Kotak Mahindra General Insurance Company Ltd. (Formerly Kotak Mahindra General Insurance Ltd.)
Registered Office: 27 BKC, C 27, G Block, Bandra Kurla Complex, Bandra East, Mumbai - 400051. Maharashtra, India.

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Kotak Health Premier
Policy Wording

This is a contract of insurance between You and Us which is subject to the receipt of the premium in full and the terms, conditions and exclusions of the Policy. This Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided by You in respect of the Insured Persons in the Proposal Form. Please inform Us immediately of any change in the address, state of health or any other changes affecting You or any Insured Person.

PART I

1. DEFINITIONS

For the purposes of this Policy, the terms specified below shall have the meaning set forth wherever appearing/specified in this Policy or related Endorsements:

Where the context so requires, references to the singular shall also include references to the plural and references to any gender shall include references to all genders. Further any references to statutory enactment include subsequent changes to the same.

Accident	means sudden, unforeseen and involuntary event caused by external, visible and violent means
Admission	means the Insured Person's admission to a Hospital as an inpatient for the purpose of medical treatment of an Injury and/or Illness
Alternative Treatments (AYUSH)	refers to the medical and/ or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems
Ambulance	means a road vehicle operated by a healthcare/ ambulance service provider and equipped for the transport and paramedical treatment of the person requiring medical attention
Any one Illness	means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken
Associated Medical Expenses	means Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioners (including surgeons, anesthetists and specialists) and costs of diagnostic tests
Base Sum Insured	a. For Individual sum insured basis (Individual Policy), the amount specified in the Policy Schedule against an Insured Person which is Our maximum, total and cumulative liability for any and all claims arising during a Policy Year in respect of that Insured Person. b. For Family Floater sum insured basis (Floater Policy), the amount specified in the Policy Schedule which is Our maximum, total and cumulative liability for any and all claims arising during a Policy Year in respect of any one and/or all Insured Persons. If the Policy Period is more than one year, then the Base Sum Insured will apply afresh to each Policy Year in the Policy Period, but any portion of the Base Sum Insured which remains un-utilised in any Policy Year shall not be carried forward to any subsequent Policy Year in the Policy Period.
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
Claim	means a demand made by You for payment of any benefit under the Policy in respect of an Insured Person
Condition Precedent	means a policy term or condition upon which the Insurer's liability under the policy is conditional upon
Congenital Anomaly	means a condition which is present since birth, and which is abnormal with reference to form, structure or position a) Internal Congenital Anomaly Congenital anomaly which is not in the visible and accessible parts of the body. b) External Congenital Anomaly Congenital anomaly which is in the visible and accessible parts of the body
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.
Cumulative Bonus	means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium
Day care centre	means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under – i. has qualified nursing staff under its employment; ii. has qualified medical practitioner/s in charge; iii. has fully equipped operation theatre of its own where surgical procedures are carried out; iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel
Day Care Treatment	means medical treatment, and/or surgical procedure which is: i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and ii. which would have otherwise required hospitalization of more than 24 hours Treatment normally taken on an out-patient basis is not included in the scope of this definition

Deductible	means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
Dental treatment	means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery
Disclosure to information norm	The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
Domiciliary Hospitalisation	means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances: i. The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or ii. The patient takes treatment at home on account of non-availability of room in a hospital.
Emergency	means a serious medical condition or symptom resulting from Injury or sickness which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an emergency anymore.
Emergency Care	means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a *medical practitioner* to prevent death or serious long term impairment of the insured person's health
Family Floater	means a Policy described as such in the Policy Schedule where You and Your family members as mentioned in Eligibility (Part III) and named in the Schedule are insured under this Policy as at the Policy Period Start Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your family members mentioned in the Policy Schedule during each Policy Period.
Grace Period	means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-existing diseases. Coverage is not available for the period for which no premium is received.
Hospital	<u>For non-AYUSH treatments:</u> means any institution established for in-patient care and day care treatment of illness and / or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulations) 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: I. has qualified nursing staff under its employment round the clock; ii. has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places; iii. has qualified medical practitioner (s) in charge round the clock; iv. has a fully equipped operation theatre of its own where surgical procedures are carried out v. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel <u>For AYUSH treatment:</u> I. Teaching hospitals of AYUSH college recognised by Central Council of Indian Medicine (CCIM) Central Council of Homeopathy (CCH) ii. AYUSH Hospitals having registration with a Government authority under appropriate Act in the State/UT compiles with the following as minimum criteria: a) Has at least 15 in-patient beds; b) Has minimum 5 qualified and registered AYUSH doctors; c) Has qualified paramedical staff under its employment round the clock; d) Has dedicated AYUSH therapy sections; e) Maintains daily records of patient and makes these accessible to the insurance company's authorized personnel.
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 24 consecutive hours
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: 1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests 2. it needs ongoing or long-term control or relief of symptoms 3. it requires your rehabilitation or for you to be specially trained to cope with it 4. it continues indefinitely 5. it recurs or is likely to recur
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
Inpatient care	means treatment for which the insured person has to stay in a Hospital for more than 24 hours for a covered event
Instalment Premium	Shall mean the defined proportion of the applicable annual premium with respect to the Insured Person(s) payable at regular frequency as defined in the Policy Schedule.
Insured Person(s)	means the persons named in the Policy Schedule, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium received
Intensive Care Unit	means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

ICU Charges	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.
Maternity expenses	Maternity expenses means; a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization); b) expenses towards lawful medical termination of pregnancy during the policy period
Medical Advice	means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription
Medical Expenses	means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
Medically Necessary Treatment	means any treatment, tests, medication, or stay in hospital or part of a stay in *hospital* which i. is required for the medical management of the illness or injury suffered by the insured; ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity; iii. must have been prescribed by a Medical Practitioner; iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India
Medical Practitioner	means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license The term Medical Practitioner would include physician, specialist, anaesthetist and surgeon but would exclude You and Your Immediate Family. "Immediate Family would comprise of Your spouse, children, brother(s), sister(s) and parent(s).
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
New Born Baby	New born baby means baby born during the Policy Period and is aged upto 90 days.
Non-Network Provider	means any Hospital, day care centre or other provider that is not part of the network
Notification of Claim	means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication
OPD treatment	means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
Plan	means the Plan stated in the Policy Schedule which is applicable to all Insured Persons and specifies the amounts of benefits available
Policy	means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to You, what is excluded from the cover and the terms & conditions on which the Policy is issued to You.
Policy Period	means the period commencing from Policy Start Date and time as specified in Policy Schedule and terminating at midnight on the Policy End Date as specified in Policy Schedule
Policy Schedule	means the schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
Policy Year	means a period of twelve months beginning from the Policy Period Start Date and ending on the last day of such twelve-month period. For the purpose of subsequent years, "Policy Year" shall mean a period of twelve months beginning from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Policy Period End Date, as specified in the Policy Schedule.
Portability	means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another or from one plan to another plan of the same insurer
Pre-existing Disease	means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.
Pre-Hospitalisation Medical Expenses	means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that: I. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
Post Hospitalisation Medical Expenses	means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that: i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and ii. The inpatient hospitalization claim for such hospitalization is admissible by the Insurance Company.
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
Reasonable & 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.
Renewal	means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods

Room Rent	means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses
Surgery or Surgical Procedure	means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a *Medical Practitioner*
Third Party Administrator (TPA)	means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulations, 2016 notified by the Authority and is engaged, for a fee or remuneration for providing health services as defined in those Regulations
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
You/Your/Policyholder	means the policyholder/Insured Person named in the Policy Schedule
We/ Our/Us	means Kotak Mahindra General Insurance Company Limited

PART II

2. WHAT WE WILL PAY (COVERS AVAILABLE UNDER THE POLICY)

The Covers available under this Policy are described below. Covers will be available to the Insured Person, only if that particular cover is specifically mentioned in the Policy Schedule as per the Plan opted by You, subject to

(a) availability of Base Sum Insured and Cumulative Bonus(if any)
(b) the terms, conditions and exclusions of this Policy and
(c) any sum insured or sub-limits specified in respect of that Cover and any limits applicable under the Plan in force for the Insured Person as specified in the Policy Schedule

2.1 In-patient Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalization that occurs during the Policy Period following an Illness or Injury provided that:

(a) The Hospitalisation is for a minimum and continuous period of 24 hours
(b) the Hospitalisation is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
(c) the Medical Expenses incurred are Reasonable and Customary and may be for one or more of the following:
  i. Room Rent and other boarding charges;
  ii. ICU Charges;
  iii. Operation theatre expenses;
  iv. Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
  v. Qualified Nurses' charges;
  vi. Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
  vii. Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized
  viii. Anaesthesia, blood, oxygen and blood transfusion charges;
  ix. Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.
  x. Inpatient physiotherapy charges;

2.2 Day Care Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Day Care Treatment during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that:

(a) the Day Care Treatment is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
(b) the Medical Expenses incurred are Reasonable and Customary ;

Further,

(a) We will only cover the Medical Expenses for those Day Care Treatments which are listed in Annexure II of this Policy. The complete list of Day Care Treatments covered is also available on Our website [www.kotakgeneralinsurance.com];
(b) We will not cover any OPD Treatment under this Benefit.

2.3 Pre-Hospitalization Medical Expenses and Post Hospitalization Medical Expenses

We will indemnify the Insured Person's Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses following an Illness or Injury that occurs during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under this Policy and the Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses relate to the same Illness/medical condition;

Further,

(a) We will pay Pre-Hospitalisation Medical Expenses up to the number of days as mentioned in the Policy Schedule preceding the Insured Person's Admission to Hospital for In-patient Care or Day Care Treatment;
(b) We will pay Post-Hospitalisation Medical Expenses up to the number of days as mentioned in the Policy Schedule immediately following the Insured Person's discharge from Hospital following In-patient Care or Day Care Treatment.

2.4 Ambulance Cover

We will indemnify the amount incurred up to the limit specified in the Policy Schedule for the reasonable expenses incurred by You on availing ambulance services offered by a healthcare or Ambulance service provider for your necessary transportation to the Hospital for treatment of an Illness or Injury following an Emergency provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy and the Ambulance service relates to the same illness / medical condition
(b) The necessity of the use of the Ambulance is certified by the treating Medical Practitioner;

Further,

(a) We will also provide cover under this benefit if the Insured Person is required to be transferred from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital or the Insured Person is required to be moved to a better Hospital facility due to lack of available/adequate treatment facilities at the existing Hospital.
(b) In case of Individual Policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.

2.5 Organ Donor Cover

We will indemnify the In-patient Hospitalisation Medical Expenses towards the donor for harvesting the organ up to the limits of the base Sum Insured (subject to availability), provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the Insured Person;
(b) The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules;
(c) The organ donated is for the use of the Insured Person who has been asked to undergo an organ transplant on Medical Advise;

Further,

(a) In case of Individual Policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.
(b) We will not cover expenses towards the donor in respect of:
  (i) Any Pre-Hospitalization Medical Expenses or Post-Hospitalization Medical Expenses;
  (ii) Costs directly or indirectly associated to the acquisition of the organ;
  (iii) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

2.6 Alternative Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Alternative Treatment during the Policy Period following an Illness or Injury that occurs during the Policy Period up to the limits of the Base Sum Insured (subject to availability), provided that:

(a) The Alternative Treatment is administered by a Medical Practitioner;
(b) The Insured Person is admitted to Hospital (For AYUSH treatment) as an Inpatient for the Alternative Treatment to be

administered.

Further,

(a) In case of Individual Policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.

2.7 Domiciliary Hospitalisation

We will indemnify the Medical Expenses incurred on the Insured Person's Domiciliary Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period up to the limits of the Base Sum Insured (subject to availability), provided that:

(a) We will cover medical expenses of an Insured person for treatment of a disease, Illness or Injury taken at home which would otherwise have required hospitalisation or since the Insured person's condition did not allow a hospital transfer or a hospital bed was unavailable.
(b) The domiciliary hospitalisation is Medically Necessary and follows the written advice of a Medical Practitioner
(c) The Medical Expenses incurred are Reasonable and Customary Charges;
(d) The Insured Person's Domiciliary Hospitalisation extends for at least 3 consecutive days in which case We will pay Medical Expenses from the first day of Domiciliary Hospitalisation;

Further,

(a) We shall not indemnify for any Medical Expenses incurred for the treatment of any of the following Illnesses/conditions under this Cover:
    i. Asthma;
    ii. Bronchitis;
    iii. Chronic Nephritis and Chronic Nephritic Syndrome;
    iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis;
    v. Diabetes Mellitus and Insipidus;
    vi. Epilepsy;
    vii. Hypertension;
    viii. Influenza, cough and cold;
    ix. All psychiatric or psychosomatic disorders;
    x. Pyrexia of unknown origin for less than 10 days;
    xi. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;
    xii. Arthritis, Gout and Rheumatism.
(b) In case of Individual Policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.

2.8 Annual Health Check-up

We will arrange for one free health check-up at Our Network Provider for each Insured Person that is above 18 years of Age, for each Policy Year for the specified tests. Availing the Annual Health Check-up will not impact the Base Sum Insured or the Cumulative Bonus. This will be offered regardless of any claim admitted/ registered under the Policy.

