**.
  - **Reduce to 0 years** → No PED waiting period; claims related to PEDs are payable from day one and the additional premium loading will be for 2 **years only**.

**Note:** Only allow selection of **1-year or 2-year reduction** options.

**Example:**

i. If the policyholder chooses the “Reduce to 1 Year” option, the Pre-Existing Disease (PED) waiting period will be reduced to 1 year. An additional premium will be charged for one year only.

ii. If the policyholder chooses the “Reduce to 0 Years” option, the PED waiting period will be completely waived. An additional premium will be charged for two years only.

3. **Royal Plan**

- **Default PED Waiting Period:**
  - **1 year** if **all members are aged ≤ 45 years**
  - **2 years** if **any member is aged > 45 years**
- **Buyback Options Available:**
  - **Reduce to 1 year** → PED waiting period becomes 1 year and additional premium will be charged for one year where all members are aged >45 years.
  - **Reduce to 0 years** → No PED waiting period; PED claims are payable from day one and additional premium will be charged for one year for all members having aged<=45 years and two years for others members.

Note: - The policyholder has the option to choose either **"Reduce to 1 year"** or **"Reduce to 0 year"** to reduce its Pre-Existing Disease (PED) waiting period.

**I.** If the policyholder selects the **"Reduce to 1 Year" option**, the Pre-Existing Disease (PED) waiting period for all members covered under the policy will be reduced to one year. **An additional premium will be charged for one year if all members are above 45 years of age.**

**II.** If the policyholder selects the **"Reduce to 0 Year" option,** claims related to pre-existing conditions will be admissible from day one, subject to the other terms and conditions of the policy. **An additional premium will be charged for one year for members aged 45 years or below, and for two years for members above 45 years of age.**

Once the PED removal option is selected and the premium is paid, claims for pre-existing diseases can be made either immediately (in case of full PED removal) or after the adjusted

waiting period (e.g., 1 or 2 years) in case of partial removal.

**Terms and Conditions:**

- The PED Buyback option is **only available for fresh policies**. It is **not applicable for migrated or ported policies,** and **not applicable for any enhanced Sum Insured.**
- ***The PED buyback option will not be applicable to the specified diseases listed in clause 4.2. The waiting period will be applicable as mentioned in the table***
- Buyback applies at the policy level – the same PED waiting period applies to all members in the policy.
- An additional premium will be charged as per the PED Buyback Premium Chart for each member covered under the policy and for the number of year bought back.
- The policyholder may choose to reduce the default PED waiting period by 1 year, 2 years or 3 years subject to plan-specific rules.
- The removal or reduction of the waiting period is only applicable to the extent of the option chosen.
- The policyholder must disclose all pre-existing conditions at the time of purchasing the policy or during renewal, subject to underwriting acceptance.
- All other policy terms, conditions, and exclusions remain in full force and effect unless expressly modified by this option.
- If the policy has a three-year waiting period and the policyholder opts for immediate PED (Pre-Existing Disease) coverage, an additional premium loading will apply for three years only.

4 **EXCLUSIONS:** The Company shall not be liable to make any payment under this Policy in respect of any expense whatsoever incurred by any Insured Person in connection with or in respect of:

**STANDARD EXCLUSIONS**

**4.1 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 36 months, 24 months, and 12 (Below 45 years of age) & 24 (<45age) months of continuous coverage for **PREMIUM**, **ELITE**, and **ROYAL** Plan respectively after the date of inception of the first policy with the insurer

B. In case of enhancement of the sum insured the exclusion shall apply afresh to the extent of the 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 the waiting period for the same would be reduced to the extent of the prior coverage

D. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer

**4.2 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 the specified waiting period of the continuous coverage after the date

of inception of the first policy with us This exclusions hall not be applicable for claims arising due to an accident b)In case of enhancement of sum insured the exclusion shall apply a fresh of the extent of sum insured increase

B. If any of the specified disease/procedures falls under the waiting period specified for pre-existing diseases ,then the longer of the two waiting periods shall apply

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

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

E. The expenses on treatment of the following ailments/diseases/surgeries, if contracted and/or manifested after the inception of the first Policy (subject to continuity being maintained),are not payable during the waiting period specified below

| No. | Ailment / Disease / Surgery | Waiting Period |
|---|---|---|
| 1 | Benign ENT disorders and surgeries ie Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty, etc | 1 year |
| 2 | Polycystic ovarian diseases | 1 year |
| 3 | Surgery of hernia | 2 years |
| 4 | Surgery of hydrocele | 2 years |
| 5 | Non-infective Arthritis | 2 years |
| 6 | Undescendent Testes | 2 Years |
| 7 | Cataract | 2 Years |
| 8 | Surgery of benign prostatic hypertrophy | 2 Years |
| 9 | Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus | 2 Years |
| 10 | Fissure / Fistula in anus | 2 Years |
| 11 | Piles | 2 Years |
| 12 | Sinusitis and related disorders | 2 Years |
| 13 | Surgery of gallbladder and bile duct excluding malignancy | 2 Years |
| 14 | Surgery of genito-urinary system excluding malignancy | 2 Years |
| 15 | Pilonidal Sinus | 2 Years |
| 16 | Gout and Rheumatism | 2 Years |
| 17 | Hypertension | 90 days* |
| 18 | Diabetes | 90 days* |
| 19 | Calculus diseases | 2 Years |
| 20 | Surgery for prolapsed inter vertebral disk unless arising from accident | 2 Years |
| 22 | Surgery of varicose veins and varicose ulcers | 2 Years |
| 23 | Joint Replacement due to Degenerative condition | 3 Years |
| 24 | Age related osteoarthritis and Osteoporosis | 3 Years |
| 25 | Obesity | 2 year |
| 26 | Waiting period for life style conditions namely, Hypertension, Diabetes, Cardiac | 90 days |

| | | |
|---|---|---|
| | conditions is not allowed for more than 90 days except if these diseases are pre-existing and disclosed at the time of underwriting. | |

***If the above diseases are pre-existing at the time of inception, Exclusion no4.1 for pre-existing disease shall be applicable**

***The PED buyback option will not be applicable to the specified diseases listed in clause 4.2. The waiting period will be applicable as mentioned in the table***

**Note:** If the continuity of the renewal is not maintained then subsequent cover will be treated as fresh Policy and clauses4.1, 4.2, and 4.3 shall apply afresh, unless agreed by the Company and suitable endorsement passed on the Policy, by the duly authorized official of the Company Similarly, if the Sum Insured is enhanced after the inception of the first Policy, clauses 4.1, 4.2 and 4.3 shall apply a fresh on the enhanced portion of the Sum Insured.

