Date: 30/01/2018

Policy Number: 30302174201703
Customer ID: 2000004506

Dear MR. KESHAV ANAND

QUATER-2 1/9 DOCTOR'S,
FLATS CANTONMENT GENERAL,
HOSPITAL SADAR BAZAR DELHI CANTT NEW DEL
-,
DELHI -110010
Mobile: 08447891447

Thank you for choosing to renew your Max Bupa health insurance policy. At Max Bupa, we put your health first and are committed to provide you access to the very best of healthcare, backed by the highest standards of service.

Please find enclosed your Max Bupa Policy Kit which will help you understand your policy in detail and give you more information on how to access our services easily. Your Policy kit includes the following:

- **Insurance Certificate:** Confirming your specific policy details like date of commencement, persons covered and specific conditions related to your plan.
- **Premium Receipt:** Receipt issued for the premium paid by you.

Do visit us online at www.maxbupa.com to view and download our updated list of network hospitals in your city, download claim forms and for other useful information. You can register with us online using your policy number, date of birth & email id and access your policy details. In case of any further assistance, call us at 1800-3010-3333 (Toll Free) or email us at customercare@maxbupa.com .

I request you to read your policy terms and conditions highlighted in the Customer Information Sheet of this document so that you are fully aware of your policy benefits.

Assuring you of our best services and wishing you and your loved ones good health always.

Yours Sincerely,

Ashish Mehrotra
Managing Director and Chief Executive Officer
Important - please read this document and keep in a safe place.

Key Benefits of your policy are as follows

Particulars	Benefit Offering (on Annual Basis)
Hospitalization Expenses	Upto Sum Insured
All Day Care Procedures	Upto Sum Insured
Pre & Post Hospitalization Expenses	Pre Hospitalization upto 60 days Post Hospitalization upto 90 days
Maternity & New Born Baby Cover	As per your plan
Living Organ Donor Transplant	Upto Sum Insured
Health Check up	As per your plan
Loyalty Benefit	As per your plan
Domiciliary Hospitalization	Upto Sum Insured
Ambulance Cover	Upto Sum Insured in case of network hospitals Upto Rs. 2000 in case of non-network hospitals

The major exclusions of your policy are as follows

Particulars	Details
Initial waiting period	30 days (not applicable for renewal policies)
Pre Existing Disease *	48 months(Silver)/24 months(Gold and Platinum) since inception of first policy with us
Specific waiting period for insured above the age of 45 years	24 months since inception of first policy with us
Personal Waiting Period *	24 months since inception of first policy with us
Permanent Exclusions +	As mentioned in Policy Wording

+ Please refer to Customer Information Sheet in this policy document to know more

* Please refer to Policy Certificate to know conditions (if any)

You can reach us on 1800-3010-3333

Policyholder Servicing Turnaround Times as prescribed by Insurance Regulatory and Development Authority of India (IRDAI)

POLICY SERVICING

	Maximum turnaround time
Processing of Proposal and Communication of decisions	**30 Days**
Providing copy of the proposal	**30 days**
Post Policy issue service requests	**10 days**

CLAIM SERVICING

	Maximum turnaround time
Settlement of claim after receiving of complete documents	**30 Days**

GREIVANCE HANDLING

	Maximum turnaround time
Acknowledge a grievance	3 days
Resolve a grievance	14 days

MAX Bupa HEALTH INSURANCE

Insurance Certificate

Policyholder's Name: MR. KESHAV ANAND	
Policyholder's Address: QUATER-2 1/9 DOCTOR'S, FLATS CANTONMENT GENERAL, HOSPITAL SADAR BAZAR DELHI CANTT NEW DEL, -, DELHI -110010	

Policy Number	30302174201703
Policy Commencement Date and Time	From 26/02/2017 00:00 a.m.
Policy Expiry Date and Time	To 25/02/2018 23:59 p.m.
Base Sum Insured (Rs.)	6,00,000
Loyalty Addition amount accrued (in Rs.)	100,000
Sum Insured (in Rs.)	6,00,000
Heartbeat Individual	No
Heartbeat Family Floater	Yes
Heartbeat Family First	No
Plan opted for	HEARTBEAT GOLD 5L 2A1C
Policy Period	1 Year
Renewal Due Date	25/02/2018

e-Issuance Details

EIA Number	None
IR NAME	None

Nominee Details

Nominee Name	Neha Anand
Relationship with the Policyholder	Spouse

Cover Details

Particulars	**Details**
Base Sum Insured (in Rs.) (only in case of Family First)	NA
Floater Sum Insured (in Rs.) (only in case of Family First)	NA
Loyalty additions amount accrued (in Rs.)	100,000
Sum Insured (in Rs.)	6,00,000

Intermediary Details

Intermediary Name	**Intermediary Code**	**Intermediary Contact No.**
Baljeet Kaur	**DEL0417809**	**09868886876**

Premium Details

Net Premium (Rs.)	**Service Tax (Rs.)**	**Swachh Bharat Cess (Rs.)**	**Krishi Kalyan Cess (Rs.)**	**Loading (Rs.)**	**Gross Premium (Rs.)**	**Gross Premium (Rs.) (in words)**
21,889.00	3,064.00	109.00	109.00	0.00	25,171.00	Twenty Five Thousand One Hundred Seventy One Only

Enhanced Geographical scope for International Coverage	NA
List of specific regions applicable for the following Additional Benefits (if any): **(i) Emergency Medical Evacuation;** **(ii) Emergency Hospitalization (outside the geographical boundaries of India);** **(iii) Specified Illness Cover (outside the geographical boundaries of India)**	

Optional Benefit/Feature Details

Particulars	**Benefit Details**
Annual Aggregate Deductible (in Rs.)	NA
Hospital Cash (in Rs.)	NA
Co-payment (in %)	NA

Permanent Exclusions (if any):

None

Servicing Branch Details:

Max Bupa Health Insurance Company Ltd, 10th Floor,Aggarwal Cyber Plaza-II, Plot no -C-7,Netaji Subhash Place,Distt. Centre, Wazirpur Delhi-110034

Insured Details

Name of the Insured Person (s)	Age (in years)	Gender	Relationship with the Policy Holder	Insured with Max Bupa (Since)	Additional Sum Insured	Pre Existing Disease #,##	Personal Waiting Period*
Mr. Keshav Anand	32	Male	Applicant	26/02/2014	0	None	None
Ms. Neha Anand	31	Female	Spouse	26/02/2014	0	None	None
Miss Khushi Anand	1	Female	Daughter	26/02/2014	0	None	None

(* - Pre Existing Disease as disclosed by you/ Insured Person or discovered by us during medical underwriting)
(# - Please refer clause 7.4 of the Policy terms & Condition)
(##-As per clause 4.a.(iii) of Part II of the Schedule "where the Policy is renewed for enhanced Sum Insured, waiting periods would start afresh for the amount of increase in Sum Insured.")