The health check-up will consist of the following tests for all eligible Insured Persons, however, these tests are subject to revision at Our discretion and will be communicated to Insured Person(s).

(a) CBC;
(b) MER;
(c) Serum Cholesterol;
(d) Serum Creatinine;
(e) SGPT /SGOT
(f) ECG;
(g) Random Blood Sugar.

2.9 Restoration Benefit

We will provide a 100% restoration of the Base Sum Insured amount once in a Policy Year if the Base Sum Insured and the Cumulative Bonus (if any) is insufficient as a result of previous Claims in that Policy Year, provided that:

(a) The restored sum insured will not be available in respect of any Illness (including its complications) for which a Claim has already been accepted / paid in that Policy Year for the same Insured Person.
(b) The restoration of sum insured shall not apply to the first claim in that Policy Year unless related to an Injury due to Accident where the claim amount exceeds the Base Sum Insured.

Further,

(a) No Cumulative Bonus will apply on the restored sum insured;
(b) The restored sum insured will apply to all Insured Persons on the same basis as the Base Sum Insured i.e. individual sum insured in case of Individual Policy and floater sum insured in case of Floater Policy;
(c) Any restored sum insured which is not utilized in a Policy Year shall not be carried forward to any subsequent Policy Year;
(d) Restoration of sum insured will be in addition to the Base Sum Insured.

2.10 Cumulative Bonus

We will increase Your Base Sum Insured by 10% subject to the maximum limit specified in the Policy Schedule at the end of the Policy Year if the Policy is renewed with Us provided that:

(a) Cumulative Bonus will accrue only if no claims have been made in respect of the Insured Person(s) in the expiring Policy Year;
(b) Cumulative Bonus under a Family Floater Policy will be available only to those Insured Persons who were Insured Persons in the immediately completed Policy Year;

Further,

(a) If the Base Sum Insured is increased at the time of Renewal, then the Cumulative Bonus will be calculated on the Base Sum Insured of the immediately completed Policy Year;
(b) If the Base Sum Insured is reduced at the time of Renewal, then the applicable Cumulative Bonus will be applicable on the renewed policy Base Sum Insured.
(c) Cumulative Bonus will be carried forward to the next Policy Year, provided the Insured Person renews the Policy before the expiry of the Grace Period.
(d) If the Policy Period is more than one year, then any Cumulative Bonus that has accrued for the Policy Year will be credited at the end of the Policy Year and shall be available for any claims made in the subsequent Policy Year.
(e) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest among all the Insured Persons.
(f) If the Insured Persons in the expiring Policy are covered on a floater basis and such Insured Persons renew their expiring Policy with Us into two or more floater/individual policies then the Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Base Sum Insured of each Renewed Policy.
(g) Any earned Cumulative Bonus shall not be available for claims under Maternity Benefit, New Born Baby Cover, Vaccination Expenses, Critical Illness Cover and Personal Accident Cover.
(h) The Cumulative Bonus is provisional and is subject to revision if a Claim is made after the acceptance of renewal premium in respect of the expiring Policy Year. . Such awarded Cumulative Bonus shall be withdrawn only in respect of the expiring year in which the Claim was admitted. Cumulative Bonus will be provided if any Claim made under the Policy has been repudiated/withdrawn.

2.11 Second E-Opinion Cover

We will facilitate the Insured person for availing a Second E-Opinion on his / her medical condition occurring during the Policy Period, provided that:

(a) We shall only provide access to an E-opinion and this shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner;

Further,

(a) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.
(b) The Insured person is free to choose whether or not to obtain the expert opinion and if obtained whether or not to act on it

2.12 Health and Rewards

We will provide incentives to reward the Insured Person(s) for taking care of his her health/fitness through regular preventative and wellness habits. You can earn reward points for the activities mentioned below. The activities may attract additional charges (decided at Our discretion) to be directly payable by You. The activities

undertaken by You will be rewarded by Us in the form of reward points as per the terms and conditions mentioned below. You can redeem these reward points in accordance with the redemption terms and conditions.

- **List of Wellness Activities:**

(a) Health Risk Assessment (HRA)
Health Risk Assessment questionnaire is used as a tool for evaluation of health and quality of life. It helps you to understand your lifestyle and its impact on your health status. The HRA will be an online assessment provided by Us through vendor tie-ups. This can be undertaken only once per Insured Person in a Policy Year.

You can earn 250 reward points on completion of HRA per Insured Person, in case of Individual Policy and maximum up to 500 reward points per family in case of Floater Policy in a Policy Year.

Insured Person(s) only above 18 years of Age will be eligible to undergo HRA.

However, this shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner. The Insured Person is free to choose whether or not to undergo the same and if done whether or not to act on it.
We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made thereby.

(b) Health Check-Up
The Company provides for health check-up as per Benefit 2.8 Annual Health Check-Up. You will be provided reward points for undergoing the Health Check-Up. We will facilitate in booking the appointment and arrange for the check-up through any of our Network Providers.
You can earn 500 reward points for undergoing Health Check-Up per Insured Person in case of Individual Policy and a maximum of 1,500 reward points per family in case of Floater Policy in a Policy Year. If the result of all the medical test parameters are within normal limit/ range, additional 500 reward points per Insured Person in case of Individual Policy and a maximum of 1,500 reward points per family in case of Floater Policy will be awarded in a Policy Year.
However, this shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner. The Insured person is free to choose whether or not to undergo the test and if done whether or not to act on it.
We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

(c) Preventive Check-Up
You can also earn reward points by undergoing certain other diagnostic and preventive health check-up at any diagnostic centre at Your own expenses. You shall have to submit medical reports of these tests to Us.

List of the Tests eligible under this are mentioned below:

Name of the Test	Applicability
Heart related screening tests (2D echo/ TMT/ ECG)	Individual above the age of 45 years
HbA1c / Complete lipid profile	Any age
PAP Smear/ Mammogram/ CA-125	Females above the age of 40 years
Prostate Specific Antigen (PSA)	Males above the age of 45 years
Vitamin Profile test (D3, B12 and TSH)	Any age
USG whole abdomen	Any age
Kidney Function test	Any age
Renal function test	Any age
Cardiac biomarker test	Any age
Body Fat Analysis	Any age

You can earn 250 reward points for undergoing preventive check-up per test per Insured Person in case of Individual Policy and a maximum of 1,500 reward points per family in case of Floater Policy in a Policy Year. If the result of the medical test parameters mentioned above are within normal limits/ range, additional 250 reward points per test per Insured Person in case of Individual Policy and a maximum of 1,500 reward points per family in case of Floater Policy will be awarded in a Policy Year. One test will be considered only once for reward points during a Policy Year.
However, this shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner. The Insured person is free to choose whether or not to undergo the test and if done whether or not to act on it.
We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

(d) Fitness Initiatives
We will reward You for the following fitness & health related activities as given below which are undertaken after Policy Start Date.

Fitness Activities	**Reward Points**
Participation in Professional sporting events like Marathon/ Swimathon /Triathlon, etc.	500 points per event and 1000 points per Policy Year
Gym/ Yoga membership for 1 year	1000 per Policy Year
Sports Activity membership (Swimming / Tennis/ Badminton/ for 1 year	1000 per Policy Year
Share your Fitness story	250 per Policy Year
Winning Health Quiz/ Contests organized by Us	250 per event and 500 points per Policy Year

- Terms for Reward Point Accumulation under Health and Rewards:

  You can earn maximum 5,000 reward points per Insured Person in case of Individual Policy and a maximum of 10,000 reward points per family in case of Floater Policy in a Policy Year. You should notify and submit relevant documents, bills etc. for various wellness activities within sixty (60) days of undertaking such activity.

- Redemption of Reward Points:

  Each Reward Point will be equivalent to 0.25 Rupees.

  You can redeem these Reward points (after conversion to the equivalent rupee amount) against any of the following options:
  (a) i) Outpatient medical expenses like consultation charges, medicine & drugs, dental expenses, wellness & preventive care and other miscellaneous charges
  ii) Diagnostic expenses and health check-ups through our Network providers.
  (b) In-patient Treatment and Day Care Treatment claims, provided that the Base Sum Insured, Cumulative Bonus and Restoration Sum Insured (if applicable) are exhausted during the Policy Year.
  (c) Payment of Co-payment, if applicable
  (d) Non-medical expenses listed under Annexure III

- Terms for Redemption:
  (a) Reward points not redeemed in the given Policy Year can be carried forward for a maximum up to 1 year from the date of expiry of the Policy Year in which they are earned.
  (b) Reward Points shall automatically lapse upon cancellation of the Policy. However, any unclaimed and accrued Points (from Previous Policy Year/ month) shall be available for redemption up to 1 year from the date of cancellation of the Policy unless the policy has been cancelled by Us on grounds of misrepresentation, fraud, non disclosure or non-cooperation of the Insured.
  (c) Reward Points cannot be redeemed for the same activity against which the Reward points were earned at first. For e.g. If reward points are earned for undergoing "Preventive Check-Up – HbA1c/ Lipid Profile" then the same points cannot be used for claiming under the diagnostic expenses for undergoing the said test.
  (d) Redemption of the rewards points can be done twice during a Policy Year.
  (e) Redemption of rewards points does not entail any cash benefit to be provided to You.

2.13 Value Added Benefits

The Benefits listed below are Value Added Benefits and shall be available to the Insured Persons specified in the Policy Schedule. Benefits under this Section are subject to the terms, conditions and exclusions of this Policy. The activities may attract additional charges (decided at Our discretion) to be payable by You directly to the vendor.

Claims under this Section will not impact the Sum Insured or the eligibility for Cumulative Bonus.

VA 1	VA 2	VA 3
Online customer profile	Online customer profile	Online customer profile
Doctor directory	Doctor directory	Doctor directory
Doctor appointment	Doctor appointment	Doctor appointment
Online Pharmacy/ Online Diagnostics tests booking	Online Pharmacy/ Online Diagnostics tests booking	Online Pharmacy/ Online Diagnostics tests booking
Health tips/ articles	Health tips/ articles	Health tips/ articles
Home Health	Home Health	Home Health
	E-consultation	E-consultation
		Dietician/ Nutritionist opinion

(a) Online customer profile
Based on the HRA taken and health check-ups, if any, undertaken by the Insured Person, We will maintain an online customer profile through our vendor tie-up which can be accessed by the Insured Person to review his Health status.

(b) Doctor directory
We will provide with or arrange for an online platform through our vendor tie-up for providing access to information on general physicians, specialists and super specialists.

(c) Doctor appointment
We will provide with or arrange for an online platform through vendor tie-ups for fixing up doctor appointments for the Insured Person(s).

(d) Online Pharmacy, Diagnostic tests and other Health/ Wellness Offering
We will facilitate the Insured Person for various offerings on health and wellness services like Diagnostic Centers, Pharmacy, Gymnasiums, Yoga, etc. through the Network Providers/ vendor tie-ups.

(e) Health tips/ articles
We will provide You information on various health related applications, wellness training, maintaining fitness and good health, information on various diseases, dietary plans, etc. through periodic communications and through online platform.

(f) Home Health
We will provide through vendor tie-ups, Home Health services like physiotherapy, nursing care, trained attendants and medical equipments, for the Insured Person.

(g) E-consultations
We will provide with or arrange for an online platform through vendor tie-ups for providing with E-consultations to the Insured Person.

(h) Dietician & Nutritionist opinion
We will arrange for dieticians/ nutritionists through our vendor tie ups to provide for counselling to the Insured Person.

Terms and Conditions for 2.12 Health and Rewards and 2.13 Value Added Benefits

- Any information provided by You shall be kept confidential
- For services which are provided through empanelled medical experts/ centres/ service providers, We are only acting as a facilitator, hence We would not be liable for any incremental cost of the services.
- All medical services are being provided by empanelled medical experts/ centres/ service providers who are empanelled after full due diligence. Nonetheless, Insured Person may consult their personal doctor before availing the medical services. The decisions to utilise the services will solely be at the Insured Person's discretion.
- We/Company/Us or its group entities, affiliates, officers, employees, agents, are not responsible for or liable for any actions, claims, demands, losses, damages, costs, charges and expenses which an Insured Person/ You may claim to have suffered or sustained or incurred by way of or on account of utilization of any benefits specified herein.
- This shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner. The Insured person is free to choose whether or not to undergo the same and if done whether or not to act on it.
- We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

2.14 Hospital Daily Cash

We will pay the daily cash amount specified in the Policy Schedule for this Benefit for each and every completed day of the Insured Person's Hospitalization during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy;
(b) The Insured Person's Hospitalization extends for at least 3 consecutive days, in which case We will make payment under this Benefit from the first day of Hospitalization;
(c) We shall not be liable to make payment for more than the maximum number of days per Policy Year specified in the Policy Schedule for this Benefit.

Further,

(a) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).
(b) The payment under this benefit is over and above the Base Sum Insured.

2.15 Convalescence Benefit

We will pay the amount specified in the Policy Schedule for this Benefit if the Insured Person is admitted in Hospital for a minimum period of 10 consecutive days provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalization;

Further,

(a) We shall not be liable to make payment under this Benefit in respect of an Insured Person more than once during the Policy Year.
(b) This benefit is applicable on an individual basis irrespective o type of policy (Individual/ Floater).
(c) The payment under this benefit is over and above the Base Sum Insured.