**4.3 30-day waiting period-code– Excl03**

**4.3.1** Expenses related to the treatment of any illness within 30days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered

**4.3.2** This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months

**4.3.3** The within-referred waiting period is made applicable to the enhanced sum insured in the event of granting a higher sum insured subsequently

**4.4 Investigation & Evaluation – Code – Excl04**

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

**4.4.2** Any diagnostic expenses that are not related or not incidental to the current diagnosis and treatment are excluded

**4.5 Rest Cure, rehabilitation and respite care– Code -Excl05**

ExpensesrelatedtoanyadmissionprimarilyforenforcedbedrestandnotforreceivingtreatmentThisalso includes:

- Custodialcareeitherathomeorinanursingfacilityforpersonalcaresuchashelpwithactivitiesofdaily

  Living such as bathing, dressing, and movingaroundeitherbyskillednursesorassistantsornon-skilledpersons

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

**4.6 Obesity/Weight Control: Code-Escl06** Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions:

**4.6.1** Surgery to be conducted is upon the advice of the Doctor

**4.6.2** The surgery/Procedure conducted should be supported by clinical protocols

**4.6.3** The member hastobe18yearsofage or older and

**4.6.4** Body Mass Index(BMI):

A. Greater than or equal to 40 or

B. greaterthanorequalto35inconjunctionwithanyofthefollowingsevereco-

morbiditiesfollowingfailuresof less invasive methods of weight loss:

- Obesity–related cardiomyopathy
- Coronary heart diseases
- Severe Sleep Apnea
- UncontrolledType2Diabetes

**4.7 Change of Gender Treatments: Code – ExcI07** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite

**4.8 Cosmetic or Plastic Surgery- Code- ExcI08** 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.

**4.9 Hazardous or Adventure sports- Code- ExcI09** 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, skydiving, deep-sea diving

**4.10 Breach of law – Code –ExcI10** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

**4.11 Excluded Providers- Code – ExcI11** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed on 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 complete claim

**4.12 Treatment for, Alcoholic drug or substance abuse** or any addictive condition and consequences thereof–Code- ExcI12

**4.13 Code-ExcI13**Treatments received in health hydro's ,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-

**4.14 Code- ExcI14** Dietary supplements and substances that can be purchased without a prescription, including but not limited to vitamins ,minerals ,and organic substances unless prescribed by a medical practitioner as part of a hospitalization claim or daycare procedure-

**4.15 Refractive Error- Code- ExcI15** Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 diopters

**4.16 Unproven Treatments- Code – ExcI16** 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

**4.17 SterilityandInfertility-Code-ExcI17** 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. Gestation Surrogacy

iv. Reversal of sterilization

Note: This exclusion does not apply to ELITE and ROYAL Plan up to the limits mentioned

therein

**4.18 Maternity-Code- Excl18**

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and cesarean 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

**NOTE:** - The above exclusion does not apply to ELITE and ROYAL Plan

**SPECIFIC EXCLUSIONS: -**

**4.19 Hormone Replacement Therapy** Expenses for hormone replacement therapy ,unless part of Medically Necessary Treatment, except or Puberty and Menopause related Disorders

**4.20 General Debility, Congenital External Anomaly** General debility, congenital external anomaly

**4.21 Self-Inflicted Injury** Treatment for intentional self-inflicted injury ,attempted suicide

**4.22 Stem Cell Surgery** Stem Cell Surgery (except Hematopoietic stem cells for bone marrow transplant for hematological conditions)

**4.23 Circumcision** unless necessary for the treatment of a disease (if not excluded otherwise)or necessitated due to an accident

**4.24 Vaccination or Inoculation** Vaccination or inoculation unless forming part of treatment and requires Hospitalization, except as and to the extent provided for under Section 3110 (Anti Rabies Vaccination)and Section3111iv(Maternity)

**4.25 Massages, Steam Bath, Alternative Treatment (Other than Ayurveda and Homeopathy)**Massages ,steam bath ,expenses for alternative or AYUSH treatments(other than Ayurveda and Homeopathy), acupuncture ,acupressure ,magneto-therapy ,and similar treatment

**4.26 Dental treatment** Dental treatment, unless necessitated due to an Injury/Accident

**4.27 Out Patient Department (OPD)** Any expenses incurred on OPD (Except OPD benefit for Dental and Ophthalmic Sum Insured linked cover provided in ELITE and ROYAL Plan)

**4.28 Stay in Hospital which is not Medically Necessary** Stay in hospital which is not medically necessary

**4.29 Spectacles, Contact Lens ,Hearing Aid, Cochlear Implants** Spectacles ,contact lens ,hearing aid, cochlear implants

**4.30 Non-Prescription Drug** Drugs not supported by a prescription ,private nursing charges, referral feet the family physician ,outstation doctor/ surgeon /consultants 'fees, and similar expenses (as listed in respective Appendix-II)

**4.31 Treatment not related to Disease for which Claim is Made** Treatment which the insured person was on before Hospitalization or the Illness /Injury ,different from the one for which claim for Hospitalization has been made

**4.32 Equipment's** External /durable medical/non-medical equipment/instruments of any kind used for diagnosis /treatment including CPAP ,CAPD ,infusion pump, ambulatory devices such as walker Crutches, belts, collars ,caps ,splints ,slings ,braces ,stockings ,diabetic foot-wear ,glucometer ,thermometer, and similar related items (as listed in respective Appendix-II) and any medical equipment which could be used at home subsequently

**4.33 Items of personal comfort** Items of personal comfort and convenience (as listed in

respectiveAppendix-II)includingtelephone,television,aya,barber,beautyservices,babyfood,cosmetics,napkins,toiletries,guest services

**4.34 Service charge / registration fee** Any kind of service charges including surcharges, admission fees, registration charges ,and similar charges (as listed in respective Appendix-II) levied by the hospital

**4.35 Home visit charges** Home visit charges during pre- and post-hospitalization of doctor, attendant, and nurse

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

**4.37 Radioactivity** Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense for this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release, or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, in capacitating disablement or death

b) Chemical attack or weapons means the emission, discharge, dispersal, release, or escape of any solid, liquid, or gaseous chemical compound which, when suitably distributed, is capable of causing any illness, in capacitating disablement, or death

c) Biological attack or weapons means the emission, discharge, dispersal, release, or escape of any pathogenic(disease-producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) that are capable of causing any Illness ,incapacitating disablement or death

**4.38 Treatment taken outside the geographic limits of India**

## 5 TERMS&CLAUSES

### STANDARD GENERAL TERMS& CLAUSES

**5.1 DISCLOSURE OF INFORMATION:** The policy shall be void and all premium paid there on 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 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)

**5.2 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

CLAIM SETTLEMENT (provision for Penal Interest):

- Once policyholders intimated the claim, Insurers and Third-Party Administrators (TPAs), will collect the required documents from the Hospitals. Policyholder will not be required to submit the documents.
- If the policyholder has opted for a monthly, quarterly, or half-yearly premium payment mode, they will be required to pay the balance of the total annual premium in full before any claim

under the policy is processed. **For example, if a policyholder has selected the monthly premium option for a one-year policy and submits a health claim after paying five monthly installments, the remaining seven installments must be paid in advance prior to the claim being processed.**

- Insurer will ensure that the claims registered are attended to at speed and the claims are settled at the earliest possible time.
- No claim shall be repudiated without the approval of Product Management Committee (PMC) or a three-member sub-group of PMC called the Claims Review Committee (CRC).
- In case, the claim is repudiated or rejected or disallowed partially, details shall be communicated to the claimant along with full details giving reference to the specific terms and conditions of the policy document.
- Settlement of claims (other than cashless) shall be settled within fifteen days from submission of claim.
- In the event of a delay in the payment of a claim (for non-cashless claims), the Company shall be liable to pay interest to the policyholder. This interest will be calculated from the date of receipt of the last necessary document until the date of claim payment, at a rate of 2% above the applicable bank rate.

**5.3 COMPLETE DISCHARGE:** Any payment to the Insured Person or his/ her nominees or his/ her legal representative or the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall be a valid and effectual discharge towards payment of a claim by the Company to the extent of that amount for the particular claim.