Product Benefit Table[2]

Inpatient Care	Up to Sum Insured
Eligible Room Rent / Room category	As per the Benefit Table in the policy kit
Pre-hospitalization Medical Expenses	Up to Sum Insured
Post-hospitalization Medical Expenses	Up to Sum Insured
Alternative Treatments	Up to Sum Insured
Day Care Treatment	Up to Sum Insured
Domiciliary Hospitalization	Up to Sum Insured
Maternity Benefit	As per the Benefit Table in the policy kit
New Born Baby	Up to Sum Insured
Living Organ Donor Transplant	Up to Sum Insured
Emergency Ambulance	Network Hospital: up to Sum Insured Non-Network Hospital: up to Rs. 2,000 per event
OPD Treatment and Diagnostic Services [3]	As per the Benefit Table in the policy kit
Child Care Benefits	Up to Sum Insured
Emergency Medical Evacuation	As per the Benefit Table in the policy kit
Emergency Hospitalization (outside the geographical boundaries of India)	As per the Benefit Table in the policy kit
Specified Illness Cover (outside the geographical boundaries of India)	As per the Benefit Table in the policy kit
Second Medical Opinion	One opinion per Specified Illness / planned Surgery / Surgical Procedure per Insured Person
Loyalty Additions	As per the Benefit Table in the policy kit
Health Checkup [4]	As per the Benefit Table in the policy kit
Hospital Cash (per day)	As per the Benefit Table in the policy kit

[2] The details of the benefits will change depending upon the plan opted. All the benefits are on per Policy Year basis, if otherwise not mentioned
[3] The amount specified against this benefit includes any carry forward amount at the start of the Policy Year
[4] If the Policy is renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable)

The stamp duty of Re.1 (Rupee one only) vide in challan no. F.10(16210)/ COS(HQ)/CD dated 16th October 2014 through e-stamp certificate No.IN-DL31147224239846M dated 10th November 2014.
Service Tax Registration No.: AAFCM7916HST001.

For and on behalf of Max Bupa Health Insurance Co. Ltd.

Location: New Delhi
Date: 30/01/2018

Ashish Mehrotra
Managing Director and Chief Executive Officer

Premium Receipt

Dear MR. KESHAV ANAND
QUATER-2 1/9 DOCTOR'S
FLATS CANTONMENT GENERAL
HOSPITAL SADAR BAZAR DELHI CANTT NEW DEL
-
DELHI -110010

We acknowledge the receipt of payment towards the premium of the following health insurance policy:

Policy Holder's Name	Mr. Keshav Anand	Policy Number	30302174201703
Plan Opted for	HEARTBEAT GOLD 5L 2A1C	Sum Insured (Rs.)	6,00,000
Commencement Date#	26/02/2017	Expiry Date	25/02/2018
Net Premium (Rs.)		21,889.00	
Service Tax (Rs.)		3,064.00	
Swachh Bharat Cess (Rs.)		109.00	
Krishi Kalyan Cess @ 0.5%		109.00	
Loading(Rs.)		0.00	
Gross Premium (Rs.)		25,171.00	

#Issuance of policy is subject to clearance of premium paid

Details of persons Insured:

Name of Person Insured	Age	Gender	Relationship to policy holder	Individual cover(Rs.) (only in case of Family First)
Mr. Keshav Anand	32	Male	Applicant	NA
Ms. Neha Anand	31	Female	Spouse	NA
Miss Khushi Anand	1	Female	Daughter	NA

Upon issuance of this receipt, all previously issued temporary receipts, if any, related to this policy are considered null and void. For the purpose of deduction under section 80D, the benefit shall be as per the provisions of the Income Tax Act, 1961 and any amendments made thereafter.
In the event of non-realization of premium, Tax benefits cannot be obtained against this premium receipt

For your eligibility and deductions please refer to provisions of Income Tax Act 1961 as modified and consult your tax consultant.

Service tax Registration number: AAFCM7916HST001

For and on behalf of Max Bupa Health Insurance Co. Ltd.

Location: New Delhi
Date: 30/01/2018

Ashish Mehrotra
Managing Director and Chief Executive Officer

Affix Stamp

Annexure I
List of Insurance Ombudsmen

Office of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C.U. Shah College, Ashram Road, **AHMEDABAD-380 014.** Tel.:- 079-27545441, Fax :079- 27546142, Email bimalokpal.ahmedabad@gbic.co.in	State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu
BENGALURU	Insurance Ombudsman, Office of the Insurance Ombudsman ,19/19,Jeevan Soudha Building , Ground Floor, 24th Main, JP Nagar First Phase, **Bengaluru–560025 .** Tel.: 080-26652049/26652048, Email:bimalokpal.bengaluru@gbic.co.in	State of Karnataka
BHOPAL	Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, **BHOPAL(M.P.)-462 023.** Tel.:- 0755-2769201/9202, Fax : 0755-2769203, Email: bimalokpal.bhopal@gbic.co.in	States of Madhya Pradesh and Chhattisgarh
BHUBNESHWAR	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, **BHUBANESHWAR-751 009.** Tel.:- 0674-2596455, Fax :0674-2596003, Email bimalokpal.bhubaneswar@gbic.co.in	State of Odisha
CHANDIGARH	Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D, **CHANDIGARH-160 017.** Tel.:- 0172-2706468/2772101, Fax : 0172-2708274, Email bimalokpal.chandigarh@gbic.coin	States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh
CHENNAI	Insurance Ombudsman, Office of the Insurance Ombudsman, Fathl ma Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, **CHENNAI-600 018.** Tel.:- 044-24333668 /5284, Fax :044-24333664, Email bimalokpal.chennai@gbic.co.in	State of Tamil Nadu and Union Territories Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry)
NEW DELHI	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf All Road, **NEW DELHI-110 002.** Tel.:- 011-23234057/23232037, Fax : 011-23230858, Email bimalokpal.delhi@gbic.co.in	State of Delhi
GUWAHATI	Insurance Ombudsman, Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road **GUWAHAT1-781 001 (ASSAM).** Tel.:- 0361-2132204/5, Fax : 0361-2732937, Email bimalokpal.guwahati@gbic.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, Ist Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, **HYDERABAD-500 004.** Tel : 040-65504123/23312122, Fax: 040-23376599, Email bimalokpal.hyderabad@gbic.co.in	States of Andhra Pradesh, Telangana and Union Territory of Yanam which is a part of Union Territory of Pondicherry
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi - II Bldg., Gr. Floor, Bhawani Singh Marg, **Jaipur -302 005.** Tel.: 0141 - 2740363, Fax: 0141 - Email: bimalokpal.jaipur@gbic.co.in	State of Rajasthan
KOCHI	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, **ERNAKULAM-682 015.** Tel : 0484-2358759/2359338, Fax :0484-2359336, Email: bimalokpal.ernakulam@ecoi.co.in	State of Kerala and Union Territory of (a) Lakshadweep (b) Mahe - a part of Union Territory of Pondicherry
KOLKATA	Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindusthan Bldg. Annexe, 4, C.R.Avenue, **Kolkatta - 700 072.** Tel: 033-22124339/22124346, Fax: 22124341, Email: bimalokpal.kolkata@gbic.co.in	States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands
LUCKNOW	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, **LUCKNOW-226 001.** Tel :0522 -2231331/2231330, Fax :0522-2231310, Email bimalokpal.lucknow@gbic.co.in	Districts of Uttar Pradesh: Lalltpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Veranasi, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Falzabad, Amethl, Kaushambi, Balrampur, Basil, Arnbedkamagar, Sultanpur, Maharajganj, Santkabimagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
MUMBAI	Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), **MUMBAI-400 054**. Tel : 022-26106960/26106552, Email bimalokpal.mumbai@gbic.co.in	States of Goa. And Mumbal Metropolitan Region excluding Areas of Navi Mumbal & Thane
NOIDA	Insurance Ombudsman, Office of the Insurance ombudsman, bhagwan sahai palace, 4th floor, Main Road, Naya Bans, Sec 15 G.B. Nagar, **Noida - 201301.** Tel : 0120 - 2514250/2514252-53 Email : bimalokpal.noida@gbic.co.in	State of Uttaranchal and the following Districts of State of Uttar Pradesh:- Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffamagar, Auraiya, Pilibhit, Etawah, Farrukhabad, Firozabad, Gautam Buddha Nagar, Ghaziabad, Kasganj, Hardoi, Shahjahanpur, Hapur, Shamll, Rampur, Sambhal, Amroha, Hathras, Kanshiram Nagar, Saharanpur
PATNA	Insurance Ombudsman, Office of the Insurance ombudsman, Kalpana Arcade Building, 1st Floor, Bazar Samiti Road, Bahadurpur, **Patna 800 006.** Tel No-0612-2680952 Email : bimalokpal.patna@gbic.co.in.	States of Bihar and Jharkhand
PUNE	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 2nd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, **Pune - 411 030.** Tel.: 020 - 32341320, Email - bimalokpal.pune@gbic.co.in	State of Maharashtra, Areas of Navi Mumbai and Thane but excluding Mumbal Metropolitan Region