2.16 Home Nursing Benefit

We will indemnify the amount specified in the Policy Schedule for this Benefit incurred for medical care services of a qualified nurse at the residence of the Insured Person following discharge from hospital after treatment for Illness/ Injury provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalisation;
(b) Such medical care services are confirmed as being necessary by the attending Medical Practitioner and the same relate directly to Illness/ Injury for which the Insured Person has undertaken treatment during the hospitalisation

Further,

(a) The cover is applicable for a maximum of 15 days during the Policy Year and after the completion of the number of days mentioned in the Post-Hospitalization Medical Expenses cover (2.3).
(b) In case of Individual policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.
(c) The payment under this benefit is within the Base Sum Insured.

2.17 Daily Cash for Accompanying an Insured Child

We will pay the Daily Cash Amount specified in the Policy Schedule for this Benefit for each and every completed day of the Insured Person's Hospitalization during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy;
(b) The Insured Person hospitalized is a Child aged 12 years or below
(c) We shall not be liable to make payment for more than the maximum number of days per Policy Year specified in the Policy Schedule for this Benefit.

Further,

(a) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).
(b) The payment under this benefit is over and above the Base Sum Insured.

2.18 Compassionate Visit

We will indemnify the costs of a return journey undertaken by air/ rail/ road (to and fro) up to the limit specified in the Policy Schedule under this Benefit for one of the Insured Person's Immediate Relative to travel from the place of the Immediate Relative's residence to the Hospital where the Insured Person is hospitalized, in case Hospitalization of the Insured Person extends beyond 5 consecutive days provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care

Treatment under the Policy

Further,

(a) In case of Individual policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.
(b) The payment under this benefit is over and above the Base Sum Insured.
(c) For the purpose of this Benefit, the term "Immediate Relative" would mean the Insured Person's spouse, children or parents.

2.19 Maternity Benefit

We will indemnify the Medical Expenses incurred up to the Maternity Benefit Sum Insured specified in the Policy Schedule for the delivery of the Insured Person's child (including cesarean section) or th Medically Necessary and lawful medical termination of pregnancy during the Policy Period provided that:

(a) The treatment is taken as an In-patient in a Hospital;
(b) The cover shall be available to the Insured Person who has been continuously covered for at least 36 months under this Benefit subject to the Portability & Continuity Benefits as applicable.

Further,

(a) We shall not be liable to pay for more than 2 events of deliveries across all Policy Periods with Us;
(b) We will cover pre-natal and post-natal expenses up to the amount specified in the Policy Schedule for this Benefit provided that We have accepted a Claim for delivery/termination under this Benefit;
(c) Ectopic pregnancy shall not be covered under this Benefit , but any Claims will be considered under In-patient Treatment;
(c) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).
(d) The payment under this benefit is over and above the Base Sum Insured.

Permanent Exclusion 3.5(13) of the Policy Wordings stands deleted to the extent of this Benefit only.

2.20 New Born Baby Cover

We will indemnify the Medical Expenses incurred on the Hospitalization of the Insured Person's New Born Baby during the Policy Period within the limits of the Maternity Sum Insured subject to the following:

(a) We have accepted a Claim for Maternity Benefit under the Policy.

Further,

(a) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).
(b) Any pre and post hospitalization expenses for the new born shall not be covered under this benefit.

You can cover the New Born Baby beyond 90 days on payment of requisite premium for the New Born Baby by way of an endorsement or at the next Renewal, whichever is earlier.

2.21 Vaccination Expenses

We will cover the Vaccination Expenses incurred on the Insured Person's Baby during the Policy Period up to the limit specified in the Policy Schedule subject to the following:

(a) We have accepted a Claim for Maternity Benefit under the Policy.
(b) The Insured Person whose maternity claim has been accepted by Us continues to renew the Policy with Us subsequently.

Further,

(a) The expenses will be covered from the birth till the Baby completes two years.
(b) Reimbursement claims for vaccination expenses can be submitted once during a Policy Year.
(c) The payment under this benefit is over and above the Base Sum Insured.

Permanent Exclusion 3.5 (7) of the Policy Wordings stands deleted to the extent of this Benefit only.

The Covers under Benefits 2.19, 2.20 and 2.21 are not available on a standalone basis and need to be availed in conjunction only.

2.22 Air Ambulance Cover

We will indemnify the amount up to the limit specified in the Policy Schedule for the reasonable expenses incurred by You for ambulance transportation in an airplane or helicopter for emergency life threatening health conditions which require immediate and rapid ambulance transportation from the site of first occurrence of the Illness /Accident to the nearest hospital provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy and the air ambulance service relates to the same Illness / medical condition
(b) The necessity of the use of the Air Ambulance is certified by the treating Medical Practitioner;

Further,

(a) We will also provide cover under this Benefit if the Insured Person is required to be transferred from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital or the Insured Person is required to be moved to a better Hospital facility due to lack of available/adequate treatment facilities at the existing Hospital.
(b) Return transportation to Your home by air ambulance is excluded
(c) In case of Individual policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.
(d) The payment under this benefit is within the Base Sum Insured.

2.23 Critical Illness Cover

If the Insured Person is first diagnosed to be suffering from any of the following Critical Illnesses during the Policy Period, We will pay sum insured upto the limit specified in the Policy Schedule for this Cover, subject to the following:

(a) On payment of additional premium, cover would be provided to each individual for the Policy Period.
(b) We shall not be liable to accept any Claim under this Cover if it pertains to any Critical Illness diagnosed within 90 days of the commencement of the first Policy Period of this Cover with Us;
(c) We shall not be liable in case any of the Critical Illnesses is a consequence of or arises out of any Pre-Existing Condition(s) /Disease.
(d) We shall not be liable to make payment under this Cover for more than once in respect of any Insured Person across all Policy Periods;

Further,

(a) This cover is applicable on an individual basis irrespective of type of policy (Individual/ Floater) and available for Insured Persons aged 18 years or above.
(b) The payment under this benefit is over and above the Base Sum Insured and will not impact the Base Sum Insured or the Cumulative Bonus (if any).
(c) Once a Claim has been accepted and paid for any of the listed Critical Illness, this benefit shall cease in respect of that Insured Person, but shall continue to be in force for other Insured Persons.
(d) Notwithstanding any provision to the contrary in the Policy, this Cover will be applicable on a worldwide basis;
(e) In the event of a Claim arising under this Cover, We shall be given written notice of the Claim within 30 days from the date of the first diagnosis of the Critical Illness and We shall be provided the following information and documentation:
    (i) The Claim documents stated in the Policy, provided that We will accept duly certified copies of the listed documents if the originals are required to be submitted to any other insurance company;
    (ii) Written confirmation of the diagnosis of the Critical Illness from the treating Medical Practitioner;

"Critical Illness" for the purpose of this Cover is as mentioned below:

- First diagnosis of the below-mentioned Illnesses more specifically described below
  1. Cancer of specified severity
  2. Kidney failure requiring regular dialysis;
  3. Multiple Sclerosis with persisting symptoms;
  4. Motor Neurone Disease with Permanent Symptoms
  5. Benign Brain Tumor
  6. Primary Pulmonary Hypertension
  7. End Stage Liver Failure
- Undergoing for the first time of the following surgical procedures, more specifically described below:

8. Major Organ / Bone Marrow Transplant;

9. Open heart replacement or repair of heart valves
10. Open chest CABG
11. Aorta Graft Surgery

- Occurrence for the first time of the following medical events more specifically described below:

12. Coma of Specified Severity
13. Stroke resulting in permanent symptoms;
14. Permanent Paralysis of Limbs;
15. First Heart Attack of specified severity.
16. Third Degree (or Major) Burns
17. Deafness
18. Loss of Speech

The Critical Illnesses and the conditions applicable to the same are more particularly described in Annexure IV.

2.24 Personal Accident Cover

We will pay Sum Insured upto the limit specified in the Policy Schedule for this Cover, subject to the following:

(a) On payment of additional premium, cover would be provided to each individual for the Policy Period.
(b) We shall not be liable to make payment under this Cover for more than once in respect of any Insured Person across all Policy Periods;

Further,
(a) This cover is applicable on an individual basis irrespective of type of policy (Individual/ Floater)
(b) The payment under this benefit is over and above the Base Sum Insured and will not impact the Base Sum Insured or the Cumulative Bonus (if any).
(c) Notwithstanding any provision to the contrary in the Policy, this Cover will be applicable on a worldwide basis;

- Accidental Death

We will pay the Sum Insured upto the limit specified in the Policy Schedule if the Insured Person dies solely and directly due to an Injury sustained in an Accident which occurs during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of that Accident.

Once a Claim has been accepted and paid under this Benefit then this Policy will automatically terminate in respect of that Insured Person only.

- Permanent Total Disablement (PTD)

We will pay the Sum Insured upto the limit specified in the Policy Schedule if the Insured Person suffers Permanent Total Disablement of the nature specified below solely and directly due to an Accident which occurs during the Policy Period provided that the Permanent Total Disablement occurs within 12 months from the date of that Accident:

(i) Loss of Use of both eyes, or Physical Separation/ Loss of Use of two entire hands or two entire feet, or one entire hand and one entire foot, or of such Loss of Use of one eye and such Physical Separation/ Loss of Use of one entire hand or one entire foot.
(ii) Physical Separation/ Loss of Use of two hands or two feet, or of one hand and one foot, or of Loss of Use of one eye and Loss of Use of one hand or one foot.
(iii) If such Injury shall as a direct consequence thereof, permanently, and totally, disable the Insured Person from engaging in any employment or occupation of any description whatsoever.

Once a Claim has been accepted and paid under this Benefit then the Personal Accident Cover will automatically terminate in respect of that Insured Person only.

2.25 Cap on Room Rent

If We have accepted a Claim for In-patient Hospitalization under the Policy and if the Insured Person incurs Room Rent that is higher than the eligible Room Rent as specified in the Policy Schedule then We will be liable to pay only a rateable proportion of the Associated Medical Expenses incurred in the proportion of the difference between the eligible Room Rent and the Room Rent actually incurred, provided that Reasonable and Customary costs incurred on medicines/pharmacy, medical consumables and medical implants will be reimbursed based on the actual amounts incurred.

In case this Cover is not opted for, Insured will get the eligible Room Rent and Associated Medical Expenses subject to Base Sum Insured including Cumulative Bonus and Restoration Benefit, if applicable.

Under this Cover, the Insured is entitled for a discount in the premium on opting for Cap on Room Rent.

3. WHAT WE WILL NOT PAY (EXCLUSIONS APPLICABLE UNDER THE POLICY)

We shall not be liable to make any payment under this Policy directly or indirectly for/ caused by/ based upon/ arising out of or howsoever attributable to any of the exclusions listed below. All waiting periods will apply individually to each Insured Person:

3.1 Pre-Existing Disease Waiting Period

Pre-existing disease waiting period will be as mentioned in the Policy Schedule.

Any Pre-Existing Disease will not be covered until waiting period months (as mentioned in the Policy Schedule) of continuous coverage has elapsed for the Insured Person, since the inception of the this Policy with Us.

This waiting period will be reduced by number of continuous preceding years of coverage of the Insured Person under previous health insurance policy by Us or any other health insurance plan with an Indian non-life insurer/ health insurer as per guidelines on portability issued by the insurance regulator.

3.2 30 Day Waiting Period

Any Illness contracted or Medical Expenses incurred in respect of an Illness will not be covered during the first 30 days from the Policy Period Start Date. This exclusion does not apply to any Medical Expenses incurred as a result of Injury or to Renewals of the Policy with Us or to any Insured Person whose Policy has been accepted under the Portability Benefit under this Policy.

3.3 2 Year Waiting Period

Any Medical Expenses incurred on the treatment of any of the following Illnesses/ conditions (whether medical or surgical and including Medical Expenses incurred on complications arising from such Illnesses/conditions) shall not be covered during the first 2 consecutive years from inception of the this Policy with Us or date of the Insured Person being included under the Policy, whichever is later:

(a) Cataract*;
(b) Benign Prostatic Hypertrophy;
(c) Myomectomy, Hysterectomy unless because of malignancy;
(d) All types of Hernia, Hydrocele;
(e) Fissures and/or Fistula in anus, haemorrhoids/piles;
(f) Arthritis, gout, rheumatism and spinal disorders;
(g) Joint replacements unless due to Accident;
(h) Sinusitis and related disorders;
(i) Stones in the urinary and biliary systems;
(j) Dilatation and curettage, Endometriosis;
(k) All types of skin and internal tumors/ cysts/ nodules/ polyps of any kind including breast lumps unless malignant;
(l) Dialysis required for chronic renal failure;
(m) Tonsillitis, adenoids and sinuses;
(n) Gastric and duodenal erosions and ulcers;
(o) Deviated nasal septum;
(p) Varicose Veins/ Varicose Ulcers.

*Our maximum liability for any Claim for an Insured Person's cataract treatment shall be 10% of the Base Sum Insured up to a maximum of INR 100,000 per eye for each Policy Year of the Policy Period.

In the event that any of the above Illnesses/conditions are Pre-existing Diseases at the Policy Period Start Date or are subsequently found to be Pre-Existing Diseases, then that Illness/condition shall be covered in accordance with the terms, conditions and exclusions of the Policy after the completion of the Pre-Existing Diseases waiting period stated above.