**5.4 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 shall be forfeited Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment For this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, 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 policy 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 mis- statement of or suppression of material fact are within the knowledge of the insurer Onus of disproving is upon the policyholder, if alive, or beneficiaries

**5.5 CANCELLATION CLAUSE**: The policyholder may cancel this Policy at any time during the term, by giving 7 days' notice in writing,

a. The Company will refund the premium on a pro-rata basis for the unexpired Policy Period if the term of the policy is one year and there is no claim(s) made during the policy period

b. The Company will refund the premium for the unexpired policy period, in respect of

policies with terms more than 1 year and risk coverage for such policy years has not commenced

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts fraud by the insured person, by giving15 days written notice There would be no refund of premium on cancellation on grounds of misrepresentation non- disclosure.

**5.6 MIGRATION:** The Insured Person may have the option to migrate this policy to another health insurance product or plan offered by the Company. To migrate, the Insured Person must submit an application at least 30 days before the policy renewal date, as per IRDAI guidelines**.** If the Insured Person is currently covered and has been continuously covered without any lapses under any health insurance product or plan offered by the Company, they will be eligible for accrued continuity benefits regarding waiting periods, as per IRDAI guidelines on migration. For Detailed Guidelines on Migration, kindly refer to the link: - https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layoutaspx?page=PageNo3987&flag=1

**5.7 MIGRATION OFFER FOR EXISTING HAPPY FAMILY FLOATER (HFF) & INDIVIDUAL MEDICAL POLICYHOLDERS:** This new product is a replacement for our existing Happy Family Floater and Individual Medical plans**.** To ensure a smooth transition, we are offering the following migration options to policyholders of Happy Family Floater and Individual Medical:

Migration Options:

**For Happy Family Floater Policyholders (HFF) (UIN: OICHLIP25046V062425):**

We offer a special discount to our existing Policyholders insured under the "Happy Family Floater Policy" who opt to migrate to the new health insurance product.

**1. Migration from ₹1 Lakh Sum Insured:**

Where the Sum Insured under the existing Happy Family Floater Policy is ₹1,00,000 (Rupees One Lakh):

- The Insured Person shall be required to migrate to a minimum Sum Insured of ₹2,00,000 (Rupees Two Lakhs) or above, as the new health insurance product does not offer a ₹1,00,000 Sum Insured option.
- A **25% (twenty-five percent) discount** shall be applied on the premium payable for the first policy year following migration.
- A **20% (twenty percent) discount** shall be applied on the premium payable for the second policy year following migration.
- From the third policy year onwards, premium shall be charged in accordance with the standard terms and conditions of the policy in force at the time of renewal.

**2. Migration from Sum Insured Above ₹1 Lakh:**

Where the Sum Insured under the existing Happy Family Floater Policy exceeds ₹1,00,000 (Rupees One Lakh):

- If the Policyholder elects to migrate to the **Premium, Elite, or Royal Plan** under the new health insurance product, a **one-time discount of 5% (five percent)** shall be applied on the total premium payable for the first policy year.
- An **additional one-time discount of 5% (five percent)** shall be applicable if the Policyholder opts for a higher Sum Insured than the Sum Insured under the previous

policy.

- The total maximum discount available under this clause shall not exceed **10% (ten percent)** of the premium payable for the first policy year post migration.

**For Individual Mediclaim Policyholders (UIN: OICHLIP25048V052425):**

We offer a special discount to our existing Policyholders insured under the "Individual Mediclaim Policy" who opt to migrate to the new health insurance product.

- If the Policyholder elects to migrate to the **Premium, Elite, or Royal Plan** under the new health insurance product, a **one-time discount of 5% (five percent)** shall be applied on the total premium payable for the first policy year.
- An **additional one-time discount of 5% (five percent)** shall be applicable if the Policyholder opts for a higher Sum Insured than the Sum Insured under the previous policy.
- The total maximum discount available under this clause shall not exceed **10% (ten percent)** of the premium payable for the first policy year post migration.

**5.8 FREE-LOOK PERIOD:** The free look period shall be applicable on new health insurance policies and not on renewals or at the time of porting/migrating the policy the insured person shall be allowed a free look period of 30 days from the date of receipt of the Policy document to review the terms and conditions of the Policy and to return the same if not acceptable If the Insured has not made any claim during the free look period, the Insured shall be entitled to

- A refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Persons and the stamp duty charges or
- where the risk has already commenced and the option of return of the Policy is exercised by the Insured person, a deduction towards the proportionate risk premium for the period on the cover or
- Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period

**5.9 RENEWAL OF POLICY:** The policy shall ordinarily be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured person

- The Company shall endeavor to give notice for renewal However, the company is not under obligation to give any notice for renewal
- Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
- No fresh underwriting unless there is an increase in the sum insured. If policyholders requested an increase in the sum insured underwriting applies to the extent of the sum insured only.
- If the product is withdrawn, the policyholder will be provided with suitable options.
- Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period
- At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain the continuity of benefits without a break in policy Coverage is not available during the grace period
- No loading shall apply on renewals based on individual experience

**5.10 PORTABILITY:**

I. The Policyholders (including all members under family cover), will have the option to transfer the credit gains from one insurer to another insurer.

II. By Porting, the policyholder 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 disease, Moratorium period etc. from the Existing Insurer to the Acquiring Insurer in the previous policy.

III. The Acquiring and the Existing Insurers will jointly, ensure that the entire underwriting details and claim history of the Policyholders are seamlessly transferred.

IV. The existing insurer will provide the information sought by the Acquiring insurer immediately but not more than 72 hours of receipt of request through Insurance Information Bureau of India (IIB) https://iib.gov.in/ portal.

V. The Acquiring insurer will decide and communicate on the proposal at the earliest possible time but not more than 5 days of receipt of information from Existing insurer.

VI. A policyholder desirous of porting his/her policy to another insurer shall apply 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 due date for renewal. Insurers are free to consider proposal for portability even if the policyholder has approached within 15 days from the renewal date of the existing policy, but in all such cases acquiring insurer shall ensure that there is no break in policy.

VII. No charges will be levied on the policyholder for porting-in or porting-out.

**5.11 WITHDRAWALOFPOLICY**

- In the likelihood of this product being withdrawn in the future, the Company will inform the Insured person about thesame90 days before the expiry of the policy.
- The insured person will have the option to migrate to a similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such accumulative bonus, waiver of the waiting period as per IRDAI guidelines, provided the policy has been maintained without break.

**5.12 MORATORIUM PERIOD** After the completion of sixty continuous months under this policy, no look-back provision shall be applied. This period of sixty continuous months is referred to as the *Moratorium Period*. The moratorium applies to the sum insured under the initial policy. In case of any enhancement in the sum insured, the moratorium for the enhanced limits will be calculated separately, starting from the date of the enhancement and completing after five continuous years. Upon the expiry of the Moratorium Period, no health insurance claim shall be contestable, except in cases of established fraud. However, the policy will remain subject to all applicable limits, sub-limits, co-payments, and deductibles as outlined in the contract.

**5.13 POSSIBILITY OF REVISION OF TERMS OF THE POLICY INCLUDING THEPREMIUM RATES**: The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

**5.14 GRIEVANCE REDRESSAL** In case of any grievance the insured person may contact the company through :Website: www.orientalinsurance.org.inToll-free:1800118485Or011-33208485 E-mail:csd@orientalinsurance.co.in

The insured person may also approach the grievance cell at any of the company's branches with details of their grievance. If the insured person is not satisfied with the resolution provided through the above methods, they may contact the Grievance Officer at: **Customer Service Department**, Corporate Office, Block - 4, Plate- A, NBCC Office Complex, Kidwai Nagar East, New Delhi - 110023. For updated details of grievance officer, Kindly refer the link:

https://orientalinsurance.org.in/grievance-redressal.