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

Smt. Ramma.Bhasin, Secretary General
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz(W),
MUMBAI - 400 021
Tel:022-26106889/6671
Fax : 022-26106949
Email- inscoun@gbic.co.in
Web: http://www.gbic.co.in/

Shri. Y. R. Raigar, The Secretary
3' Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz (W),
MUMBAI - 400 021.
Tel :022-26106980
Fax : 022-26106949

List of Unrecognized Hospital

S.No.	City	Hospital Name	S.No.	City	Hospital Name
1	Surat	Aakansha Hospital	34	Surat	Shubham General Hospital
2	Surat	Abhinav Hospital	35	Surat	Siddhi Clinic & Nursing Home
3	Surat	Adhar Ortho Hospital	36	Surat	Sparsh MultySpecality Hospital & Trauma Care Center
4	Surat	Aris Care Hospital	37	Surat	Sree Uday Narayan General Hospital
5	Surat	Arzoo Hospital	38	Surat	TripathiChartiable Hospital
6	Surat	Auc Hospital	39	Ahmedabad	Umiya Medical & Surgical Hospital
7	Surat	Dharamjivan General Hospital & Trauma Centre	40	Surat	Varachha General Hospital
8	Surat	Dr. Santosh Basotia Hospital	41	Kushi Nagar	Aastha Multispecialty Hospital
9	Surat	Ghevariya Dental Clinic	42	Thane	Ashwini Nursing Home
10	Surat	God Father Hospital	43	Thane	Asmita Nursing Home
11	Surat	Govind-PrabhaArogyaSankool	44	Thane	Balaji Nursing Home
12	Surat	Hari Milan Hospital	45	Rohtak	Channan Devi Memorial Hospital
13	Surat	JaldhiAno-Rectal Hospital	46	Hyderabad	Goodlife Hospitals
14	Surat	Jeevan Path Gen. Hospital	47	Dhenkanal	Jagannath Clinic & Nursing Home
15	Surat	Kalrav Children Hospital	48	Allahabad	Jeevan Jyoti Hospital
16	Surat	Kanchan General Surgical Hospital	49	Mayiladuthurai	Krishna Hospital
17	Surat	Krishnavati General Hospital	50	Mumbai	Mumtaz Nursing Home
18	Surat	Mantra Orthopaedic Hospital Gandhidham (Kutch)	51	Kesava Nagar	Colony Padmaja Hospital
19	Surat	Metas Adventist Hospital	52	Harnaut	Pragya Nurshing Home
20	Surat	NiramayamHosptial&Prasutigruah	53	Jeedimetla	Ram Hospitals
21	Surat	Patna Hospital	54	Gurgaon	Ramanarayan Hospital
22	Surat	Poshia Children Hospital	55	Mumbai	Royal Nursing Home
23	Surat	Prayosha Hospital	56	Cuttak	Sabarmati General Hospital
24	Surat	R.D Janseva Hospital	57	Meerut	Sahara Hospital
25	Surat	Radha Hospital & Maternity Home	58	Mumbai	Sb Nursing Home
26	Surat	Santosh Hospital	59	Meerut	Shagun Hospital
27	Surat	Shaurya Hospital	60	Gurgaon	Shri Balaji Hospital & Trauma Center
28	Surat	Shikha General Hospital Changed Name To Sai Hospital	61	Hyderabad	Sri Sai Thirumala Hospitals
29	Surat	Shishumangal Children Hospital	62	Bhopal	Venus Hospital And Medical Research Centre
30	Surat	Shree Ramdev General & Surgical Hospital	63	Vanasthali Puram	Vijaya Nursing Home
31	Surat	Shree Sai Hospital & PrasutiGruh	64	Allahabad	Virendra Hospital
32	Surat	ShreyansAnorectal & Daycare Hospital	65	Meerut	Yog Nursing Home
33	Surat	Shri Panchratna Hospital & Prasutugruah			

CUSTOMER INFORMATION SHEET (Key Feature Document (KFD))