3.4 Maternity Benefit Waiting Period

Any treatment arising from or traceable to pregnancy, childbirth including caesarean section will not be covered until 36 months of continuous coverage has elapsed for that particular Insured Person since the inception of the Maternity Expenses Benefit under the Policy for that Insured Person.

This waiting period will be reduced by number of continuous preceding years of Maternity coverage of the Insured Person under previous health insurance policy by Us or any other health insurance plan with an Indian non-life insurer/ health insurer as per guidelines on portability issued by the insurance regulator.

3.5 Permanent Exclusions

We will not be liable under any circumstances, for any Claim in connection with or with regard to any of the following permanent exclusions as specified below:

1. Costs of routine medical, eye or ear examinations preventive health check-ups, spectacles, laser surgery for correction of refractory errors, contact lenses, hearing aids, dentures or artificial teeth;
2. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively;
3. Any expenses incurred on personal comfort, cosmetics, convenience and hygiene related items and services, medical supplies including elastic stockings, diabetic test strips, and similar products.
4. Expenses incurred on all dental treatment unless necessitated due to an Accident and treatment is taken in in-patient department of hospital or day care centre;
5. Acupressure, acupuncture, magnetic and such other therapies;
6. Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident;
7. Vaccination or inoculation of any kind, unless it is post animal bite and there is hospitalisation as an in-patient;
8. Sterility, venereal disease or any sexually transmitted disease;
9. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise) and Injury or Illness due to use, misuse or abuse of intoxicating drugs or alcohol;
10. Any expenses incurred on treatment of mental Illness, stress, psychiatric or psychological disorders;
11. Any aesthetic treatment, cosmetic surgery or plastic surgery including any complications arising out of or attributable to these, unless necessitated due to Accident or as a part of any Illness;
12. Any treatment/surgery for change of sex or treatment/surgery /complications/Illness arising as a consequence thereof;
13. Any expenses incurred on treatment arising from or traceable to pregnancy [including voluntary termination of pregnancy, childbirth, miscarriage (unless caused due to accident), abortion or complications of any of these, including cesarean section] and any fertility, infertility, sub fertility or assisted conception treatment or sterilization or procedure, birth control procedures and hormone replacement therapy. However, this exclusion does not apply to ectopic pregnancy proved by diagnostic means and which is certified to be life threatening by the Medical Practitioner;
14. Treatment relating to Congenital external Anomalies;
15. All expenses arising out of any condition directly or indirectly caused to or associated with Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind;
16. Admission primarily for diagnostic purposes not related to Illness for which Hospitalization has been done.
17. Charges incurred at Hospital primarily for evaluative or diagnostic or observation purposes for which no active treatment is given, X-Ray or laboratory examinations or other diagnostic studies, not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, whether or not requiring Hospitalization;
18. Expenses on supplements, vitamins and tonics unless forming part of treatment for Injury or Illness taken in in-patient department in hospital / day care centre and as certified by the attending Medical Practitioner;
19. Weight management services and treatment, vitamins and tonics related to weight reduction programs including treatment of obesity (including morbid obesity), any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition or rest cures;
20. Costs incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose;
21. Experimental, unproven or non-standard treatment which is not consistent with or incidental to the usual diagnosis and treatment of any Illness or Injury;
22. Any Claim directly or indirectly related to criminal acts;
23. Any treatment taken outside India;
24. Any treatment taken from anyone not falling within the scope of definition of Medical Practitioner. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council;
25. Any consequential or indirect loss arising out of or related to Hospitalization;
26. Any Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority;
27. Any Illness or Injury directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel;
28. All non-medical expenses listed in Annexure III of the Policy.
29. Any OPD treatment will not be covered
30. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.
31. Treatment for Age Related Macular Degeneration (ARMD), Treatment such as External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), and Hyperbaric Oxygen Therapy will not be covered unless it forms a part of In-Patient Treatment in case of hospitalisation or part of discharge advice upto the Post hospitalisation period as specified in the Policy Schedule.

4. CLAIM ADMINISTRATION

The fulfillment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complie with by You or any Insured Person, including complying with the following in relation to claims, shall be Condition Precedent to admission of Our liability under this Policy:

(a) On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed;

(b) The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payments that are brought about or contributed to as a consequence of intentional/deliberate failure to follow such directions, advice or guidance;

(c) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the facts surrounding the Claim. Such medical examination will be carried out only in case of reimbursement claims with prior consent of the Insured Person;

(d) We/Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of such Claim;

(e) If the Insured Person suffers a relapse within 45 days of the date of discharge from Hospital for a Claim that has been made, then such relapse shall be deemed to be part of the same Claim and all limits for Any One Illness under this Policy shall be applied as if they were part of a single claim.

5. CLAIMS PROCEDURE

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

5.1 For Cashless Facility

Cashless Facility is only available at a Network Provider. The complete list of Network Providers is available on Our website (The list is updated as and when there is any change in the Network Provider) or can be obtained from Our call centre. In order to avail of Cashless Facility, the following procedure shall be followed:

(a) Pre-authorization for Planned Hospitalization:
At least 48 hours prior to a planned Hospitalization, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that planned Hospitalisation. Each such

request must be accompanied by all the following details:

(I) Pre-authorization form available at the hospital helpdesk to be duly filled in and signed by Insured and treating doctor
(ii) Copy of the Health Card We have issued to the Insured Person;
(iii) Proposed date of Admission.
(iv) Medical papers viz. All prescriptions, medical investigation reports etc.
(v) Photo ID
(vi) Address proof, and photo to comply with KYC norms

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/Our TPA will request additional information or documentation in respect of that request.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.

Turn Around Time (TAT) for issue of Pre-Authorization within 6 hours from receipt of complete documents

In Case of Claim Contact Us at:
24x7 Toll Free number: 1800 266 4545 or may write an e- mail at care@kotak.com

In the event of claims, please send the relevant documents to:
Family Health Plan (TPA) Ltd,
Srinilaya – Cyber Spazio
Suite # 101,102,109 & 110, Ground Floor,
Road No. 2, Banjara Hills,
Hyderabad, 500 034.

(b) Pre-authorization for Emergency Care:

If the Insured Person has been admitted into Hospital for Emergency Care, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that Emergency Care within 24 hours of commencement of Hospitalisation. Each such request must be accompanied by all the following details:

(I) Pre-authorization form available at the hospital helpdesk to be duly filled in and signed by Insured and treating doctor
(ii) Copy of the Health Card We have issued to the Insured Person;
(iii) Medical papers viz. All prescriptions, medical investigation reports etc.
(iv) Photo ID
(v) Address proof, and photo to comply with KYC norms

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/ Our TPA will request additional information or documentation in respect of that request.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection. In circumstances where We/Our TPA refuse the request for pre authorisation as there is insufficient Base Sum Insured or there is insufficient information to determine the admissibility of the request for pre-authorisation, a claim for reimbursement may be submitted to Us in accordance with the procedure set out below and We will consider the Claim in accordance with the policy terms, conditions and exclusions.

Turn Around Time (TAT) for settlement of Reimbursement is within 30 days from the receipt of the complete documents.

We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities in Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers on Our website or by calling Our call centre.

5.2 For Reimbursement Claims

We shall be given written notice of the Claim for reimbursement along with the following details at least within 30 days of the Insured Person's discharge from Hospital:

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

If the Claim is not notified to Us within 30 days of the Insured Person's discharge from Hospital, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

Kindly note that Company may de-list few of the hospitals and the Company shall not service any claims including re-imbursement claims for the treatment undertaken at these hospitals other than in case of medical Emergency. List of de-listed hospitals would be available on our website and is subject to updates from time to time.

6. CLAIM DOCUMENTS

We shall be provided the following necessary information and documentation in respect of all Claims within 30 days of the Insured Person's discharge from Hospital. For Claims under which the use of Cashless Facility has been approved, We will be provided with these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:

(a) Duly completed Claim form signed by You and the Medical Practitioner (only for reimbursement claims);
(b) Hospital discharge summary;
(c) First consultation and follow up treatment papers;
(d) Original bills and receipts from the Hospital/Medical Practitioner;
(e) Original bills from chemists supported by proper prescription;
(f) Original investigation test reports (including CT/MR/USG/ECG, as applicable) and payment receipts;
(g) Indoor case papers, if available;
(h) Implant Invoice/ Sticker, if available;
(i) Ambulance Invoice, if applicable;
(j) FIR (if done) or MLC (if conducted) for Accident cases ;
(k) Post mortem report (if conducted);
(l) KYC documents viz. Photo ID and address proof along with duly completed form.
(m) Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

For claims under which cashless facility has been approved, following documents will be provided by the Network hospital along with the above:

(n) Original Pre – authorization request
(o) Copy of Pre – authorization approval letter
(p) Copy of the photo identity document of the Insured Person;
(q) KYC documents obtained at the time of cashless facility.

- **Additional Documents for Personal Accident Cover:**

Accidental Death

(a) Original Death certificate issued by the office of Registrar of Birth & Deaths;
(b) Death summary issued by a Hospital, if applicable;

Permanent Total Disablement (PTD) resulting from Accident

(a) Original treating Medical Practitioner's certificate describing the disablement;
(b) Photograph of the Insured Person reflecting the disablement;
(c) Prescriptions and consultation papers of the treatment;
(d) Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable

- **Critical Illness Claim Documents**

a. Common list of documents for all Critical Illness:
   1) Duly completed claim form;
   2) Certificate from the attending Medical Practitioner of the Insured Person confirming, inter alia,
      i. Name of the Insured Person;
      ii. Name, date of occurrence and medical details confirming the event giving rise to the Claim.
      iii. Written confirmation from the treating Medical Practitioner that the event giving rise to the Claim does not relate to any Pre-Existing Disease or any Illness or Injury which was diagnosed within the first 90 days of

commencement of first Policy Period with Us.
3) Original Policy document;
4) Original Discharge Certificate/Death Summary/Card from the hospital/ Medical Practitioner;
5) Original investigation test reports, indoor case papers;
6) In the cases where Critical Illness arises due to an Accident, FIR copy or medico legal certificate (if done/conducted) will also be required wherever conducted. We may call for any additional necessary documents/information as required based on the circumstances of the claim.
7) Any other documents as may be required by Us.

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

b. Specific Documentation Required for each of the Critical Illnesses Please note that the following are illustrative lists and we may seek additional documentation based on the facts and circumstances of the Claim and if done/conducted/available

1) CANCER OF SPECIFIED SEVERITY
   i. Hospital Discharge Card photocopy
   ii. Hospital Bills photocopy
   iii. Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Details of the treatment received by the Insured Person from the inception of the ailment.
   vi. Letter from treating consultant stating presenting complaints with duration and the past medical history.
   vii. Histopathology / Cytology / FNAC / Biopsy / Immuno-histochemistry reports.
   viii. X-Ray / CT scan / MRI scan / USG / Radioisotope / Bone scan Reports.
   ix. Blood Tests.
   x. Any other specific investigation done to support the diagnosis like the PAP Smear/ Mammography, etc.
   xi. Any other documents as may be required by Us.

2) KIDNEY FAILURE REQUIRING REGULAR DIALYSIS
   i. Hospital Discharge Card photocopy
   ii. Photocopy Hospital Bills.
   iii. Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   vi. Blood Tests- Renal Function Tests specifically: Serum Creatinine, Blood Urea Nitrogen,
   Serum Electrolytes done in the recent past (Not more than Two Week period from the date of intimation of Loss)
   vii. Dialysis Papers/Receipts done in recent past.
   viii. Renal scan
   ix. Letter from the nephrologists stating the diagnosis of End Stage Kidney Failure.
   x. Any other documents as may be required by Us.

3) MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS
   i. Hospital Discharge Card photocopy
   ii. Photocopy Hospital Bills.
   iii. Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   vi. MRI / CT Scan Report.
   vii. Electro-myogram report
   viii. Biopsy / Cytology Report
   ix. Specific Blood Tests: Creatinine Phosphokinase /Anti-nuclear antibodies, C- reactive protein /autoimmune work up
   x. Any other relevant Blood investigations.
   xi. Confirmation from the Central/State Government Hospital about diagnosis of Multiple Sclerosis and the duration of the same.
   xii. Any other documents as may be required by Us.

4) MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS
   i. Hospital Discharge Card photocopy (in case of Hospitalization)
   ii. Investigations Reports like Blood tests, EEG, Nerve Conduction test, etc
   iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment
   iv. Electro-myogram Report
   v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit and the degree/current status
   vii. Any other document as may be required by th company

5) BENIGN BRAIN TUMOR
   i. Hospital Discharge Card photocopy
   ii. Hospital Bills photocopy
   iii. Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Details of the treatment received by the Insured Person from the inception of the ailment.
   vi. Letter from treating consultant stating presenting complaints with duration and the past medical history.
   vii. Histopathology / Cytology / FNAC / Biopsy / Immuno-histochemistry reports.
   viii. X-Ray / CT scan / MRI scan / USG / Radioisotope / Bone scan Reports.
   ix. Blood Tests.
   x. Neurological examination report by Neurologist
   xi. Any other documents as may be required by Us.