**5.15 INSURANCE OMBUDSMAN:** If the insured person is not satisfied with the resolution of their grievance through the above methods, they may also approach the office of the Insurance Ombudsman for their respective area or region for further redressal.

The contact details of the Insurance Ombudsman offices are provided in Annexure III, and any revised details will be updated on the website**: http://ecoicoin/ombudsmanhtml.**

**5.16 NOMINATION:** At the inception of the policy, the policyholder is required to nominate a beneficiary for claim payments in the event of the policyholder's death. The nomination can be changed at any time during the policy term. Any changes to the nomination must be communicated to the Company in writing, and such changes will take effect only after an endorsement is made on the policy.

For claims under reimbursement, the company will make the payment to the policyholder. In the event of the policyholder's death, the company will pay the nominee (as named in the Policy Schedule/Policy Certificate/Endorsement, if any). If no nominee exists, payment will be made to the legal heirs of the policyholder, whose receipt will be considered a full and final discharge of the company's liability under the policy.

**SPECIFIC TERMS & CLAUSES: -**

**5.17 ENTIRE CONTRACT:** This Policy /Prospectus/ Proposal Form and declaration given by the insured constitute the complete contract Insurer may alter the terms and conditions of this Policy/contract Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the Policy

**5.18 COMMUNICATION:** Every notice or communication to be given or made under this Policy shall be delivered in writing at the address of the Policy issuing office / Third Party Administrator as shown in the Schedule

**5.19 PAYMENT OF PREMIUM:** The premium under this Policy shall be paid in advance. A valid receipt for the premium shall only be recognized if it is issued on the official form of the Company and signed by a duly authorized representative .The Company's liability to make any payment under this Policy is contingent upon the Insured Person's full compliance with the payment of the premium and the adherence to all terms, provisions, conditions, and endorsements of this Policy, as applicable. No waiver of any terms, provisions, conditions, or endorsements of this Policy shall be effective unless made in writing and signed by an authorized official of the Company.

**For all the Plans, the premium in the policy will be charged based on the 2 Zones, as defined below:**

**Zones areas defined below:**

**Zone I:** Gujarat, Mumbai, Greater Mumbai, Chennai, Bengaluru, Pune, and Delhi NCR (including Ghaziabad, Faridabad, Noida, Greater Noida & Guru gram)

**Zone II:** Rest of India

**5.20 NOTIFICATION OF CLAIM**: Immediate notice of claim with particulars relating to Policy Number, ID Card No, Name of Insured Person in respect of whom claim is made, Nature of disease / Injury, and Name and Address of the attending Medical Practitioner / Hospital /Nursing Home, etc. should be given to the Company/ TPA while taking treatment in the Hospital / Nursing Home by fax, e-mail Such notice should be given within 48 hours of admission but before discharge from Hospital / Nursing Home, unless waived in writing

**5.21 CLAIM DOCUMENTS**: The final claim, along with original bills, cash memos, reports, claim form, and the required documents listed below, must be submitted to the Company or TPA within 15 days of discharge from the hospital or nursing home. This clause is applicable in cases of claim reimbursement.

- Original bills, all receipts, and discharge certificate/card from the Hospital
- All documents pertaining to the Illness, starting from the date it was first detected, i.e. Doctor's consultation reports/history
- Medical history of the patient recorded by the Hospital
- Original Cash-memo from the Hospital (s) /chemist (s) supported by proper prescription
- Original receipt, pathological and other test reports from a pathologist/radiologist including film, etc. supported by the note from the attending Medical Practitioner / Surgeon demanding such tests
- Original attending Consultants / Anesthetists / Specialist certificates regarding diagnosis and bills/receipts etc.
- Surgeon's original certificate stating diagnosis and nature of operation performed along with bills/receipts etc.
- MLC/FIR/Post Mortem Report, (if applicable)
- Disability certificate, Death certificate(if applicable)
- Documents in respect of organ donation claim, shall be in accordance with the extant Act, Central/State Rules/regulations, as applicable, in respect of transplantation of human organs
- Details of previous policies, if the details are already not with TPA
- Any other information required by TPA /Company

**5.21.1** All documents must be duly attested by the Insured Person/Claimant

**5.21.2** In case of Post Hospitalization treatment (limited to 60 days) all supporting claim papers/documents as listed above should also be submitted within 15 days from completion of such treatment (upto 60 days or the actual period whichever is less) to the Company / TPA in addition insured should also provide the Company / TPA such additional information and assistance as the Company/ TPA may require in dealing with the claim

**5.21.3** Waiver of the condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed, it was not possible for him or any other person to give such notice or file claim within the prescribed time limit Otherwise Company has a right to reject the claim

**5.21.4** On receipt of the last document /clarification, the Company/TPA shall within a period of 30days offer a settlement of the claim to the insured If the Company/TPA, for any reasons to be recorded in writing and communicated to the insured, decides to reject a claim under the Policy, it shall do so within a period of 30 days from the receipt of the last document/clarification

**5.22 PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICES IN NETWORK HOSPITAL/ NURSING HOME:**

- Claim in respect of Cashless Access Services will be through the Company / TPA provided admission is in a network Hospital/ Nursing Home and is subject to pre admission authorization

The Company / TPA shall, upon getting the related medical details / relevant information from the Insured Person / Network Hospital / Nursing Home, verify that the person is eligible to claim under the Policy and after satisfying itself will issue a pre-authorization letter / guarantee of payment letter to the Hospital / Nursing Home mentioning the sum guaranteed as payable, also the ailment for which the person is seeking to be admitted as an in-patient The Company/ TPA reserves the right to deny pre-authorization in case the Hospital / Insured Person is unable to provide the relevant information/medical details as required by the Company/ TPA In such circumstances denial of Cashless Access should in no way be construed as denial of liability The Insured Person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the Company / TPA within 15 days of the discharge from Hospital / Nursing Home for consideration of Company/TPA

- Should any information be available with the Company / TPA that makes the claim inadmissible or doubtful, and warrants further investigations, the authorization of the cashless facility may be withdrawn However this shall be done by the Company / TPA before the patient is discharged from the Hospital and notice to this effect given to the treating Hospital/insured
- Turn Around Time for cashless: Pre-authorization will be provided immediately, but no later than one hour from the receipt of the request. Final bill authorization will be issued within three hours of receiving the discharge authorization from the hospital.
- A list of network Hospitals is available on our official website-and will also be provided by the concerned TPA on demand

**5.23 MEDICAL RECORDS:**

- The Insured Person hereby agrees to and authorizes the disclosure, to the Company/ TPA or any other person nominated by the Company, of any and all Medical records and information held by any Institution / Hospital or Person from which the Insured Person has obtained any medical or other treatment to the extent reasonably required by the Company

/ TPA in connection with any claim made under this Policy or the Company's liability thereunder

- The Company / TPA agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to (i) above and will only use in connection with any claim made under this Policy or the Company's liability thereunder
- Any Medical Practitioner authorized by the Company / TPA shall be allowed to examine the Insured Person in case of any alleged Injury or disease requiring Hospitalization when and so often as the same may reasonably be required on behalf of the Company/TPA