TITLE	DESCRIPTION	REFER TO POLICY SECTION NUMBER
Product Name	Heartbeat	
What am I covered for:	a. **Inpatient Care:** Medical Expenses for room rent; nursing charges for Hospitalization as an inpatient excluding Private Nursing charges; Medical Practitioners' fees, excluding any charges or fees for Standby Services; Physiotherapy, investigation and diagnostics procedures directly related to the current admission; Medicines, drugs as prescribed by the treating Medical Practitioner; Intravenous fluids, blood transfusion, injection administration charges and /or consumables; Operation theatre charges; the cost of prosthetics and other devices or equipment if implanted internally during Surgery and Intensive Care Unit charges..	2.1
	b. **Pre hospitalization Medical Expenses & Post hospitalization Medical Expenses:** Medical Expenses incurred following an Illness/Injury accepted under Inpatient Care for up to 60 days period immediately before Insured Person's admission to a Hospital and up to 90 days immediately after Insured Person's discharge from Hospital.	2.2 and 2.3
	c. **Alternative Treatment:** We will cover medical expenses for Ayurveda, Unani, Sidha and Homeopathy (AYUSH) taken in government hospital or in any institute recognized by the government and /or accredited by the Quality Council of India.	2.4
	d. **Day Care Treatment:** Medical Expenses for day care treatment where such procedures are undertaken by an Insured Person as an inpatient in a Hospital/Day Care Center for a continuous period of less than 24 hours.	2.5
	e. **Domiciliary Hospitalization:** Medical Expenses for medical treatment taken at home on the advice of attending Medical Practitioner if the treatment continues for an uninterrupted period of 3 days and the condition for which treatment is taken would otherwise have necessitated hospitalization.	2.6
	f. **Maternity Benefit:** Reasonable Medical Expenses for delivery of a child & medically necessary termination of pregnancy, where female Insured Person of age 18 years or above is covered under Family First Policy; Or both Insured Person and his / her legally married spouse are covered under Family Floater Policy, after a period of 24 months of continuous coverage since the inception of the first Policy, with maternity as a benefit, with Us. Medical Expenses for Pre and Post Hospitalization under Maternity Benefit will not be available.	2.7
	g. **New Born Baby:** New born baby will be covered as an insured person from birth till the end of policy year in which the baby is born, subject to Maternity Benefits should be payable. Vaccination expenses of the new born baby for the first Year, subject to addition of the new born baby in the policy at renewal of the policy.	2.8
	h. **Living Organ Donor Transplant:** Medical Expenses for an organ donor's treatment for harvesting of the organ.	2.9
	i. **Emergency ambulance:** Reasonable charges for Ambulance expenses incurred to transfer the Insured Person by surface transport following an Emergency to a Hospital. There is a sub-limit of Rs 2,000 per hospitalization, in out of network hospitals.	2.10
	j. **OPD Treatment and Diagnostic Services (For Platinum Policyholders only):** Expenses of medically necessary consultation as an outpatient with a Medical Practitioner to assess the Insured Person's condition. Any diagnostic tests or prescribed medicines prescribed by the Medical Practitioner are also covered under this benefit.	3.1
	k. **Child Care Benefits (For Platinum Policyholders only):** Specified vaccination expenses for Insured children until they have completed 12 years are covered. Expenses for nutrition and growth consulting provided for the child during a visit for such vaccination.	3.2
	l. **Emergency Medical Evacuation (For Platinum Policyholders only):** We will cover Emergency Medical Evacuation, outside India, but within only those regions specified in the Schedule of Insurance Certificate. We will also cover Emergency Medical Evacuation within India, if the condition requires air ambulance or commercial flight for evacuation purposes.	3.3
	m. **Emergency Hospitalization (For Platinum Policyholders only):** We will cover Emergency Hospitalization if required immediately after the emergency medical evacuation outside India, but within only those regions specified in the Schedule of Insurance Certificate.	3.4
	n. **Specified Illness Cover (For Platinum Policyholders only):** If an Insured Person suffers a Specified Illness during the Policy Period and while the Policy is in force, We will cover Reasonable and Customary expenses In-patient treatment and Hospital Accommodation as long as: a. The symptoms of the Specified Illness first occur or manifest itself during the Policy Period and after completion of 90 day from the inception of 1st Policy with us. b. The Specified Illness is diagnosed by a Medical practitioner within India during the Policy Period and after completion of 90 day from the inception of 1st Policy with us. c. Medical treatment for the Specified Illness is taken outside India, but only within those regions specified	3.5

	in the Schedule of Insurance Certificate. d. The Specified Illnesses covered are as follows, Cancer, Myocardial Infarction (Heart Attack), Coronary Artery Bypass Graft (CABG), Major Organ Transplant, Stroke, Surgery of Aorta, Coronary Angioplasty, Primary Pulmonary Arterial Hypertension & Brain Surgery. o. **Second medical option (For Platinum Policyholders only)**: Consultation on the diagnosis of specified illness or planned surgery or surgical procedure. p. **Hospital Cash (Optional benefit)**: If the Insured Person is Hospitalized and if We have accepted an In-patient Care Hospitalization claim, We will pay the Hospital Cash amount specified in the Product Benefit Table for each continuous and completed period of 24 hours of Hospitalization provided that: i. The Insured Person should have been Hospitalized for a minimum period of 48 hours continuously; ii. We will not make any payment under this endorsement in respect of an Insured Person for more than 30 days of Hospitalization in total under any Policy Year. Cash benefit will be payable on per day basis from day1, Claims made in respect of this benefit will not be subject to the Base Sum Insured. q. **Enhanced Geographical Scope for International coverage (Optional benefit):** Geographic coverage for the Emergency Medical Evacuation – outside India, Emergency Hospitalization – outside India & Specified Illness cover – outside India is extended to include USA & Canada.	3.6 5.1 5.2
What are the major exclusions in the policy:	• Ancillary Hospital Charges • Adventure or Hazardous Sports • Artificial life maintenance • Autoimmune Disorders • Behavioural, Neuro developmental and Neurodegenerative Disorders • Circumcision • Complementary and Alternative Treatment• Conflict & Disaster • External Congenital Anomaly, Hereditary and Genetic Disorders • Convalescence & Rehabilitation • Cosmetic and Reconstructive Surgery • Dental/oral treatment • Eyesight & Optical Services • Experimental/Investigational or Unproven Treatment • HIV, AIDS, and related complex • Hospitalization not justified • Inconsistent, Irrelevant or Incidental Diagnostic procedures • Mental and Psychiatric Conditions • Non Medical Expenses, Items of personal comfort and convenience, External or Ambulatory Devices, Visiting Charges • Obesity and Weight Control Programs • Off Label Drug or Treatment • Puberty and Menopause related Disorders • Reproductive medicine: Any assessment or treatment method for Birth Control, Assisted Reproduction, Sexual disorder and Erectile Dysfunction• Robotic assisted Surgery and LASER & Light based Treatment • Sexually transmitted Infections & diseases •Sleep disorders • Substance related and Addictive Disorders • Traffic Offences & Unlawful Activity • Treatment received outside India (except for treatment undertaken under "Emergency Medical Evacuation, Emergency Hospitalization or Specified Illness Cover) • Unrecognized Physician or Hospital • Generally Excluded Expenses• Drugs and dressings for OPD Treatment or take-home use •	8.1 to 8.31
Waiting Period	• Initial waiting period of 30 days for all illnesses except any accidents. • For all Insured Persons who are above 45 years of age as on the date of inception of the first Policy with us , the medical conditions and/or surgical treatment listed below will be subject to a waiting period of 24 months unless the condition is directly caused by cancer or an accident and will be covered in the third Policy Year as long as the Insured Person has been insured continuously under the Policy without any break: • Pancreatitis and Stones in Biliary and Urinary System • Cataract, Glaucoma and other disorders of lens, disorders of Retina • Hyperplasia of Prostate, Hydrocele and spermatocele • Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, PCOD, or any condition requiring dilation and curettage or Hysterectomy • Hemorrhoids, Fissure or Fistula or Abscess of anal and rectal region • Hernia of all sites • Osteoarthritis, Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, inflammatory Polyarthropathies, Arthrosis such as RA, Gout, Intervertebral Disc disorders • Chronic kidney disease & failure • Diabetes and its related complications • Varicose Veins of lower extremities • Disease of middle ear and mastoid including Otitis Media, Cholesteatoma, Perforation of Tympanic Membrane • All internal or external benign or In Situ Neoplasm's/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump • Ulcer, Erosion and Varices of Upper Gastro Intestinal Tract • Tonsils and Adenoids, Nasal Septum & Nasal Sinuses •Internal congenital Anomaly. Note: For all existing Insured Persons for whom the Policy document stated that this Specific Waiting Period applies when they are above 60 years of age and who have already served a part or whole of the waiting period will not be required to serve the waiting period afresh. The medical conditions and/or surgical treatment applicable to such existing Insured Person(s) are as follows: 2 years specific waiting period for the following conditions for persons above 60 years of age • Stones in the urinary system • Stones in billiary system • Cataract • Benign prostatic hypertrophy • Mennoraghia, Fibromyoma, Uterine prolapse including any condition requiring Hysterectomy • Piles • Hernia • Degenerative disorders of knee/hip • Chronic renal failure or end stage renal failure • Retinopathy • Diabetes and related treatments • 2 years personal waiting period for certain conditions	7.2 7.3 (a) to (n) 7.4