6) PRIMARY PULMONARY HYPERTENSION
   i. Hospital Discharge Card photocopy
   ii. Photocopy Hospital Bills.
   iii. Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   vi. MRI / CT Scan Report.
   vii. Echocardiography report
   viii. Computed tomography (CT), magnetic resonance imaging (MRI), and lung scanning
   ix. Pulmonary angiography
   x. Any other documents as may be required by Us.

7) END STAGE LIVER DISEASE / FAILURE
   i. Hospital Discharge Card photocopy
   ii. Photocopy Hospital Bills.
   iii. Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   vi. Ultrasound scan of liver
   vii. CT and/or MRI scan of the liver
   viii. X-ray and Liver function test
   ix. Biopsy / FNAC (where applicable)
   x. Any other documents as may be required by Us.

8) MAJOR ORGAN /BONE MARROW TRANSPLANT
   i. Hospital Discharge Card photocopy
   ii. Photocopy Hospital Bills.
   iii. Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   vi. Scan / Histopathology / Cytology / FNAC / Biopsy report suggesting irreversible & non-compensatory changes of the particular organ. 8 Bone Marrow Biopsy Reports (Specifically In Case of Bone Marrow Transplant)
   vii. Letter from a specialist Doctor confirming the need of transplantation (Organs Specified are: Heart, lung, Liver, pancreas, kidney, bone marrow)
   viii. Any other documents as may be required by Us.

9) OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES
   i. Hospital Discharge Card photocopy
   ii. Photocopy Hospital Bills.
   iii. Pharmacy/Investigations Bills

iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. X-ray and 2D-Echocardiography Report.
vii. Letter from the Cardiologist / Cardiothoracic Surgeon suggesting valve replacement with the type of valve to be used.
viii. Any other documents as may be required by Us.

10) OPEN CHEST CABG
i. Photocopy Hospital Discharge Card
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. ECG at the time of detection of Coronary Artery Disease and Subsequent ECG's
vii. Stress test/ Tread Mill Test
viii. Letter from treating consultant suggesting Coronary Angiography and CABG
ix. Coronary Angiography report / CT Angiography Report
x. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT,
xi. LDH / Electrolytes
xii. X-ray / 2D-Echocardiography Report
xiii. Thallium Scan Report
xiv. Any other documents as may be required by Us.

11) AORTA GRAFT SURGERY
i. Photocopy Hospital Discharge Card
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. ECG at the time of detection of Coronary Artery Disease and Subsequent ECG's
vii. Stress test/ Tread Mill Test
viii. Letter from treating consultant suggesting Coronary Angiography and CABG
ix. Coronary Angiography report / CT Scan
x. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT,
xi. LDH / Electrolytes
xii. X-ray / 2D-Echocardiography Report
xiii. Thallium Scan Report
xiv. Bio-markers for Aortic dissection
xv. Any other documents as may be required by Us.

12) COMA OF SPECIFIED SEVERITY
i. Hospital Discharge Card photocopy
ii. Investigations Reports like Blood tests, EEG, etc
iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment
iv. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Glasgow coma scale grading.
v. Indoor case papers and / or ICU case papers indicating the history, signs, symptoms, line of treatment and daily charts like TPR, etc
vi. FIR / MLC / Panch nama for accident induced coma
vii. Any other document as may be required by the company

13) STROKE RESULTING IN PERMANENT SYMPTOMS
i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit.
vii. MRI / CT scan/ 2D Echocardiography Reports or any other Imaging technique Used during the diagnosis and treatment of the Stroke
viii. Blood tests (Lipid profile/Random Blood Sugar / Prothrombin Time/APTT/ Bleeding Time/ Clotting Time/Homocystiene levels)
ix. Any other documents as may be required by Us.

14) PERMANENT PARALYSIS OF LIMBS
i. Hospital Discharge Card photocopy
ii. Investigations Reports
iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment of the Stroke
iv. Electro-myogram Report
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit and the degree/current status and duration of the Paralysis.
vii. Any other document as may be required by the company

15) FIRST HEART ATTACK - OF SPECIFIED SEVERITY
i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Casualty Medical Officers/Emergency room papers with all details of Presenting Complaints and the Medical Examination by the attending physician.
vi. Subsequent Consultation Papers with the treating Medical Practitioner and the treatment received
vii. ECG on admission and subsequent ECG's
viii. Stress test/ Tread Mill Test
ix. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT, LDH / Electrolytes
x. X-ray / 2D-Echocardiography Report
xi. Thallium Scan Report
xii. Any other documents as may be required by Us.

16) THIRD DEGREE (OR MAJOR) BURNS
i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports, treatment papers
v. Certificate from the treating specialist Doctor indicating the classification / degree of burns
vi. Following medico-legal documents if applicable
(i) FIR
(ii) Panchanama
(iii) Inquest Panchanama
(iv) Police Final Report/Charge Sheet (Based on FIR)
vii. Any other documents as may be required by Us.

17) DEAFNESS OR LOSS OF HEARING
i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Pure tone testing report
vii. Audiometry report
viii. Confirmation of Diagnosis by ENT specialist along with duration
ix. All treatment papers and medical investigation test reports
x. Any other documents as may be required by Us.

18) LOSS OF SPEECH
i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Confirmation of Diagnosis by ENT specialist along with

cause and duration
vii. All treatment papers and medical investigation test reports

Any other documents as may be required by Us.

- Claims For Pre-Hospitalisation Medical Expenses And Post-Hospitalisation Medical Expenses

(a) All Claims for Pre-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the Insured Person's discharge from Hospital along with the following information and documentation:

(i) Duly Completed Claim Form
(ii) Investigation Payment Receipt
(iii) Original Investigation Report
(iv) Original Pharmacy Bills
(v) Original Pharmacy Prescription
(vi) Copy of Discharge Summary

(b) All Claims for Post-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the completion of post hospitalisation period as mentioned in your plan. You need to send Medical Expenses being incurred along with the following information and documentation:

(i) Duly Completed Claim Form
(ii) Original bills and receipts from the Hospital/Medical Practitioner;
(iii) Investigation Payment Receipt
(iv) Original Investigation Report
(v) Original Pharmacy Bills
(vi) Original Pharmacy Prescription
(vii) Copy of Discharge Summary

7. CLAIM INVESTIGATION, SETTLEMENT & REPUDIATION

(a) We may investigate claims at Our own discretion to determine the validity of a claim. This investigation will be conducted within 15 days of the date of assigning the claim for investigation and not later than 30 days from the date of receipt of last necessary document. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals/entities that are authorised by Us in writing.

(b) We shall settle or repudiate a Claim within 30 days of the receipt of the last necessary information and documentation. In case of suspected frauds, where Investigation is initiated, We shall settle the claim within 45 days from the date of receipt of the last necessary document.

(c) Payment for reimbursement claims will be made to You. In the unfortunate event of Your death, We will pay the Nominee named in the Policy Schedule.

(d) In case of delay in payment, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us.

PART III

General Terms and Conditions

1. Eligibility

Self, Your legally married spouse, Your natural or adopted dependent children, Your parents, Your parents-in-law and Your siblings

Natural/ Appointed Guardian can also take insurance for minor under their guardianship.

In case of multiple Insured Person(s) covered under a Policy, the covers mentioned in Part II are applicable to all the Insured Person(s) in accordance with the premium paid and Plan opted unless specifically excluded as per the terms and conditions of the respective Cover.

2. Disclosure of Information

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or on non-disclosure in any material particulars in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a Claim being fraudulent or any fraudulent means or devices being used by You/Insured Person or any one acting on Your/Insured Person's behalf to obtain any benefit under this Policy.

3. Observance of terms and conditions

The due observance and fulfilment of the terms, conditions and endorsements of this Policy in so far as they relate to anything to be done or complied with by You, shall be a Condition Precedent to any of Our liability to make any payment under this Policy.

4. Material Change

Material information to be disclosed to Us includes every matter that You are aware of or could reasonably be expected to know that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk and the terms of acceptance of the risk.

5. No constructive Notice

Any knowledge or information of any circumstances or condition in Your connection in possession of any of Our personnel and not specifically informed to Us by You shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

6. Terms and condition of the Policy

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

7. Multiple Policies:

a. If two or more policies are taken by an Insured during a period from one or more insurers, the contribution shall not be applicable where the cover/ benefit offered:
   - o Is fixed in nature;
   - o Does not have any relation to the treatment costs;

b. In case of multiple policies which provide fixed benefits, on the occurrence of the Insured event in accordance with the terms and conditions of the policies, each insurer shall make the claim payments independent of payments received under other similar policies.

c. If two or more policies are taken by an insured during a period from one more insurers to indemnify treatment costs, the policy holder shall have the right to require a settlement of his/her claim in terms of any of his/her policies.
   - o In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
   - o Policyholder having multiple policies shall also have the right to prefer claims from other policy/ policies for the amount disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall settle the claim subject to the terms and conditions of the other policy / policies so chosen.

d. If the amount to be claimed exceeds the Base Sum Insured under a single policy after considering the deductible or co-pays, the policy holder shall have the right to choose insurers from whom he/she wants to claim balance amount.

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

8. Zone Classification

Zone I: Mumbai (including Thane and Navi Mumbai) and Delhi (including NCR areas)
Zone II: Kolkata, Hyderabad, Chennai, Pune, Bangalore and Gujarat
Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II

- Identification of Zone will be based on the city of the Proposer.
- A single Zone shall be applicable to all members covered under the Policy.
- You also have an option of selecting another Zone from the applicable Zones of any of the Insured Person(s) in the Policy.
- Option to select a Zone higher than that of the actual Zone is available on payment of relevant premium at the time of buying the Policy or at the time of Renewal.
- Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalisation due to an Accident.

Co-payment

- Persons paying Zone I premium can avail treatment all over India without any Co-payment.
- Persons paying Zone II premium can avail treatment in Zone II and Zone III without any co-payment
- Persons paying Zone III premium can avail treatment in Zone III only without any co-payment

Co-payment for treatment in a Higher Zone

In case of treatment taken in a city, in a Zone higher than the eligible Zone for the Insured Person, the Co-payment percentages as below shall apply:

Applicable Zone	Treatment Taken at	Co-payment applicable
Zone II	**Zone I**	**10%**
Zone III	**Zone I**	**20%**
Zone III	**Zone II**	**10%**

9. Underwriting and Loadings

We may apply a risk loading up to a maximum of 200 % per Insured Person on the premium payable (excluding statutory levies & taxes) based on the declarations made in the proposal form and the health status of the persons proposed for insurance.

Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s). There will be no loadings based on individual claims experience.

In case of loading on 2 or more ailments, the loadings shall apply in conjunction, however maximum risk loading per individual shall not exceed 200% of Premium excluding applicable Taxes.

We will inform You about the applicable risk loading or special condition through a counter offer letter and We will only issue the Policy once We receive your consent on the applicable additional premium.

In case policies are accepted with loadings, waiting period for Pre Existing Disease Waiting Period (Section 3.1) as well as 2 Year Waiting Period (Section 3.3) shall continue to be applicable.

10. Free Look Period

The free look period shall be applicable at the inception of the policy and:

(a) The insured will be allowed a period of at least 15 days(Health Insurance policy contracts with a term of 3 years or more offered over distance marketing mode viz. telephone, website, internet, etc. shall have 30 days provided no claim has already been made on the policy) from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable

(b) If the insured has not made any claim during the free look period, the insured shall be entitled to
- o A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or;
- o Where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or;
- o Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

11. Cancellation/ Termination/ Refund

(a) For Policyholder's initiated cancellation, the Company would compute refund amount as pro-rata (for the unexpired duration) premium. This would further be deducted by 25% of computed refundable premium.

This is provided no claim has been made under the Policy.

(b) No refund of premium is applicable when policy is cancelled by the Insurer on grounds of misrepresentation, fraud, non disclosure or non-cooperation of the Insured.

12. Cause of Action/ Currency for payments

No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Policy. All Claims shall be payable in India and shall be in Indian Rupees only.

13. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed by both You and Us to be adjudicated or interpreted in accordance with Indian law and only competent Courts of India shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

14. Portability & Continuity Benefits

Portability means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another or from one plan to another plan of the same insurer.

It is further agreed and understood that:

(a) You have been covered under an Indian health insurance policy from a non-life insurance company or Health Insurance company registered with IRDAI without any break;

(b) We should have received Your application for Portability with complete documentation at least 45 days, but not earlier than 60 days from the premium renewal date of his/her existing policy;

(c) If the Base Sum Insured under the previous Policy is higher than the Base Sum Insured chosen under this Policy, the applicable waiting periods under Section 3 shall be waived to the extent of the Base Sum Insured and eligible cumulative bonus under the expiring policy with the previous insurer;

(d) In case the proposed Base Sum Insured opted for under Our Policy is more than the insurance cover under the previous policy, then all applicable waiting periods under Sections 3 shall be applicable afresh to the extent of the amount by which the Base Sum Insured under this Policy exceed the total of Base Sum Insured and eligible cumulative bonus under the expiring health insurance policy;

(e) We will apply the waiting periods under Sections 3 individually for each Insured Person based on his previous policy details and claims shall be assessed accordingly.

(f) Portability benefit will be offered to the extent of sum of previous Base Sum Insured (if opted for), and Portability shall not apply to any other additional increased Base Sum Insured.

(g) Portability benefit will be offered to the nearest Base Sum Insured, in case exact Sum Insured option is not available.