**5.24 PAYMENT OF CLAIM:** All medical treatment for the purpose of this insurance will have to be taken in India only (except where the Policy has been extended to SAARC countries) and all claims shall be payable in Indian currency only For the purpose of claims settlement, currency conversion rate on the date of admission to Hospital would apply The Company shall settle the claim within 30days from the date of the receipt of last necessary documents in accordance with the provisions of Regulation 27 of IRDAI (Health Insurance) Regulations, 2016. Upon acceptance of an offer of settlement by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document In such cases, the Company shall settle the claim within 45 days from the date of receipt of

lastnecessarydocumentIncaseofanydelayinthepayment,theCompanyshallbeliabletopayinterest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is settled

**5.25MULTIPLEPOLICIES**

- If an insured person holds multiple policies from one or more insurers to cover treatment costs, the insured person has the right to choose which policy to use for settling the claim. The insurer selected by the insured person is obligated to settle the claim, provided the claim is within the limits and in accordance with the terms of the chosen policy.
- The insurer of that policy will be treated as the primary insurer. If the available coverage under the selected policy is less than the admissible claim amount, the primary insurer shall request details of any other policies held by the policyholder. The primary insurer will then coordinate with the other insurers to settle the balance amount in accordance with the respective policy conditions, ensuring a hassle-free process for the policyholder
- If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose the insurer from whom he/she wants to claim the balance amount
- Where an insured person has policies from more than one insurer to cover the same risk on the indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy

**5.26 CLAIM FALLING IN TWO POLICY PERIODS:** If the claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available Sum Insured in the two Policy Periods, including the Deductibles for each Policy Period Such eligible claim amount to be payable to the Insured, shall be reduced to the extent of premium to be received for the renewal/due date of premium of Health Insurance Policy, if not received earlier

**5.27 REPUDIATION:**

- The Company, shall repudiate the claim if not payable under the Policy the Company/TPA shall mention there as on for repudiation in writing to the Insured Person. The Insured person shall have the right to appeal/approach the Customer Service department of the Company at its Policy issuing office, concerned Divisional Office, concerned Regional Office ,or of the Corporate Office, A, Block-4, Plate-A, NBCC Office Complex, Kidwai Nagar East, New Delhi – 110023
- If the insured is not satisfied with the reply of the Customer Service department under 511(i), he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance The Insurance Ombudsman is empowered to adjudicate on personal line insurance claims upto ₹50 lakhs.

**5.28 DISCLAIMER OF CLAIM:** If the Company shall disclaim liability and communicate in writing(either through the TPA or by itself) to the Insured in respect of any claim hereunder and such claim has not within 12 calendar months from the date of such disclaimer been made the subject matter of a suit in a Court of Law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable here under

**OTHERTERMS & CONDITIONS**

**5.29 FAMILY SIZE:** Minimum two persons (falling within the definition at 3.13) to be covered under the Policy Persons becoming ineligible on account of the above provision for coverage under the existing Policy, may migrate to another suitable Policy at the expiry of this Policy Upon such migration, the credits gained by the concerned Insured Person, for pre-existing conditions and time-bound exclusions shall be transferred to the migrated Policy, provided

the Policy has been maintained without a break

**5.30 SUM INSURED:** The policy has three Plans –**PREMIUM** Plan-Sum Insured upto₹10 lakhs, **ELITE** Plan upto₹50lakhs,and **ROYAL** Plan upto ₹500lakhs

**5.31 ENTRY AGE:** There is no Minimum or Maximum entry age for new policyholders. The premium will be charged as prescribed in the table only.

**5.32 MIDTERM INCLUSION**: Midterm inclusion of members is permitted under the Policy, on payment of pro-rata premium only for

- Newlywed spouse within 90 days of marriage or at the time of renewal of the Policy
- Newborn child from the date of birth or at the time of renewal of the Policy

For members subsequently added, Exclusion No 4.1, 4.2, and 4.3 shall apply from the date of their inclusion in the Policy

**5.33 ENHANCEMENT OF SUMINSURED& PLAN MOVEMENT:** An increase in Sum Insured under the Policy may be considered by the Company only at the time of renewal If at all allowed:

- Policyholders have the option to increase the sum insured either on renewal or increase in the number of family members as per applicable conditions mentioned in the **Benefit Table**
- The Policyholder may upgrade from a lower plan to a higher plan only. Downgrading from a higher plan to a lower plan is not permitted.

**5.34 PROPORTIONATE CLAUSE** - If the Insured Person is admitted in the hospital in a room where the room category or the Room Rent incurred is higher than the eligibility as specified in the Policy Schedule/ Certificate of Insurance, then the Policyholder/ Insured Person shall bear a ratable proportion of the total & specified Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category/eligible Room Rent to the Room Rent actually incurred However, this will not be applicable in respect of Medicines/Pharmacy/ Drugs, Consumables, Medical Devices/ implants and Cost of Diagnostics

**5.35 ASSOCIATED MEDICALEXPENSES:**

- Doctor's fees /Consultant fees/RMO fees
- Nursing expenses including administration charges/ transfusion charges/ injection charges
- Surgeon fees/Asst Surgeon fees
- Anesthesia fees
- Procedure charges of any kind which includes:-
- Chemotherapy/Radiotherapy charges Nebulization
- Haemodialysis PICC
- line insertion
- Catheterization charges Tracheostomy etc.
- IV charges
- Blood transfusion charges
- Dialysis
- Surgery Charges
- OT charges including OT gas ,equipment charges

**5.36 GRACE PERIOD FOR PAYMENT of PREMIUM:** In the event of a delay in the renewal of the Policy, a grace period of 15days (where premium is paid on a monthly installment) and 30 days (where premium is paid quarterly/half-yearly/annual/biennial/triennial installments)

is allowed. However, no coverage shall be available during the grace period and any disease/Injury contracted during the break period shall not be covered and shall be treated as a Pre-existing disease in case of renewal only.

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

**5.37 CHANGE OF ADDRESS:** The Insured must inform the Company immediately in writing of any change in the address

**5.38 QUALITY OF TREATMENT:** The insured hereby acknowledges and agrees that pre-authorization or payment of any claim by or on behalf of the Company shall not constitute on the part of the Company, a guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by the Insured Person It being agreed and recognized by the Insured Person that the Company is in no way responsible or liable for the availability or quality of any services(Medical or otherwise) rendered by any institution (including a Network Hospital)

**5.39 ID CARD:** The card is issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital only Upon the cancellation or nonrenewal of this Policy, all ID cards shall immediately be returned to the TPA at the insured's expense and each Insured Person agrees to hold and keep harmless, the Company and the TPA against any or all costs, expenses, liabilities and claims arising in respect of use or misuse of such ID cards before their return to the TPA

**5.40 DISCOUNT ON OMP PREMIUM:** A discount of 15% on the premium of the Overseas Mediclaim Policy would be allowed when an Insured Person covered under this Policy, takes the Overseas Mediclaim Policy from the Company, provided this Policy is valid as of the date of taking the Overseas Mediclaim Policy of the Company

**5.41 ON-LINE DISCOUNT:** A discount of 10% (maximum ₹ 5000/-) on premium is allowed, if the Policy is purchased online and no Intermediary is involved This discount is also applicable in case of Online renewal of Policies, where no Intermediary was involved at any stage- either on the first purchase or in any subsequent renewal thereof.

**5.42 FAMILY DISCOUNT:** If more than one member is cover under the same policy and opted for Sum Insured on individual member wise. Then a flat discount 5% shall be given on total premium of the policy.