<table>
<tr><td></td><td>• 4 years (for silver plan) / 2 years (for gold & platinum plans) waiting period for pre-existing diseases cover</td><td>7.1</td></tr>
<tr><td>Payout basis</td><td>Cashless facility or reimbursement of covered expenses up to specified limits.</td><td>9.2(a) and (b)</td></tr>
<tr><td>Cost Sharing</td><td>1. 10% / 20% Co-Payment: For all insured persons we will only pay 90% / 80% respectively of any amount, we assess for payment or reimbursement in respect of any claim under the Policy made by that Insured Person and the balance will be borne by the Insured Person.
2. Annual Aggregate Deductible (not available for new business): options of Rs 1 Lac, 2 Lac and 3 Lac can be availed along with premium Discount. Available only for Silver plan for Family Floater and Individual Silver variants.</td><td>6.1
6.2</td></tr>
<tr><td>Renewal Conditions</td><td>i. The Benefits under the Policy can be availed continuously after completion of the Policy Period if the Renewal request is made along with the applicable premium on a timely basis.
ii. The Renewal premium is payable on or before the due date and in any circumstances before the expiry of Grace Period, at such rate as may be reviewed and notified by Us before completion of the Policy Period provided that all such changes are approved by IRDAI and in accordance with the IRDAI's rules and regulations as applicable from time to time.
iii. Renewal premium rates for this Policy may be further altered by Us including in the following circumstances:
A. You proposed to add an Insured Person to the Policy
B. You change any coverage provision
C. You change Your residence to different zip code
iv. Renewal premium will alter based on individual age. The reference of age for calculating the premium for Family Floater Policies shall be the age of the eldest Insured Person, and for Family First policies it shall be the individual age of each Insured Person of the Family.
v. Renewal premium will not alter based on individual claims experience.Renewal premium rates may be changed by Us provided that such changes are approved by IRDAI and in accordance with the IRDAI's rules and regulations as applicable from time to time.</td><td>11.4 (a)</td></tr>
<tr><td>Renewal Benefits</td><td>1. Loyalty Additions: If the Policy is renewed with us without any break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable), insured person become eligible for a 10% increase in Sum Insured as defined below:
a. The Base Sum Insured increases if the Policy is an individual or Family Floater Policy;
b. The individual Base Sum Insured increases if the Policy is a Family First Policy.
For each Policy Year, We offer an additional 10% of expiring Base sum insured up to at any time a maximum of 50% (for silver plan) / 100% (for gold & platinum plans) of base Sum Insured of that Policy Year provided that the Policy is renewed continuously. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the increase in Sum Insured.
2. Health Checkup: If the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable), then the Insured Person may avail a health check-up as per the plan eligibility.
3. OPD Treatment and Diagnostic Services (For Platinum Policyholders only): If the Policy is renewed without any break and there is a unutilized amount in a Policy Year, 80% of this amount can be carried forward to the immediately succeeding Policy Year provided the total amount (including the unutilized amount available under this benefit) shall at no time exceed 2.5 times the amount of the entitlement under the plan.</td><td>4.1
4.2
3.1</td></tr>
<tr><td>Cancellation</td><td>a. Cancellation by You: You may terminate this Policy by giving 30 days prior written notice to Us. We shall cancel the Policy for the balance of the Policy Period and refund the premium (exclusive of service tax) for the unexpired term as mentioned herein below, provided that no claim has been made and the Second Medical Opinion or health check-up have not been availed under the Policy by or on behalf of any Insured Person:
<table>
<tr><th rowspan="2">Policy in-force up to</th><th>Policy Period 1 year</th><th>Policy Period 2 years</th></tr>
<tr><th>Refund Premium (%)</th><th>Refund Premium (%)</th></tr>
<tr><td>Up to 30 days</td><td>75%</td><td>87.5%</td></tr>
<tr><td>31 to 90 days</td><td>50%</td><td>75%</td></tr>
<tr><td>91 to 180 days</td><td>25%</td><td>62.5%</td></tr>
<tr><td>181 to 365 days</td><td>0%</td><td>50%</td></tr>
<tr><td>366 to 455 days</td><td>Not applicable</td><td>25%</td></tr>
<tr><td>456 to 545 days</td><td>Not applicable</td><td>12%</td></tr>
<tr><td>Exceeding 545 days</td><td>Not applicable</td><td>0%</td></tr>
</table>
b. Automatic Cancellation:
i. Individual Policy:</td><td>11.2 and 11.9</td></tr>
</table>

	The Policy shall automatically terminate in the event of death of the Insured Person. ii. For Family Floater Policies and Family First Policies: The Policy shall automatically terminate in the event of the death of all the Insured Persons. iii. Refund: A refund in accordance with the above table shall be payable if there is an automatic cancellation of the Policy provided that no claim has been made and the Second Medical Opinion or health check-up have not been availed under the Policy by or on behalf of any Insured Person. c. **Cancellation by Us:** We may terminate this Policy during the Policy Period by sending 30 days prior written notice to Your address shown in the Schedule of Insurance Certificate without refund of premium (for cases other than non cooperation) if: i. You or any Insured Person or any person acting on behalf of either has acted in a dishonest or fraudulent manner under or in relation to this Policy; and/or ii. You or any Insured Person has not disclosed the material facts or misrepresented in relation to the Policy; and/or iii. You or any Insured Person has not co-operated with Us. In such cases, premium will be refunded on pro-rata basis provided that no claim has been filed under the Policy by or on behalf of any Insured Person; and/or iv. You fail or refuse to pay or refund any amount You owe Us. For avoidance of doubt, it is clarified that no claims shall be admitted and/or paid by Us and the Second Medical Opinion and health check-up cannot be availed during the notice period. **Note -** If a claim is in any way found to be fraudulent, or if any false statement, or declaration is made or used in support of such a claim, or if any fraudulent means or devices are used by the Insured Person or anyone acting on behalf of the Insured Person or any false or incorrect Disclosure to Information Norms to obtain any benefit under this Policy, then We may reserve the right to re-underwrite or cancel the Policy and all claims being processed shall be forfeited for all Insured Persons and all sums paid under this Policy shall be repaid to Us by You who shall be jointly liable for such repayment.	