(h) Portability benefit will be offered to any other suitable policy, in case exact option is not available.

(i) We may subject Your proposal to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be as per our underwriting practices and underwriting policy of the Company.

(j) There is no obligation on Us to insure all Insured Persons on the proposed terms, even if You have given Us all documentation.

(k) We should have received the database and claim history from the previous insurance company for Your previous policy.

(l) Portability will be allowed in the following cases:
- o All Individual health insurance policies issued by General Insurers and Health Insurers including family floater policies
- o Individual members, including the family members covered under any group health insurance policy of a General Insurers and Health Insurers shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. One year thereafter, he or she shall be accorded the right mentioned in clause (b) above.

(m) The Portability provisions will apply to You, if You wish to migrate from this Policy to any other health insurance policy on Renewals. In case You have opted to switch to any other insurer under Portability provisions and the outcome of acceptance o the Portability request is awaited from the new insurer on the date of renewal,
- o We may upon Your request extend this Policy for a period of not less than one month at an additional premium to be paid on a pro-rata basis
- o If during this extension period a claim has been reported, You shall be required to first pay the full premium so as to make the Policy Period of full 12 calendar months. Our liability for the payment of such claim shall commence only once such premium is received. Alternately We may deduct the premium for the balance period.

15. Grace Period & Renewal

(a) A health insurance Policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non cooperation by the insured, provided the Policy is not withdrawn.

(b) The Policy will automatically terminate at the end of the Policy Period and must be renewed within the Grace Period of at least 30 days or as informed by Insurer from time to time. The provisions of Section 64VB of the Insurance Act 1938 shall be applicable. All policies Renewed within the Grace Period shall be eligible for continuity of cover.

(c) If We have discontinued or withdrawn this product/plan You will have the option to renewal under the nearest substitute Policy being issued by Us, provided however benefits payable shall be

subject to the terms contained in such other policy which has been approved by IRDAI

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

(e) We may, revise the Renewal premium payable under the Policy or the terms of cover, provided that all such changes are approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premium will not alter based on individual claims experience. We will intimate You of any such changes at least 90 days prior to date of such revision or modification.

(f) Alterations such as increase/ decrease in Base Sum Insured or change in plan/product or addition/deletion of Insured Persons will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy. Underwriting in relation to acceptance of request for changes will be based mainly as per underwriting policy of the company. The terms and conditions of the existing policy will not be altered. Increase/ Enhancement of Base Sum Insured shall be allowed up to maximum Base Su Insured available under the Plan.

(g) On Renewal of the Policy if an increased Base Sum Insured is requested then the elapsed period for existing diseases/ illness / injury shall be limited to the Base Sum Insured of the immediately completed Policy Period. Further, the waiting periods will apply afresh in relation to the amount by which the Base Sum Insured has been enhanced.

16. Special Provision for Insured Person who are Senior citizen

The premium charged for health Insurance products offered to Senior citizens shall be fair, justified, transparent and duly disclosed upfront. The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of policy.

17. Communications & Notices

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

In Your case, at Your last known address per Our records in respect of this Policy.

In Our case, at Our address specified in the Policy Schedule.

No insurance agent, broker or any other person is authorised to receive any notice on Our behalf.

18. Customer Service

If at any time You require any clarification or assistance, You may contact Our offices at the address specified in the Policy Schedule, during normal business hours or contact Our call centre.

19. Instalment Facility

If You have opted for a Policy Period of one year and payment of premium on an instalment basis of monthly / quarterly / half yearly, as specified in the Schedule, the following conditions shall apply (notwithstanding any terms contained elsewhere in the Policy):

(a) Premiums on policies may be accepted in instalment provided that the instalments covering a particular period shall be received within the 15 days relaxation period from the due date of payment of instalment premium.

(b) The Policy will get cancelled in the event of non-receipt of premium within the relaxation period.

(c) Coverage will be available during the relaxation period of 15 days.

(d) In case of any admissible claim in a Policy year:
- o If the claim amount is equivalent or higher than the balance of the instalment premiums payable in that Policy Year, would be recoverable from the admissible claim amount payable in respect of the Insured Person.
- o If the claim amount is lesser than the balance premium payable, then no claim would be payable till the applicable premium is recovered.

20. ECS/ Auto Debit Payment Facility

You are eligible for availing the ECS / Auto Debit payment facility for your premium payments under this Policy. This facility can be opted for automatic premium payment under this Policy for such premium paying term as availed by you under this Policy by submitting a duly signed ECS / Auto Debit mandate form. You may opt for any premium payment term as per your convenience but in accordance with the Policy terms and conditions. Please note that this facility may not be available for all the Banks at present however and you are requested to kindly visit website: www.kotakgeneralinsurance.com to check the updated list of all partner banks facilitating the ECS /Auto Debit facility from time to time. Additionally, the following conditions shall apply in case of ECS / Auto Debit facility opted by you –

a. The premium payment under the Policy shall be subject to change on renewal which would be in accordance with the terms and conditions of the Policy

b. The Policy shall get cancelled in the event of failure of ECS transaction towards payment of premium under the Policy and/or non-receipt of premium within the Grace Period under the Policy

c. The renewal premium amount under the Policy shall be communicated to you in advance i.e. minimum 45 days before the renewal date

d. You have the right to withdraw the ECS /Auto Debit mandate by giving Us at least 15 days' notice before the due date of next premium due under the Policy

The term ECS / Auto Debit herein shall be governed by the Electronic Clearing Service (Debit) Procedural Guidelines issued by the Reserve Bank of India (as may be amended from time to time) and shall mean an electronic facility for effecting periodic insurance premium payment transactions in an automated manner.

20. Electronic Transactions:

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

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/confirmed by the Insured.

21. Grievances:

For resolution of any query or grievance, insured may contact the respective branch office of the Company or may call at 18002664545 or may write an e- mail at care@kotak.com. For senior citizens, please contact the respective branch office of the Company or call at 18002664545 or may write an e- mail at seniorcitizen@kotak.com.
In case the insured is not satisfied with the response of the office, insured may contact the Grievance Officer of the Company at grievanceofficer@kotak.com. In the event of unsatisfactory response from the Grievance Officer, he/she may, subject to vested jurisdiction, approach the Insurance Ombudsman for the redressal of grievance. The details of the Insurance Ombudsman is available at website: www.kotakgeneralinsurance.com The updated details of Insurance Ombudsman offices are also available on the website of Executive Council of Insurers: www.ecoi.co.in/ombudsman.html
The details of the Insurance Ombudsman is available at Annexure I

Annexure I
Details of Insurance Ombudsman

Office Details	Jurisdiction of Office Union Territory, District
Ahmedabad: Office of the Insurance Ombudsman, 6th Floor, Jeevan Prakash Bldg, Tilak Marg, Relief Road, Ahmedabad - 380001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@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, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049. Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
Bhopal: Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL (M.P.) - 462003 Tel.:- 0755-2769201 / 2769202, Fax : 0755-2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh and Chattisgarh.
Bhubneshwar: Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455, Fax: 0674 - 2596429, Email:bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
Chandigarh: Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468, Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
Chennai: Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453,Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284, Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
New Delhi: Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in	Delhi
Guwahati: Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205, Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Hyderabad: Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122, Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
Jaipur: Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363, Email: bimalokpal.jaipur@ecoi.co.in	Rajasthan.
Ernakulam: Office of the Insurance Ombudsman,2nd floor, Pulinat Building, Opp. Cochin Shipyard, M.G. Road, Ernakulam - 682 015. Tel.:- 0484-2358759 / 2359338, Fax:- 0484-2359336, Email: bimalokpal.ernakulum@ecoi.co.in	Kerala, Lakshadweep, Mahe - a part of Pondicherry.
Kolkata: Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340, Fax : 033 - 22124341, Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
Lucknow: Office of the Insurance Ombudsman,6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
Mumbai: Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052. Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
Noida: Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector-15, Distt: Gautam Buddh Nagar, Noida, U.P - 201301. Tel.: 0120-2514250 / 2514252 / 2514253. Email:- bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffar nagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodha nagar, 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. Email:- bimalokpal.patna@ecoi.co.in	Bihar and Jharkhand.
Pune: Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune - 411 030. Tel.: 020 - 41312555. Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure II
List of Day Care Surgeries

Sr. No.	ENT		
1)	Stapedotomy	23)	Tympanoplasty (Type II)
2)	Myringoplasty(Type I Tympanoplasty)	24)	Reduction of fracture of Nasal Bone
3)	Revision stapedectomy	25)	Excision and destruction of lingual tonsils
4)	Labyrinthectomy for severe Vertigo	26)	Conchoplasty
5)	Stapedectomy under GA	27)	Thyroplasty Type II
6)	Ossiculoplasty	28)	Tracheostomy
7)	Myringotomy with Grommet Insertion	29)	Excision of Angioma Septum
8)	Tympanoplasty (Type III)	30)	Turbinoplasty
9)	Stapedectomy under LA	31)	Incision & Drainage of Retro Pharyngeal Abscess
10)	Revision of the fenestration of the inner ear	32)	Uvulo Palato Pharyngo Plasty
11)	Tympanoplasty (Type IV)	33)	Palatoplasty
12)	Endolymphatic Sac Surgery for Meniere's Disease	34)	Tonsillectomy without adenoidectomy
13)	Turbinectomy	35)	Adenoidectomy with Grommet insertion
14)	Removal of Tympanic Drain under LA	36)	Adenoidectomy without Grommet insertion
15)	Endoscopic Stapedectomy	37)	Vocal Cord lateralisation Procedure
16)	Fenestration of the inner ear	38)	Incision & Drainage of Para Pharyngeal Abscess
17)	Incision and drainage of perichondritis	39)	Transoral incision and drainage of a pharyngeal abscess
18)	Septoplasty	40)	Tonsillectomy with adenoidectomy
19)	Vestibular Nerve section	41)	Tracheoplasty
20)	Thyroplasty Type I	42)	Excision of Ranula under GA
21)	Pseudocyst of the Pinna - Excision	43)	Meatoplasty
22)	Incision and drainage - Haematoma Auricle		
	Ophthalmology		
44)	Incision of tear glands	54)	Removal of Foreign body from cornea
45)	Other operation on the tear ducts	55)	Incision of the cornea
46)	Incision of diseased eyelids	56)	Other operations on the cornea
47)	Excision and destruction of the diseased tissue of the eyelid	57)	Operation on the canthus and epicanthus
48)	Removal of foreign body from the lens of the eye	58)	Removal of foreign body from the orbit and the eye ball
49)	Corrective surgery of the entropion and ectropion	59)	Surgery for cataract
50)	Operations for pterygium	60)	Treatment of retinal lesion
51)	Corrective surgery of blepharoptosis	61)	Removal of foreign body from the posterior chamber of the eye
52)	Removal of foreign body from conjunctiva	62)	glaucoma surg
53)	Biopsy of tear gland		

Oncology			
63)	IV Push Chemotherapy	91)	Telecobalt Therapy
64)	HBI-Hemibody Radiotherapy	92)	Telecesium Therapy
65)	Infusional Targeted therapy	93)	External mould Brachytherapy
66)	SRT-Stereotactic Arc Therapy	94)	Interstitial Brachytherapy
67)	SC administration of Growth Factors	95)	Intracavity Brachytherapy
68)	Continuous Infusional Chemotherapy	96)	3D Brachytherapy
69)	Infusional Chemotherapy	97)	Implant Brachytherapy
70)	CCRT-Concurrent Chemo + RT	98)	Intravesical Brachytherapy
71)	2D Radiotherapy	99)	Adjuvant Radiotherapy
72)	3D Conformal Radiotherapy	100)	Afterloading Catheter Brachytherapy
73)	IGRT- Image Guided Radiotherapy	101)	Conditioning Radiothearpy for BMT
74)	IMRT- Step & Shoot	102)	Extracorporeal Irradiation to the Homologous Bone grafts
75)	Infusional Bisphosphonates	103)	Radical chemotherapy
76)	IMRT- DMLC	104)	Neoadjuvant radiotherapy
77)	Rotational Arc Therapy	105)	LDR Brachytherapy
78)	Tele gamma therapy	106)	Palliative Radiotherapy
79)	FSRT-Fractionated SRT	107)	Radical Radiotherapy
80)	VMAT-Volumetric Modulated Arc Therapy	108)	Palliative chemotherapy
81)	SBRT-Stereotactic Body Radiotherapy	109)	Template Brachytherapy
82)	Helical Tomotherapy	110)	Neoadjuvant chemotherapy
83)	SRS-Stereotactic Radiosurgery	111)	Adjuvant chemotherapy
84)	X-Knife SRS	112)	Induction chemotherapy
85)	Gammaknife SRS	113)	Consolidation chemotherapy
86)	TBI- Total Body Radiotherapy	114)	Maintenance chemotherapy
87)	intraluminal Brachytherapy	115)	HDR Brachytherapy
88)	Electron Therapy	116)	Mediastinal lymph node biopsy
89)	TSET-Total Electron Skin Therapy	117)	High Orchidectomy for testis tumours
90)	Extracorporeal Irradiation of Blood Products		
Plastic Surgery			
118)	Construction skin pedicle flap	125)	Fibro myocutaneous flap
119)	Gluteal pressure ulcer-Excision	126)	Breast reconstruction surgery after mastectomy
120)	Muscle-skin graft, leg	127)	Sling operation for facial palsy
121)	Removal of bone for graft	128)	Split Skin Grafting under RA
122)	Muscle-skin graft duct fistula	129)	Wolfe skin graft
123)	Removal cartilage graft	130)	Plastic surgery to the floor of the mouth under GA
124)	Myocutaneous flap		