**5.43 IRDAI REGULATION:** This Policy is subject to IRDAI (Protection of Policy holders' Interest)Regulation, 2024 and IRDAI (Health Insurance) Regulations 2024 and Guidelines on Standardization in health insurance ,as amended from time to time

**5.44 JURISDICTION:** All disputes or differences under or in relation to the Policy shall be determined by the Indian Courts and in accordance with the Indian Laws

## Appendix I

| Day care procedures / surgeries | |
|---|---|
| **A** | **Microsurgical Operations on the Middle Ear** |
| 1 | Stapedotomy |
| 2 | Stapedectomy |
| 3 | Revision of a stapedectomy |
| 4 | Myringoplasty (Type -I Tympanoplasty) |
| 5 | Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles) |

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| 6 | Revision of a tympanoplasty |
| 7 | Other operations on the auditory ossicles |
| 8 | Other microsurgical operations on the middle ear |
| **B** | **Other operations on the middle & internal ear** |
| 9 | Myringotomy |
| 10 | Removal of a tympanic drain |
| 11 | Incision of the mastoid process and middle ear |
| 12 | Mastoidectomy |
| 13 | Reconstruction of the middle ear |
| 14 | Fenestration of the inner ear |
| 15 | Revision of a fenestration of the inner ear |
| 16 | Incision (opening) and destruction (elimination) of the inner ear |
| 17 | Other excisions of the middle and inner ear |
| 18 | Other operations on the middle and inner ear |
| **C** | **Operations on the nose & the nasal sinuses** |
| 19 | Excision and destruction of diseased tissue of the nose |
| 20 | Operations on the turbinates (nasal concha) |
| 21 | Nasal sinus aspiration |
| 22 | Other operations on the nose |
| **D** | **Operations on the eyes** |
| 23 | Incision of tear glands |
| 24 | Incision of diseased eyelids |
| 25 | Excision and destruction of diseased tissue of the eyelid |
| 26 | Operations on the canthus and epicanthus |
| 27 | Corrective Surgery for entropion and ectropion |
| 28 | Corrective Surgery for blepharoptosis |
| 29 | Removal of a foreign body from the conjunctiva |
| 30 | Removal of a foreign body from the cornea |
| 31 | Incision of the cornea |
| 32 | Operations for pterygium |
| 33 | Removal of a foreign body from the lens of the eye |
| 34 | Removal of a foreign body from the posterior chamber of the eye |
| 35 | Removal of a foreign body from the orbit and eyeball |
| 36 | Operation of cataract |
| 37 | Anterior Chamber Paracentesis / Cyclodiathermy /Cyclocryotherapy / Goniotomy/Trabeculotomy and Filtering and Allied Operations to Treat Glaucoma |

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| 38 | Diathermy/cryotherapy To Treat Retinal Tear |
| 39 | Other operations on Cornea |
| **E** | **Operations on the skin & subcutaneous tissues** |
| 40 | Incision of a pilonidal sinus |
| 41 | Free skin transplantation, donor site |
| 42 | Free skin transplantation, recipient site |
| 43 | Revision of skin plasty |
| 44 | Simple restoration of surface continuity of the skin and subcutaneous tissues |
| 45 | Destruction of diseased tissue in the skin and subcutaneous tissues |
| 46 | Local excision of diseased tissue of the skin and subcutaneous tissues |
| 47 | Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues |
| 48 | Chemo Surgery to the skin |
| 49 | Excision Of Soft Tissue Rhabdomyosarcoma |
| 50 | Other incisions of the skin and subcutaneous tissues |
| 51 | Other excisions of the skin and subcutaneous tissues |
| **F** | **Operations on the tongue** |
| 52 | Incision, excision and destruction of diseased tissue of the tongue |
| 53 | Partial glossectomy |
| 54 | Glossectomy |
| 55 | Reconstruction of the tongue |
| 56 | Other operations on the tongue |
| **G** | **Operations on the salivary glands & salivary ducts** |
| 57 | Incision and lancing of a salivary gland and a salivary duct |
| 58 | Excision of diseased tissue of a salivary gland and a salivary duct |
| 59 | Resection of a salivary gland |
| 60 | Reconstruction of a salivary gland and a salivary duct |
| 61 | Other operations on the salivary glands and salivary ducts |
| **H** | **Other operations on the mouth & face** |
| 62 | External incision and drainage in the region of the mouth, jaw and face |
| 63 | Incision of the hard and soft palate |
| 64 | Excision and destruction of diseased hard and soft palate |
| 65 | Incision, excision and destruction in the mouth |
| 66 | Plastic Surgery to the floor of the mouth |
| 67 | Palatoplasty |
| 68 | Other operations in the mouth except dental unless necessitated due to an injury |

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| **I** | **Operations on the tonsils & adenoids** |
| 69 | Trans oral incision and drainage of a pharyngeal abscess |
| 70 | Tonsillectomy without adenoidectomy |
| 71 | Tonsillectomy with adenoidectomy |
| 72 | Excision and destruction of a lingual tonsil |
| 73 | Adenoidectomy |
| 74 | Adenoidectomy With Grommet Insertion |
| 75 | Adenoidectomy Without Grommet Insertion |
| 76 | Other operations on the tonsils and adenoids |
| **J** | **Trauma Surgery and orthopaedics** |
| 77 | Incision on bone, septic and aseptic |
| 78 | Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis |
| 79 | Reduction of dislocation under GA |
| 80 | Arthroscopic knee aspiration |
| 81 | Abscess Knee Joint Drainage |
| 82 | Arthroscopic Meniscectomy - Knee |
| 83 | Carpal Tunnel Release |
| 84 | Elbow Arthroscopy |
| 85 | Repair Of Ruptured Tendon |
| 86 | Repair/ graft Achilles Tendon |
| 87 | Surgery For Ligament Tear |
| 88 | Surgery For Meniscus Tear |
| 89 | Tennis Elbow Release |
| 90 | Thyroid Abscess Incision and Drainage |
| 91 | Suture and other operations on tendons and tendon sheath |
| **K** | **Operations on the breast** |
| 92 | Incision of the breast |
| 93 | Operations on the nipple |
| 94 | Excision Of Single Breast Lump |
| **L** | **Operations on the digestive tract** |
| 95 | Incision and excision of tissue in the perianal region |
| 96 | Surgical treatment of anal fistulas |
| 97 | Surgical treatment of haemorrhoids |
| 98 | Division of the anal sphincter (sphincterotomy) |
| 99 | Ultrasound guided aspirations |