NOTE: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the KFD and the policy document the terms and conditions mentioned in the policy document shall prevails.

Terms & Conditions of the Policy

1. Preamble

This is a contract of insurance between **You** and **Us** which is subject to the realisation of the full premium in advance and the terms, conditions and exclusions to this **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 and the **Information Summary Sheet.**

Please inform Us immediately of any change in the address, state of health or any other changes affecting You or any Insured Person.

Note: The terms listed in Section 12 (Definitions & Interpretation) and used elsewhere in the Policy in Initial Capitals and Bold shall have the meaning set out against them in Section 12 wherever they appear in the Policy.

2. Benefits available under the Policy

a. The Benefits available under this **Policy** are described below.

b. The **Policy** covers **Reasonable and Customary Charges** incurred towards medical treatment taken by the **Insured Person** during the **Policy Period** for an **Illness, Injury** or conditions described in the sections below, if it is contracted or sustained by an Insured Person during the Policy Period. The Benefits listed in the sections below will be payable subject to the terms, conditions and exclusions of this Policy and the availability of the Sum Insured and subject always to any sub-limits in respect of that Benefit as specified in the **Product Benefits Table** and any limits specified in the **Product Benefits Table** as applicable under the Plan in force for the **Insured Person** as specified in the **Schedule of Insurance Certificate.**

c. All claims for any benefits under the **Policy** must be made in accordance with the process defined under Section 9 (Claim process & Requirements).

d. All claims paid under any benefit except for Section 3.6 **(Second Medical Opinion),** Section 4.2 (Health Checkup) and Section 5.1 (Hospital Cash) shall reduce the **Sum Insured** for that **Policy Year** and only the balance **Sum Insured** after payment of claim amounts admitted shall be available for all future claims arising in that **Policy Year.**

2.1 Inpatient Care

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

a. The **Hospitalization** is **Medically Necessary** and advised and follows **Evidence Based Clinical Practices** and Standard Treatment Guidelines.

b. The **Medical Expenses** incurred are **Reasonable and Customary Charges** for one or more of the following:

i. **Room Rent;**

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

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

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

v. Medicines, drugs as prescribed by the treating **Medical Practitioner;**

vi. Intravenous fluids, blood transfusion, injection administration charges and /or consumables;

vii. Operation theatre charges;

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

ix. Intensive Care Unit charges.

c. If the **Insured Person** is admitted in the Hospital in a room category/Room Rent higher than the eligibility as specified in the Product Benefits Table, then We shall be liable to pay only a pro-rated proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent actually incurred and the entitled room category/eligible Room Rent to the Room Rent actually incurred.

d. **We** shall not be liable to pay the visiting fees or consultation charges for any Medical Practitioner visiting the **Insured Person** unless such:

i. Medical Practitioner's treatment or advice has been sought by the Hospital; and

ii. Visiting fees or consultation charges are included in the Hospital's bill; and

iii. Visiting fees or consultation charges are not more than the treating or referral Medical Practitioner's consultation charges.

2.2 Pre-hospitalization Medical Expenses

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

a. We have accepted a claim for Inpatient Care under Section 2.1 (Inpatient Care) above.

b. We will not be liable to pay Pre-hospitalization Medical Expenses for more than 60 days immediately preceding the Insured Person's admission to Hospital for Inpatient Care or such expenses incurred prior to inception of the first Policy with Us.

c. Pre-hospitalization Medical Expenses can be claimed under the Policy on a Reimbursement basis only.

d. This benefit is not applicable for expenses incurred outside India as defined under Section 3.3.1 (Emergency Medical Evacuation – outside the geographical boundaries of India), Section 3.4 (Emergency Hospitalization – outside the geographical boundaries of India) and Section 3.5 (Specified Illness cover – outside the geographical boundaries of India).

e. Pre-hospitalization Medical Expenses incurred on Physiotherapy will also be payable provided that such Physiotherapy is Medically Necessary and advised by the treating Medical Practitioner and has been availed under as Complementary & Alternative Medicine only.

2.3 Post-hospitalization Medical Expenses

We will indemnify the Insured Person's Post-hospitalization Medical Expenses incurred following an Illness or Injury that occurs during the Policy Period as advised by the treating Medical Practitioner provided that:

a. We have accepted a claim for Inpatient Care under Section 2.1 (Inpatient Care) above.

b. We will not be liable to pay Post-hospitalization Medical Expenses for more than 90 days immediately following the Insured Person's discharge from Hospital.

c. Post-hospitalization Medical Expenses can be claimed under the Policy on a Reimbursement basis only.

d. This benefit is not applicable for expenses incurred outside India as defined under Section 3.3.1 (Emergency Medical Evacuation – outside the geographical boundaries of India), Section 3.4 (Emergency Hospitalization – outside the geographical boundaries of India) and Section 3.5 (Specified Illness cover for treatment outside the geographical boundaries of India).

e. Post-hospitalization Medical Expenses incurred on Physiotherapy will also be payable provided that such Physiotherapy is Medically Necessary and advised by the treating Medical Practitioner and has been availed under as Complementary & Alternative Medicine only.

2.4 Alternative Treatments

We will indemnify the Reasonable and Customary Charges for Medical Expenses incurred on the Insured Person's Medically Necessary and Medically Advised Inpatient Hospitalization during the Policy Period on treatment taken under Ayurveda, Unani, Sidha and Homeopathy (AYUSH) in a government Hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health.

Pre-hospitalization Medical Expenses incurred for upto 60 days prior to the Alternative Treatments being commenced and Post-hospitalization Medical Expenses incurred for up to 90 days following the Alternative Treatment being concluded will also be indemnified under this Benefit provided that these Medical Expenses relate only to Alternative Treatments only and not Allopathy.

Section 8.7 of the Permanent Exclusions shall not apply to the extent this Benefit is applicable.