Urology			
131	AV fistula - wrist	149	Ureter endoscopy and treatment
132	URSL with stenting	150	Vesico ureteric reflux correction
133	URSL with lithotripsy	151	Surgery for pelvi ureteric junction obstruction
134	Cystoscopic Litholapaxy	152	Anderson hynes operation
135	ESWL	153	Kidney endoscopy and biopsy
136	Haemodialysis	154	Paraphimosis surgery
137	Bladder Neck Incision	155	injury prepuce- circumcision
138	Cystoscopy & Biopsy	156	Frenular tear repair
139	Cystoscopy and removal of polyp	157	Meatotomy for meatal stenosis
140	Suprapubic cystostomy	158	surgery for fournier's gangrene scrotum
141	percutaneous nephrostomy	159	surgery filarial scrotum
142	Cystoscopy and "SLING" procedure	160	surgery for watering can perineum
143	TUNA- prostate	161	Repair of penile torsion
144	Excision of urethral diverticulum	162	Drainage of prostate abscess
145	Removal of urethral Stone	163	Orchiectomy
146	Excision of urethral prolapse	164	Cystoscopy and removal of FB
147	Mega-ureter reconstruction	165	Surgery for SUI
148	Kidney renoscopy and biopsy	166	URS + LL
Neurology			
167	Facial nerve physiotherapy	174	Stereotactic Radiosurgery
168	Nerve biopsy	175	Percutaneous Cordotomy
169	Muscle biopsy	176	Intrathecal Baclofen therapy
170	Epidural steroid injection	177	Entrapment neuropathy Release
171	Glycerol rhizotomy	178	Diagnostic cerebral angiography
172	Spinal cord stimulation	179	VP shunt
173	Motor cortex stimulation	180	Ventriculoatrial shunt
Thoracic surgery			
181	Thoracoscopy and Lung Biopsy	185	Thoracoscopy and pleural biopsy
182	Excision of cervical sympathetic Chain Thoracoscopic	186	EBUS + Biopsy
183	Laser Ablation of Barrett's oesophagus	187	Thoracoscopy ligation thoracic duct
184	Pleurodesis	188	Thoracoscopy assisted empyaema drainage

Gastroenterology			
189	Pancreatic pseudocyst EUS & drainage	199	Colonscopy stenting of stricture
190	RF ablation for barrett's Oesophagus	200	Percutaneous Endoscopic Gastrostomy
191	ERCP and papillotomy	201	EUS and pancreatic pseudo cyst drainage
192	Esophagoscope and sclerosant injection	202	ERCP and choledochoscopy
193	EUS + submucosal resection	203	Proctosigmoidoscopy volvulus detorsion
194	Construction of gastrostomy tube	204	ERCP and sphincterotomy
195	EUS + aspiration pancreatic cyst	205	Esophageal stent placement
196	Small bowel endoscopy (therapeutic)	206	ERCP + placement of biliary stents
197	Colonoscopy ,lesion removal	207	Sigmoidoscopy w / stent
198	ERCP	208	EUS + coeliac node biopsy
General Surgery			
209	infected keloid excision	251	Pancreatic Pseudocysts Endoscopic Drainage
210	Incision of a pilonidal sinus / abscess	252	ZADEK's Nail bed excision
211	Axillary lymphadenectomy	253	Subcutaneous mastectomy
212	Wound debridement and Cover	254	Rigid Oesophagoscopy for dilation of benign Strictures
213	Abscess-Decompression	255	Eversion of Sac a) Unilateral, b)Bilateral
214	Cervical lymphadenectomy	256	Lord's plication
215	infected sebaceous cyst	257	Jaboulay's Procedure
216	Inguinal lymphadenectomy	258	Scrotoplasty
217	Incision and drainage of Abscess	259	Surgical treatment of varicocele
218	Suturing of lacerations	260	Epididymectomy
219	Scalp Suturing	261	Circumcision for Trauma
220	infected lipoma excision	262	Intersphincteric abscess incision and drainage
221	Maximal anal dilatation	263	Psoas Abscess Incision and Drainage
222	Piles A)Injection Sclerotherapy, B)Piles banding	264	Thyroid abscess Incision and Drainage
223	liver Abscess- catheter drainage	265	TIPS procedure for portal hypertension
224	Fissure in Ano- fissurectomy	266	Esophageal Growth stent
225	Fibroadenoma breast excision	267	PAIR Procedure of Hydatid Cyst liver
226	Oesophageal varices Sclerotherapy	268	Tru cut liver biopsy
227	ERCP - pancreatic duct stone removal	269	Photodynamic therapy or esophageal tumour and Lung tumour

228	Perianal abscess I&D	270	Excision of Cervical RIB
229	Perianal hematoma Evacuation	271	laparoscopic reduction of intussusception
230	Fissure in ano sphincterotomy	272	Microdochectomy breast
231	UGI scopy and Polypectomy oesophagus	273	Surgery for fracture Penis
232	Breast abscess I& D	274	Sentinel node biopsy
233	Feeding Gastrostomy	275	Parastomal hernia
234	Oesophagoscopy and biopsy of growth oesophagus	276	Revision colostomy
235	UGI scopy and injection of adrenaline, sclerosants - bleeding ulcers	277	Prolapsed colostomy- Correction
236	ERCP - Bile duct stone removal	278	Testicular biopsy
237	Ileostomy closure	279	laparoscopic cardiomyotomy(Hellers)
238	Colonoscopy	280	Sentinel node biopsy malignant melanoma
239	Polypectomy colon	281	laparoscopic pyloromyotomy(Ramstedt)
240	Splenic abscesses Laparoscopic Drainage	282	Keratosis removal under GA
241	UGI SCOPY and Polypectomy stomach	283	Excision Sigmoid Polyp
242	Rigid Oesophagoscopy for FB removal	284	Rectal-Myomectomy
243	Feeding Jejunostomy	285	Rectal prolapse (Delorme's procedure)
244	Colostomy	286	Orchidopexy for undescended testis
245	Ileostomy	287	Detorsion of torsion Testis
246	colostomy closure	288	lap.Abdominal exploration in cryptorchidism
247	Submandibular salivary duct stone removal	289	EUA + biopsy multiple fistula in ano
248	Pneumatic reduction of intussusception	290	Excision of fistula-in-ano
249	Varicose veins legs - Injection sclerotherapy	291	TURBT
250	Rigid Oesophagoscopy for Plummer vinson syndrome		
Orthopedics			
292	Arthroscopic Repair of ACL tear knee	323	Partial removal of metatarsal
293	Closed reduction of minor Fractures	324	Partial removal of metatarsal
294	Arthroscopic repair of PCL tear knee	325	Revision/Removal of Knee cap
295	Tendon shortening	326	Amputation follow-up surgery
296	Arthroscopic Meniscectomy - Knee	327	Exploration of ankle joint
297	Treatment of clavicle dislocation	328	Remove/graft leg bone lesion
298	Arthroscopic meniscus repair	329	Repair/graft achilles tendon

299	Haemarthrosis knee- lavage	330	Remove of tissue expander
300	Abscess knee joint drainage	331	Biopsy elbow joint lining
301	Carpal tunnel release	332	Removal of wrist prosthesis
302	Closed reduction of minor dislocation	333	Biopsy finger joint lining
303	Repair of knee cap tendon	334	Tendon lengthening
304	ORIF with K wire fixation- small bones	335	Treatment of shoulder dislocation
305	Release of midfoot joint	336	Lengthening of hand tendon
306	ORIF with plating- Small long bones	337	Removal of elbow bursa
307	Implant removal minor	338	Fixation of knee joint
308	K wire removal	339	Treatment of foot dislocation
309	POP application	340	Surgery of bunion
310	Closed reduction and external fixation	341	intra articular steroid injection
311	Arthrotomy Hip joint	342	Tendon transfer procedure
312	Syme's amputation	343	Removal of knee cap bursa
313	Arthroplasty	344	Treatment of fracture of ulna
314	Partial removal of rib	345	Treatment of scapula fracture
315	Treatment of sesamoid bone fracture	346	Removal of tumor of arm/ elbow under RA/GA
316	Shoulder arthroscopy / surgery	347	Repair of ruptured tendon
317	Elbow arthroscopy	348	Decompress forearm space
318	Amputation of metacarpal bone	349	Revision of neck muscle (Torticollis release)
319	Release of thumb contracture	350	Lengthening of thigh tendons
320	Incision of foot fascia	351	Treatment fracture of radius & ulna
321	calcaneum spur hydrocort injection	352	Repair of knee joint
322	Ganglion wrist hyalase injection		
Paediatric surgery			
353	Excision Juvenile polyps rectum	358	Sternomastoid Tenotomy
354	Vaginoplasty	359	Infantile Hypertrophic Pyloric Stenosis pyloromyotomy
355	Dilatation of accidental caustic stricture oesophagea	360	Excision of soft tissue rhabdomyosarcoma
356	Presacral Teratomas Excision	361	Excision of cervical teratoma
357	Removal of vesical stone	362	Cystic hygroma - Injection treatment

	Gynaecology		
363	Hysteroscopic removal of myoma	379	uterine artery embolization
364	D&C	380	Bartholin Cyst excision
365	Hysteroscopic resection of septum	381	Laparoscopic cystectomy
366	thermal Cauterisation of Cervix	382	Hymenectomy(imperforate Hymen)
367	MIRENA insertion	383	Endometrial ablation
368	Hysteroscopic adhesiolysis	384	vaginal wall cyst excision
369	LEEP	385	Vulval cyst Excision
370	Cryocauterisation of Cervix	386	Laparoscopic paratubal cyst excision
371	Polypectomy Endometrium	387	Repair of vagina (vaginal atresia)
372	Hysteroscopic resection of fibroid	388	Hysteroscopy, removal of myoma
373	LLETZ	389	Ureterocoele repair - congenital internal
374	Conization	390	Vaginal mesh For POP
375	polypectomy cervix	391	Laparoscopic Myomectomy
376	Hysteroscopic resection of endometrial polyp	392	Repair recto- vagina fistula
377	Vulval wart excision	393	Pelvic floor repair(excluding Fistula repair)
378	Laparoscopic paraovarian cyst excision	394	Laparoscopic oophorectomy
	Critical care		
395	Insert non- tunnel CV cath	398	Insertion catheter, intra anterior
396	Insert PICC cath (peripherally inserted central catheter)	399	Insertion of Portacath
397	Replace PICC cath (peripherally inserted central catheter		
	Dental		
400	Splinting of avulsed teeth	403	Oral biopsy in case of abnormal tissue presentation
401	Suturing lacerated lip	404	FNAC
402	Suturing oral mucosa	405	Smear from oral cavity

Annexure III		
List of Expenses Generally Excluded ('Non-admissible Expenses') in Hospitalisation Policy		
Sr. No.	**Items**	**Suggestions**
I Toiletries/Cosmetics/Personal Comfort Or Convenience Items/Similar Expenses		
1	Hair Removing Cream	Not Payable
2	Baby Charges (unless specified/indicated)	Not Payable
3	Baby Food	Not Payable
4	Baby Utilites Charges	Not Payable
5	Baby Set	Not Payable
6	Baby Bottles	Not Payable
7	Brush	Not Payable
8	Cosy Towel	Not Payable
9	Hand Wash	Not Payable
10	Moisturiser Paste Brush	Not Payable
11	Powder	Not Payable
12	Razor	Payable
13	Shoe Cover	Not Payable
14	Beauty Services	Not Payable
15	Belts/ Braces	Essential and Should be Paid at least Specifically for Cases who have undergone surgery of Thoracic or Lumbar Spine.
16	Buds	Not Payable
17	Barber Charges	Not Payable
18	Caps	Not Payable
19	Cold Pack/Hot Pack	Not Payable
20	Carry Bags	Not Payable
21	Cradle Charges	Not Payable
22	Comb	Not Payable
23	Disposable Razor Charges (For Site Preparations)	Payable
24	Eau-De-Cologne / Room Freshners	Not Payable
25	Eye Pad	Not Payable
26	Eye Sheild	Not Payable
27	Email / Internet Charges	Not Payable

28	Food Charges (other than Patient's Diet Provided by Hospital)	Not Payable
29	Foot Cover	Not Payable
30	Gown	Not Payable
31	Leggings	Essential in Bariatric and Varicose Vein Surgery and may be considered for at least these conditions where Surgery itself is Payable.
32	Laundry Charges	Not Payable
33	Mineral Water	Not Payable
34	Oil Charges	Not Payable
35	Sanitary Pad	Not Payable
36	Slippers	Not Payable
37	Telephone Charges	Not Payable
38	Tissue Paper	Not Payable
39	Tooth Paste	Not Payable
40	Tooth Brush	Not Payable
41	Guest Services	Not Payable
42	Bed Pan	Not Payable
43	Bed Under Pad Charges	Not Payable
44	Camera Cover	Not Payable
45	Cliniplast	Not Payable
46	Crepe Bandage	Not Payable/ Payable by the Patient
47	Curapore	Not Payable
48	Diaper Of Any Type	Not Payable
49	DVD, CD Charges	Not Payable (However if CD is specifically sought by Insurer/ TPA then Payable)
50	Eyelet Collar	Not Payable
51	Face Mask	Not Payable
52	Flexi Mask	Not Payable
53	Gause Soft	Not Payable
54	Gauze	Not Payable
55	Hand Holder	Not Payable
56	Hansaplast/ Adhesive Bandages	Not Payable
57	Infant Food	Not Payable
58	Slings	Reasonable costs for one sling in case of Upper Arm Fractures may be considered