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| 100 | Sclerotherapy etc |
| 101 | Lap Appendicectomy |
| 102 | Lap Cholecystectomy and Choledocho-jejunostomy/Duodenostomy / Gastrostomy / Exploration Common Bile Duct |
| 103 | Colonoscopy, lesion removal |
| 104 | Colonscopy Stenting Of Stricture |
| 105 | Esophagoscopy, Gastroscopy, Duodenoscopy With Polypectomy /Removal Of Foreign Body/diathermy Of Bleeding Lesions |
| 106 | Oesophageal varices Sclerotherapy |
| 107 | UGI Scopy and Injection Of Adrenaline, Sclerosants Bleeding Ulcers |
| 108 | UGI Scopy and Polypectomy Oesophagus/stomach |
| 109 | Other operations on the anus |
| **M** | **Operations on the female sexual organs** |
| 110 | Incision of the ovary |
| 111 | Insufflation of the Fallopian tubes |
| 112 | Dilatation of the cervical canal |
| 113 | Conisation of the uterine cervix |
| 114 | Incision in the uterus (hysterotomy) |
| 115 | Therapeutic curettage |
| 116 | Culdotomy |
| 117 | Incision of the vagina |
| 118 | Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas |
| 119 | Incision of the vulva |
| 120 | Operations on Bartholin’s glands (cyst) |
| 121 | Endoscopic Polypectomy |
| 122 | Hymenectomy( imperforate Hymen) |
| 123 | Hysteroscopic adhesiolysis |
| 124 | Hystero scopic Removal Of Myoma |
| 125 | Hystero scopic Resection Of Endometrial Polyp |
| 126 | LLETZ -Large Loop Excision of the Transformation Zone |
| 127 | Other Operations on Fallopian tubes |
| 128 | Other Operations on uterine cervix |
| **N** | **Operations on the prostate & seminal vesicles** |
| 129 | Incision of the prostate |
| 130 | Transurethral excision and destruction of prostate tissue |
| 131 | Transurethral and percutaneous destruction of prostate tissue |

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| 132 | Open surgical excision and destruction of prostate tissue |
| 133 | Radical prostatomy/vesiculectomy |
| 134 | Incision and excision of peri-prostatic tissue |
| 135 | Operations on seminal vesicles |
| 136 | Other excision and destruction of prostate tissue |
| 137 | Other operations on the prostate |
| **O** | **Operations on the scrotum & tunica vaginalis testis** |
| 138 | Incision of the scrotum and tunica vaginalis testis |
| 139 | Operation on a testicular hydrocele |
| 140 | Excision and destruction of diseased scrotal tissue |
| 141 | Plastic reconstruction of the scrotum and tunica vaginalis testis |
| 142 | Other operations on the scrotum and tunica vaginalis testis |
| **P** | **Operations on the testes** |
| 143 | Incision of the testes |
| 144 | Excision and destruction of diseased tissue of the testes |
| 145 | Unilateral orchidectomy |
| 146 | Bilateral orchidectomy |
| 147 | Orchidopexy |
| 148 | Abdominal exploration in cryptorchidism |
| 149 | Surgical repositioning of an abdominal testis |
| 150 | Reconstruction of the testis |
| 151 | Implantation, exchange and removal of a testicular prosthesis |
| 152 | Detorsion Of Torsion Testis |
| 153 | Other operations on the testis |
| **Q** | **Operations on the spermatic cord, epididymis and ductus deferens** |
| 154 | Surgical treatment of a varicocele and a hydrocele of the spermatic Cord |
| 155 | Excision in the area of the epididymis |
| 156 | Epididymectomy |
| 157 | Reconstruction of the spermatic cord |
| 158 | Reconstruction of the ductus deferens and epididymis |
| 159 | Other operations on the spermatic cord, epididymis and ductus deferens |
| **R** | **Operations on the penis** |
| 160 | Operations on the foreskin |
| 161 | Local excision and destruction of diseased tissue of the penis |
| 162 | Amputation of the penis |

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| 163 | Plastic reconstruction of the penis |
| 164 | Other operations on the penis |
| **S** | **Operations on the urinary system** |
| 165 | Cystoscopical removal of stones |
| 166 | Cystoscopic Litholapaxy |
| 167 | Cystoscopy and "SLING" Procedure |
| 168 | Cystoscopy and Removal Of Foreign Body |
| 169 | Cystoscopy and Removal Of Polyp |
| 170 | Cystoscopy with Deflux Injection in VUR |
| 171 | Excision Of Urethral Diverticulum |
| 172 | Excision Of Urethral Prolapse |
| **T** | **Other Operations** |
| 173 | Lithotripsy |
| 174 | Coronary angiography |
| 175 | Haemodialysis |
| 176 | Radiotherapy for Cancer |
| 177 | Cancer Chemotherapy |
| 178 | Axillary/cervical Lymphadenectomy |
| 179 | Drainage Of Pyonephrosis/perinephric Abscess |
| 180 | External Arterio-venous Shunt |

| **List I – List of which coverage is not available in the policy** | |
|---|---|
| **No.** | **Item** |
| 1 | BABY FOOD |
| 2 | BABY UTILITIES CHARGES |
| 3 | BEAUTY SERVICES |
| 4 | BELTS/ BRACES |
| 5 | BUDS |
| 6 | COLD PACK/HOT PACK |
| 7 | CARRY BAGS |
| 8 | EMAIL / INTERNET CHARGES |
| 9 | FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL) |
| 10 | LEGGINGS |
| 11 | LAUNDRY CHARGES |
| 12 | MINERAL WATER |

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|---|---|
| 13 | SANITARY PAD |
| 14 | TELEPHONE CHARGES |
| 15 | GUEST SERVICES |
| 16 | CREPE BANDAGE |
| 17 | DIAPER OF ANY TYPE |
| 18 | EYELET COLLAR |
| 19 | SLINGS |
| 20 | BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES |
| 21 | SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED |
| 22 | Television Charges |
| 23 | SURCHARGES |
| 24 | ATTENDANT CHARGES |
| 25 | EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE) |
| 26 | BIRTH CERTIFICATE |
| 27 | CERTIFICATE CHARGES |
| 28 | COURIER CHARGES |
| 29 | CONVEYANCE CHARGES |
| 30 | MEDICAL CERTIFICATE |
| 31 | MEDICAL RECORDS |
| 32 | PHOTOCOPIES CHARGES |
| 33 | MORTUARY CHARGES |
| 34 | WALKING CHARGES |
| 35 | OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL) |
| 36 | SPACER |
| 37 | SPIROMETRE |
| 38 | NEBULIZER KIT |
| 39 | STEAM INHALER |
| 40 | ARMSLING |
| 41 | THERMOMETER |
| 42 | CERVICAL COLLAR |
| 43 | SPLINT |
| 44 | DIABETIC FOOT WEAR |
| 45 | KNEE BRACES (LONG/ SHORT/ HINGED) |
| 46 | KNEE IMMOBILIZER/SHOULDER IMMOBILIZER |

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|---|---|
| 47 | LUMBO SACRAL BELT |
| 48 | NIMBUS BED OR WATER OR AIR BED CHARGES |
| 49 | AMBULANCE COLLAR |
| 50 | AMBULANCE EQUIPMENT |
| 51 | ABDOMINAL BINDER |
| 52 | PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES |
| 53 | SUGAR FREE Tablets |
| 54 | CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable) |
| 55 | ECG ELECTRODES |
| 56 | GLOVES |
| 57 | NEBULISATION KIT |
| 58 | ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY, KIT etc. |
| 59 | KIDNEY TRAY |
| 60 | MASK |
| 61 | OUNCE GLASS |
| 62 | OXYGEN MASK |
| 63 | PELVIC TRACTION BELT |
| 64 | PAN CAN |
| 65 | TROLLY COVER |
| 66 | UROMETER, URINE JUG |
| 67 | AMBULANCE |
| 68 | VASOFIX SAFETY |
| | |
| **List II – Items that are to be subsumed into Room Charges** | |
| **Sl** | **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 |