2.5 Day Care Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalization for any 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 Medically Necessary and follows the written advice of a Medical Practitioner.

b. The Medical Expenses incurred are Reasonable and Customary Charges for any procedure where such procedure is undertaken by an Insured Person as Day Care Treatment.

c. The following procedures will be covered as Day Care Treatment under this benefit as they each require a period of specialized observation or care after completion of the procedure :

   i. Stereotactic radiotherapy, radiotherapy, chemotherapy and immunotherapy for cancer (approved immunosuppressant drugs will be payable only if administered as a part of these procedures)

   ii. Renal dialysis(Erythropoietin for chronic renal failure will be payable only if administered as a part of this procedure)

d. We will not cover any OPD Treatment and Diagnostic Services under this Benefit.

2.6 Domiciliary Hospitalization

We will indemnify on a Reimbursement basis the Medical Expenses incurred for Domiciliary Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that:

a. The Domiciliary Hospitalization continues for at least 3 consecutive days in which case We will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization;

b. The treating Medical Practitioner confirms in writing that the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital OR the Insured Person satisfies Us that a Hospital bed was unavailable.

2.7 Maternity Benefit

We will indemnify the Maternity Expenses incurred during the Policy Period provided that:

a. This benefit is available only if:

   i. The female Insured Person of Age 18 years or above is covered under a Family First Policy; or

   ii. Both the Insured Person and his / her legally married spouse are covered under a Family Floater Policy.

b. This Benefit cannot be availed under an Individual Policy.

c. The female Insured Person in respect of whom a claim for Maternity Benefits is made must have been covered as an Insured Person for a period of 24 months of continuous coverage since the inception of the First Policy, with maternity as a benefit, with Us.

d. For the purposes of this benefit, We shall consider any eligibility period for maternity benefits served by the Insured Person under any previous policy with Us.

e. The Maternity Expenses incurred are Reasonable and Customary Charges.

f. The Maternity Benefit may be claimed under the Policy in respect of eligible Insured Person(s) only twice during the lifetime of the Policy including any Renewal thereafter for the delivery of a child or Medically Necessary and lawful termination of pregnancy up to maximum 2 pregnancies or terminations.

g. Any treatment related to the complication of pregnancy or termination will be treated within the maternity sub limits.

h. On Renewal, if an enhanced Sum Insured is applied, 24 months of continuous coverage (as per Section 2.7 c.) would apply afresh to the extent of the increased benefit amount.

We shall not be liable to make any payment in respect of the following:

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

b. Medical Expenses for ectopic pregnancy will be covered under the Section 2.1 (Inpatient Care) and shall not fall under the Maternity Benefit.

c. Sections 2.2 (Pre-hospitalization Medical Expenses) and Section 2.3 (Post- hospitalization Medical Expenses) are not payable under this benefit.

d. Any Maternity Expenses or complications arising from or relating to pregnancy, complication of pregnancy or termination of pregnancy within 24 months from the inception of the First Policy with Us.

e. Pre-natal and post-natal Medical Expenses are not payable under this benefit.

2.8 New Born Baby

We will cover the Medical Expenses incurred towards the medical treatment of the Insured Person's New Born Baby from the date of delivery until the expiry of the Policy Year, subject to continuous coverage of 24 months of that Insured Person since the inception of the First Policy which offers Maternity Benefit with Us, without the requirement of payment of any additional premium provided that;

a. All the terms and conditions mentioned in Section 2.7 (Maternity Benefit) shall apply to this benefit as well.

b. We have accepted the addition of the New Born Baby as an endorsement within 90 days from date of delivery

c. We will indemnify the Reasonable and Customary Charges for Medical Expenses incurred for the vaccination of the New Born Baby shown in Annexure II to this Policy until the New Born Baby completes one year.

d. If the Policy expires before the New Born Baby has completed one year, then Medical Expenses for vaccination will be covered only if the Policy is Renewed with the New Born Baby as an Insured Person.

e. On the expiry of the Policy Year We will cover the baby as an Insured Person under the Policy on request of the Proposer, subject to Our Board approved underwriting policy and payment of the applicable additional premium.

2.9 Living Organ Donor Transplant

We will indemnify the Medical Expenses incurred for a living organ donor's Inpatient treatment for the harvesting of the organ donated provided that:

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

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

c. We have accepted the recipient Insured Person's claim under Section 2.1 (Inpatient Care).

d. Medical Expenses incurred are Reasonable and Customary Charges.

We shall not be liable to make any payment in respect of:

a. The living organ donor's stay in a Hospital that is needed for them to donate their organ.

b. Stem cell donation except for Bone Marrow Transplant.

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

d. Screening or any other Medical Expenses of the organ donor.

e. Costs directly or indirectly associated with the acquisition of the donor's organ.

f. Transplant of any organ/tissue where the transplant is experimental or investigational.

g. Expenses related to organ transportation or preservation.

h. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

2.10 Emergency Ambulance

We will indemnify the Reasonable and Customary Charges for ambulance expenses incurred to transfer the Insured Person by surface transport following an Emergency provided that:

a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is injured or is ill to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Hospitalization.

b. This benefit is available for one transfer per Hospitalization.

c. The ambulance service is offered by a healthcare or ambulance Service Provider.

d. We have accepted a claim under Section 2.1 (Inpatient Care) above.

e. If the ambulance is provided by a Non-Network provider, We will cover expenses up to the amount specified in the Product Benefits Table.

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

3. Additional Benefits (for Platinum Policyholders only)

Note: The following benefits shall be available within the Policy Period only if the Insured Person is eligible to receive the benefits as per the Insured Person's Plan in the Product Benefits Table and as specified in the Schedule of Insurance Certificate.

The Additional Benefits cover Reasonable and Customary Charges incurred towards the medical treatment taken by the Insured Person during the Policy Period for an Illness, Injury or conditions described in the sections below, if it is contracted or sustained by an Insured Person during the Policy Period.

Additional Benefits will be payable subject to the terms, conditions and exclusions of this Policy and the availability of the Sum Insured and subject always to any sub-limits in respect of that Additional Benefit as specified in the Product Benefits Table and any limits specified in the Product Benefits Table as applicable under the Plan in force for the Insured Person as specified in the Schedule of Insurance Certificate.

All Waiting Periods under Section 7 and Permanent Exclusions under Section 8 shall apply to this section, unless specified otherwise in the Policy.

All claims for any benefits under the Policy must be made in accordance with the process defined under Section 9 (Claim process & Requirements).

3.1 OPD Treatment and Diagnostic Services

We will indemnify the Reasonable and Customary Charges incurred for OPD Treatment and/or Diagnostic Services and/or prescribed medicines for the OPD Treatment taken during the Policy Period provided that:

a. Expenses under this benefit are covered for ayurvedic or homeopathic or unani or sidha or allopathic services only and not in conjugation with each other.

b. For treatment taken under ayurveda, homeopathy, unani or sidha (AYUSH), expenses are covered only if taken in a government Hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health.

c. The OPD Treatment and/or Diagnostic Services are Medically Necessary and follow the written advice of a Medical Practitioner.

d. Diagnostic Services are performed on an outpatient basis with or without local anesthetics for topical, infiltration, nerve block anesthesia and require Hospitalization for less than 24 hours.

e. If the Policy is Renewed with Us without any break and there is a unutilized amount (not used by the Insured Person) under the applicable sub-limit (as specified in the Product Benefits Table) in a Policy Year, then We will carry forward 80% of this unutilized amount to the immediately succeeding Policy Year, provided that the total amount (including the unutilized amount available under this Additional Benefit) shall at no time exceed 2.5 times the amount of the entitlement in respect of this Additional Benefit under the Plan applicable to the Insured Person.

f. Section 8.7 of the Permanent Exclusions shall not apply to this benefit.