B Items Specifically Excluded in Policies		
59	Weight Control Programs/ Supplies/ Services	Exclusion in Policy unless otherwise specified
60	Cost Of Spectacles/ Contact Lenses/ Hearing Aids Etc.,	Exclusion in Policy unless otherwise specified
61	Dental Treatment Expenses that do not require Hospitalisation	Exclusion in Policy unless otherwise specified
62	Hormone Replacement Therapy	Exclusion in Policy unless otherwise specified
63	Home Visit Charges	Exclusion in Policy unless otherwise specified
64	Infertility/ Subfertility/ Assisted Conception Procedure	Exclusion in Policy unless otherwise specified
65	Obesity (including Morbid Obesity) Treatment if Excluded in Policy	Exclusion in Policy unless otherwise specified
66	Psychiatric & Psychosomatic Disorders	Exclusion in Policy unless otherwise specified
67	Corrective Surgery for Refractive Error	Exclusion in Policy unless otherwise specified
68	Treatment of Sexually Transmitted Diseases	Exclusion in Policy unless otherwise specified
69	Donor Screening Charges	Exclusion in Policy unless otherwise specified
70	Admission/ Registration Charges	Exclusion in Policy unless otherwise specified
71	Hospitalisation for Evaluation/ Diagnostic Purpose	Exclusion in Policy unless otherwise specified
72	Expenses for Investigation/ Treatment irrelevant to the Disease for which admitted or diagnosed	Exclusion in Policy not payable unless otherwise specified
73	Any Expenses when the Patient is diagnosed with Retro Virus + or suffering from /HIV/ Aids etc is detected/ directly or indirectly	Not Payable as per HIV/ AIDS Exclusion
74	Stem Cell Implantation/ Surgery & Storage	Not Payable except Bone Marrow Transplantation where covered by Policy
75	Ward and Theatre Booking Charges	Payable Under OT Charges, Not Payable Separately
76	Arthroscopy & Endoscopy Instruments	Rental Charged By The Hospital Payable. Purchase of Instruments Not Payable.
77	Microscope Cover	Payable Under OT Charges, Not Payable Separately
78	Surgical Blades, Harmonic Scalpel, Shaver	Payable Under OT Charges, Not Payable Separately
79	Surgical Drill	Payable Under OT Charges, Not Payable Separately
80	Eye Kit	Payable Under OT Charges, Not Payable Separately
81	Eye Drape	Payable Under OT Charges, Not Payable Separately
82	X-Ray Film	Payable Under Radiology Charges, Not as Consumable
83	Sputum Cup	Payable Under Investigation Charges, Not as Consumable
84	Boyles Apparatus Charges	Part Of OT Charges, Not Separately
85	Blood Grouping and Cross Matching of Donors Samples	Part Of Cost Of Blood, Not Payable
86	Antiseptic & Disinfectant Lotions	Not Payable-Part of Dressing Charges
87	Band Aids, Bandages, Sterile Injections, Needles, Syringes	Not Payable - Part of Dressing Charges
88	Cotton	Not Payable-Part of Dressing Charges

89	Cotton Bandage	Not Payable-Part of Dressing Charges
90	Micropore/ Surgical Tape	Not Payable-payable by the Patient when Prescribed, otherwise included as Dressing Charges
91	Blade	Not Payable
92	Apron	Not Payable -Part of Hospital Services/Disposable Linen to be Part of OT/ ICU Charges
93	Torniquet	Not Payable (service is charged by Hospitals, Consumables cannot be separately charged)
94	Orthobundle, Gynaec Bundle	Part of Dressing Charges
95	Urine Container	Not Payable
II Elements of Room Charge		
96	Luxury Tax	**Policy Exclusion - Not Payable.** If there is no Policy Exclusion, then Actual Tax Levied by Government is Payable - Part of Room Charge for Sub Limits
97	HVAC	Part of Room Charge Not Payable Separately
98	House Keeping Charges	Part of Room Charge Not Payable Separately
99	Service Charges where Nursing Charge also charged	Part of Room Charge Not Payable Separately
100	Television & Air Conditioner Charges	Payable Under Room Charges Not if separately levied
101	Surcharges	Part of Room Charge Not Payable Separately
102	Attendant Charges	Not Payable - Part of Room Charges
103	IM/ IV Injection Charges	Part of Nursing Charges, Not Payable
104	Clean Sheet	Part of Laundry/housekeeping Not Payable Separately
105	Extra Diet of Patient(other than that which forms part of Bed Charge)	**Not Payable**. Patient Diet Provided by Hospital is Payable
106	Blanket/Warmer Blanket	Not Payable- Part of Room Charges
III Administrative or Non-medical Charges		
107	Admission Kit	Not Payable
108	Birth Certificate	Not Payable
109	Blood Reservation Charges and Ante Natal Booking Charges	Not Payable
110	Certificate Charges	Not Payable
111	Courier Charges	Not Payable
112	Conveyance Charges	Not Payable
113	Diabetic Chart Charges	Not Payable
114	Documentation Charges / Administrative Expenses	Not Payable
115	Discharge Procedure Charges	Not Payable
116	Daily Chart Charges	Not Payable

117	Entrance Pass / Visitors Pass Charges	Not Payable
118	Expenses Related to Prescription on Discharge	To be Claimed by Patient under Post -Hospitalisation where admissible
119	File Opening Charges	Not Payable
120	Incidental Expenses / Misc. Charges (not Explained)	Not Payable
121	Medical Certificate	Not Payable
122	Maintenance Charges	Not Payable
123	Medical Records	Not Payable
124	Preparation Charges	Not Payable
125	Photocopies Charges	Not Payable
126	Patient Identification Band / Name Tag	Not Payable
127	Washing Charges	Not Payable
128	Medicine Box	Not Payable
129	Mortuary Charges	Payable Up to 24 Hrs, Shifting Charges Not Payable
130	Medico Legal Case Charges (MLC Charges)	Not Payable
	IV External Durable Devices	
131	Walking Aids Charges	Not Payable
132	Bipap Machine	Not Payable
133	Commode	Not Payable
134	CPAP/ CPAD Equipments	Not Payable
135	Infusion Pump - Cost	Not Payable
136	Oxygen Cylinder (for Usage outside the Hospital)	Not Payable
137	Pulseoxymeter Charges	Not Payable
138	Spacer	Not Payable
139	Spirometre	Not Payable
140	SPO2 Probe	Not Payable
141	Nebulizer Kit	Not Payable
142	Steam Inhaler	Not Payable
143	Armsling	Not Payable
144	Thermometer	Not Payable (paid By Patient)
145	Cervical Collar	Not Payable
146	Splint	Not Payable
147	Diabetic Foot Wear	Not Payable
148	Knee Braces (Long/ Short/ Hinged)	Not Payable
149	Knee Immobilizer/Shoulder Immobilizer	Not Payable
150	Lumbo Sacral Belt	Essential and should be paid at least specifically for cases who have undergone Surgery of Lumbar Spine
151	Nimbus Bed or Water or Air Bed Charges	Payable for any ICU Patient requiring more than 3 Days in ICU; All Patients with Paraplegia/Quadriplegia for any reason and at Reasonable Cost of approximately Rs 200/Day
152	Ambulance Collar	Not Payable
153	Ambulance Equipment	Not Payable
154	Microsheild	Not Payable
155	Abdominal Binder	Essential and should be Paid at least in post surgery patients of Major Abdominal Surgery Including TAH, LSCS, Incisional Hernia Repair, Exploratory Laparotomy for Intestinal Obstruction, Liver Transplant Etc

V Items Payable If Supported By A Prescription		
156	Betadine \ Hydrogen Peroxide\spirit\ Disinfectants Etc	May be Payable when prescribed for Patient, Not Payable for Hospital use in OT or Ward or for dressings ward or for dressings
157	Private Nurses Charges- Special Nursing Charges	Post Hospitalization Nursing Charges Not Payable
158	Nutrition Planning Charges - Dietician Charges- Diet Charges	Patient Diet provided by Hospital is Payable
159	Sugar Free Tablets	Payable -Sugar Free variants of admissable medicines are not Excluded
160	Cream Powder Lotion (Toiletries are Not Payable, only Prescribed Medical Pharmaceuticals Payable)	Payable when Prescribed
161	Digestion Gels	Payable when Prescribed
162	ECG Electrodes	Up to 5 Electrodes are Required for every case visiting OT or ICU. For longer stay in ICU, may Require a Change and at least one set every second day must be Payable.
163	Gloves	Sterilized Gloves Payable / Unsterilized Gloves not payable
164	HIV Kit	Payable - Pre-Operative Screening
165	Listerine/ Antiseptic Mouthwash	Payable When Prescribed
166	Lozenges	Payable When Prescribed
167	Mouth Paint	Payable When Prescribed
168	Nebulisation Kit	If used during Hospitalization is Payable Reasonably
169	Novarapid	Payable When Prescribed
170	Volini Gel/ Analgesic Gel	Payable When Prescribed
171	Zytee Gel	Payable When Prescribed
172	Vaccination Charges	Routine Vaccination Not Payable / Post Bite Vaccination Payable
VI Part of Hospital's own Costs and not Payable		
173	AHD	Not Payable - Part of Hospital's Internal Cost
174	Alcohol Swabes	Not Payable - Part of Hospital's Internal Cost
175	Scrub Solution/ Sterillium	Not Payable - Part of Hospital's Internal Cost
I OTHERS		
176	Vaccine Charges for Baby	Payable in case of Benefit is opted
177	Aesthetic Treatment / Surgery	Not Payable
178	TPA Charges	Not Payable
179	Visco Belt Charges	Not Payable
180	Any Kit with no details mentioned [Delivery Kit, Orthokit, Recovery Kit, Etc]	Not Payable
181	Examination Gloves	Not Payable
182	Kidney Tray	Not Payable
183	Mask	Not Payable
184	Ounce Glass	Not Payable
185	Outstation Consultant's/ Surgeon's Fees	Not Payable, Except For Telemedicine Consultations Where Covered by Policy
186	Oxygen Mask	Not Payable
187	Paper Gloves	Not Payable
188	Pelvic Traction Belt	Should be Payable in case of PIVD requiring traction as this is generally not reused
189	Referal Doctor's Fees	Not Payable
190	Accu Check (Glucometery/ Strips)	Not Payable. Pre-Hospitilasation or Post-Hospitalisation / Reports and Charts Required/ Device Not Payable

191	Pan Can	Not Payable
192	Sofnet	Not Payable
193	Trolly Cover	Not Payable
194	Urometer, Urine Jug	Not Payable
195	Ambulance	Payable - Ambulance from home to Hospital or inter-hospital shifts is Payable/ RTA - As Specific Requirement for critical injury is Payable
196	Tegaderm / Vasofix Safety	Payable - Maximum of 3 in 48 Hrs and then 1 in 24 Hrs
197	Urine Bag	Payable where medicaly necessary till a reasonable cost - Maximum 1 Per 24 Hrs
198	Softovac	Not Payable
199	Stockings	Essential for case like CABG etc. Where it should be paid.

Annexure IV
List of Critical Illness

1) Cancer Of Specified Severity

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

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

2) Kidney Failure Requiring Regular Dialysis

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

3) Multiple Sclerosis With Persisting Symptoms

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

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

4) Motor Neurone Disease With Permanent Symptoms

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

5) Benign Brain Tumor

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

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
   i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

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

III. The following conditions are excluded:

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

6) Primary (Idiopathic) Pulmonary Hypertension

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

II. The NYHA Classification of Cardiac Impairment are as follows:
   i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
   ii. Class IV: Unable to engage in any physical activity without discomfort.

   Symptoms may be present even at rest.

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

7) End Stage Liver Failure

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

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

8) Major Organ /Bone Marrow Transplant

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

undergoing of a transplant has to be confirmed by a specialist medical practitioner.

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

9) Open Heart Replacement Or Repair Of Heart Valves

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

10) Open Chest CABG

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

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

11) Aorta Graft Surgery

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

(i) The following conditions are excluded:
   a. Surgery performed using only minimally invasive or intra-arterial techniques.
   b. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.

(ii) The diagnosis to be evidenced by any two of the following:
   a. Computerized tomography (CT) scan
   b. Magnetic Resonance Imaging (MRI) scan
   c. Echocardigraphy (an ultrasound of the heart)
   d. Angiography (Injecting X ray dye)
   e. Abdominal ultrasound

12) Coma Of Specified Severity

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

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

13) Stroke Resulting In Permanent Symptoms

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

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

14) Permanent Paralysis Of Limbs

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

15) Myocardial Infarction (First Heart Attack Of Specified Severity)

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

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

16) Third Degree Burns

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

17) Deafness

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

18) Loss Of Speech

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

II. All psychiatric related causes are excluded.

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