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|---|---|
| 10 | SLIPPERS |
| 11 | TISSUE PAPER |
| 12 | TOOTH PASTE |
| 13 | TOOTH BRUSH |
| 14 | BED PAN |
| 15 | FACE MASK |
| 16 | FLEXI MASK |
| 17 | HAND HOLDER |
| 18 | SPUTUM CUP |
| 19 | DISINFECTANT LOTIONS |
| 20 | LUXURY TAX |
| 21 | HVAC |
| 22 | HOUSE KEEPING CHARGES |
| 23 | AIR CONDITIONER CHARGES |
| 24 | IM IV INJECTION CHARGES |
| 25 | CLEAN SHEET |
| 26 | BLANKET/WARMER BLANKET |
| 27 | ADMISSION KIT |
| 28 | DIABETIC CHART CHARGES |
| 29 | DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES |
| 30 | DISCHARGE PROCEDURE CHARGES |
| 31 | DAILY CHART CHARGES |
| 32 | ENTRANCE PASS / VISITORS PASS CHARGES |
| 33 | EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE |
| 34 | FILE OPENING CHARGES |
| 35 | INCIDENTAL EXPENSES / MISC CHARGES (NOT EXPLAINED) |
| 36 | PATIENT IDENTIFICATION BAND / NAME TAG |
| 37 | PULSEOXYMETER CHARGES |
| | |
| **List III – Items that are to be subsumed into Procedure Charges** | |
| **No.** | **Item** |
| 1 | HAIR REMOVAL CREAM |
| 2 | DISPOSABLES RAZORS CHARGES (for site preparations) |
| 3 | EYE PAD |
| 4 | EYE SHEILD |

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|---|---|
| 5 | CAMERA COVER |
| 6 | DVD, CD CHARGES |
| 7 | GAUSE SOFT |
| 8 | GAUZE |
| 9 | WARD AND THEATRE BOOKING CHARGES |
| 10 | ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS |
| 11 | MICROSCOPE COVER |
| 12 | SURGICAL BLADES, HARMONICSCALPEL,SHAVER |
| 13 | SURGICAL DRILL |
| 14 | EYE KIT |
| 15 | EYE DRAPE |
| 16 | X-RAY FILM |
| 17 | BOYLES APPARATUS CHARGES |
| 18 | COTTON |
| 19 | COTTON BANDAGE |
| 20 | SURGICAL TAPE |
| 21 | APRON |
| 22 | TORNIQUET |
| 23 | ORTHOBUNDLE, GYNAEC BUNDLE |
| | |
| **List IV – Items that are to be subsumed into costs of treatment** | |
| | |
| **Sl** | **Item** |
| 1 | ADMISSION/REGISTRATION CHARGES |
| 2 | HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE |
| 3 | URINE CONTAINER |
| 4 | BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES |
| 5 | BIPAP MACHINE |
| 6 | CPAP/ CAPD EQUIPMENTS |
| 7 | INFUSION PUMP– COST |
| 8 | HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC |
| 9 | NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES |
| 10 | HIV KIT |
| 11 | ANTISEPTIC MOUTHWASH |
| 12 | LOZENGES |

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|---|---|
| 13 | MOUTH PAINT |
| 14 | VACCINATION CHARGES |
| 15 | ALCOHOL SWABES |
| 16 | SCRUB SOLUTION/STERILLIUM |
| 17 | Glucometer & Strips |
| 18 | URINE BAG |

## ANNEXURE-I: CONTACT DETAILS OF INSURANCE OMBUDSMEN

| Office Details | Jurisdiction of Office (Union Territory, District) |
|---|---|
| **AHMEDABAD** – Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near CU Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014, Tel: 079 - 27546150 / 27546139 Fax: 079 - 27546142, Email: bimalokpalahmedabad@ecoi.co.in | Gujarat, Dadra & Nagar Haveli, Daman and Diu |
| **BENGALURU** – Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No 57-27-N- 19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078, Tel: 080 - 26652048 / 26652049 Email: bimalokpalbengaluru@ecoi.co.in | Karnataka |
| **BHOPAL –** Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp Airtel Office, Near New Market, Bhopal – 462 003 Tel: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpalbhopal@ecoi.co.in | Madhya Pradesh & Chhattisgarh |
| **BHUBANESHWAR –** Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneshwar – 751 009 Tel: 0674 - 2596461 /2596455 Fax: 0674- 2596429 Email: bimalokpalbhubaneswar@ecoi.co.in | Orissa |
| **CHANDIGARH –** Office of the Insurance Ombudsman, SCO No 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017 Tel: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpalchandigarh@ecoi.co.in | Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir & Chandigarh |

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|---|---|
| **CHENNAI -** Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018<br>Tel: 044 - 24333668 / 24335284 Fax: 044 - 24333664<br>Email: bimalokpalchennai@ecoi.co.in | Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry) |
| **DELHI –** Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002<br>Tel: 011 - 23239633 / 23237532 Fax: 011 - 23230858<br>Email: bimalokpaldelhi@ecoi.co.in | Delhi |
| **GUWAHATI -** Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr Pan bazar over bridge, SS Road, Guwahati – 781001<br>Tel: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937<br>Email: bimalokpalguwahati@ecoi.co.in | Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland & Tripura |
| **HYDERABAD -** Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp Saleem Function Palace, A C Guards, Lakdi-Ka-Pool, Hyderabad - 500 004<br>Tel: 040 - 65504123 / 23312122 Fax: 040 - 23376599<br>Email: bimalokpalhyderabad@ecoi.co.in | Andhra Pradesh, Telangana,<br>Yanam & part of Territory of Pondicherry |
| **JAIPUR –** Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr Floor, Bhawani Singh Marg, Jaipur - 302 005<br>Tel: 0141 - 2740363<br>Email: bimalokpaljaipur@ecoi.co.in | Rajasthan |
| **ERNAKULAM -** Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg, Opp Cochin Shipyard, M G Road, Ernakulam - 682 015<br>Tel: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336<br>Email: bimalokpalernakulam@ecoi.co.in | Kerala, Lakshadweep, Mahe - a part of Pondicherry |
| **KOLKATA –** Office of the Insurance Ombudsman, Hindustan Bldg., Annexe, 4th Floor, 4,<br>CR Avenue, KOLKATA - 700 072<br>Tel: 033 - 22124339 / 22124340 Fax : 033 - 22124341<br>Email: bimalokpalkolkata@ecoi.co.in | West Bengal, Sikkim, Andaman & Nicobar Islands |

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| **LUCKNOW –** Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001<br>Tel: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310<br>Email: bimalokpallucknow@ecoi.co.in | Districts of Uttar Pradesh: Laitpur, Jhansi,Mahoba, Hamirpur,Banda,Chitraoot,All ahabad, 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,<br>Ghazipur, Chandauli, Ballia & Sidharathnagar |
| **MUMBAI -** Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S V Road, Santacruz (W), Mumbai - 400 054<br>Tel: 022 - 26106552 / 26106960 Fax: 022 - 26106052<br>Email: bimalokpalmumbai@ecoi.co.in | Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane |
| **NOIDA –** Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, UP-201301<br>Tel: 0120-2514250 / 2514252 / 2514253<br>Email: bimalokpalnoida@ecoi.co.in | State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar & Saharanpur |
| **PATNA –** Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna - 800 006 Tel: 0612-2680952<br>Email: bimalokpalpatna@ecoi.co.in | Bihar & Jharkhand |
| **PUNE –** Office of the Insurance Ombudsman, Jeevan Darshan Bldg, 3rd Floor, CTS Nos 195 to 198, NC Kelkar Road, Narayan Peth, Pune – 411 030<br>Tel: 020-41312555<br>Email: bimalokpalpune@ecoi.co.in | Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region |