3.2 Child Care Benefits

We will indemnify the Reasonable and Customary Charges, once during a Policy Period, incurred for the vaccination of the Insured Persons less than 12 years of Age for the vaccinations shown in Annexure III to this Policy.

We will also cover expenses towards one consultation for nutrition and growth provided to the child during a visit for vaccination.

3.3 Emergency Medical Evacuation

We will indemnify the Reasonable and Customary Charges for the Insured Person's Medical Evacuation in an Emergency and for which medical facilities are not available locally, but within the regions specified in the Schedule of Insurance Certificate during the Policy Period on Cashless Facility basis only provided that:

3.3.1 Outside the geographical boundaries of India

a. We will provide this benefit from the place of Insured Person's Hospitalization (required for stabilization) to a Hospital where adequate treatment is available, if necessary treatment is not available locally or Medical Evacuation is Medically Necessary for saving the life of the Insured Person.

b. Medical Evacuation is Medically Necessary and advised in the opinion of the treating Medical Practitioner.

c. We or Our Service Provider has approved the request for Medical Evacuation.

d. We or Our Service Provider, will arrange for the evacuation utilizing the means best suited to do so, based on the medical severity of Insured Person(s) condition.

e. We will also cover the costs of transportation of an attending Medical Practitioner if this is Medically Necessary and advised.

f. Under this benefit We will cover expenses for services provided and/or arranged by Us for the transportation of the Insured Person and shall include medical services and cost for medical supplies necessarily incurred as a result of the Emergency Medical Evacuation.

g. We shall not be liable if necessary medical treatment can be provided at the Hospital where the Insured Person is situated at the time of Emergency.

3.3.2 Within the geographical boundaries of India

a. We will provide this benefit from the place of Insured Person's Hospitalization (required for stabilization) to a Hospital where adequate treatment is available.

b. Medical Evacuation by means of Air Transportation through air ambulance or commercial flight is Medically Necessary and advised in the opinion of treating Medical Practitioner.

c. We or Our Service Provider has approved the request for Medical Evacuation and has certified that Insured Person to be evacuated is medically fit to be evacuated by Air Transportation through air ambulance/commercial flight.

d. We or Our Service Provider, will arrange for the evacuation by means of Air Transportation through air ambulance or commercial flight utilizing the means best suited to do so, based on the medical severity of Insured Person(s) condition.

e. We will also cover the costs of transportation of an attending Medical Practitioner if this is Medically Necessary and is advised by Our Service Provider.

f. Under this benefit, We will cover expenses for services provided and/or arranged by Us for the transportation of the Insured Person and shall include medical services and cost for medical supplies necessarily incurred as a result of the Emergency Medical Evacuation.

g. We shall not be liable to make any payment under this Benefit if necessary medical treatment can be provided at the Hospital where the Insured Person is situated at the time of Emergency.

For **Emergency Medical Evacuation, We** will not pay for:

a. Any costs or expenses incurred in relation to any persons accompanying the Insured Person to be evacuated, even if such persons are also Insured Person(s).

b. Any expenses already included in the cost of a scheduled trip, including but not limited to the unutilized portion of the return air ticket for the scheduled trip.

c. Any expenses for a service not approved and arranged by Us or Our authorized representative.

3.4 Emergency Hospitalization (outside the geographical boundaries of India)

If the Insured Person is required to be admitted in a Hospital immediately after the Emergency Medical Evacuation for the same diagnosis, We will indemnify the Medical Expenses incurred on Hospitalization of that Insured Person untill the Insured Person reaches a Medically Stable Condition during the Policy Period on Cashless Facility basis only provided that:

a. The Hospitalization is Medically Necessary and follows the written advice of the treating Medical Practitioner.

b. The Insured Person is required to be admitted in a Hospital in an Emergency when the Insured Person is outside India, but within those regions specified in the Schedule of Insurance Certificate.

c. The Medical Expenses incurred are Reasonable and Customary Charges for one or more of the following:

i. Room Rent;

ii. Nursing charges for Hospitalization as an Inpatient;

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

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

v. Medicines, drugs as prescribed by the treating Medical Practitioner;

vi. Intravenous fluids, blood transfusion, injection administration charges and /or consumables;

vii. Operation theatre charges;

viii. The cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure;

ix. Intensive Care Unit charges.

3.5 Specified Illness Cover (outside the geographical boundaries of India)

If an Insured Person suffers a Specified Illness as defined under Section 12.76 during the Policy Period, We will indemnify the Reasonable and Customary Charges for Medical Expenses of the Insured Person incurred towards treatment of that Specified Illness that would otherwise have been payable under Section 2.1 (Inpatient Care), on Cashless Facility basis only, provided that:

a. The symptoms of the Specified Illness first occur or manifest itself during the Policy Period and after completion of the 90 day from the inception of the First Policy with Us.

b. The Specified Illness is diagnosed by a Medical Practitioner within India during the Policy Period and after completion of the 90 day from the inception of the First Policy with Us.

c. Medical treatment for the Specified Illness is taken outside India within the Policy Period but only within those regions specified in the Schedule of Insurance Certificate.

d. It is agreed and understood that We shall not cover:

i. Any claims for Reimbursement of the costs incurred in relation to the treatment of the Specified Illness or any claims which are not pre-authorized by Us.

ii. Any costs or expenses incurred in relation to any persons accompanying the Insured Person during any period of treatment, even if such persons are also Insured Persons.

iii. Any costs or expenses incurred in relation to the travel to or from the overseas location where treatment is being taken.

iv. Any costs or expenses incurred in relation to personal stay or transportation in the overseas location where treatment is being taken.

v. Any pre-hospitalization or post-hospitalization costs or expenses incurred by or on behalf of the Insured Person.

vi. Any costs or expenses incurred in relation to transportation of repatriation of the mortal remains of the Insured Person.

vii. Any costs or expenses incurred by any organ donor in relation to harvesting of organs.

viii. Any OPD Treatment taken outside India.

3.6 Second Medical Opinion

If the Insured Person is diagnosed with a Specified Illness as defined under Section 12.76 or is planning to undergo a planned Surgery or a Surgical Procedure for any Illness or Injury, the Insured Person can, at the Insured Person's choice, obtain a Second Medical Opinion during the Policy Period provided that:

a. Our Service Provider is contacted seeking the Second Medical Opinion.

b. The Second Medical Opinion will be arranged by Our Service Provider and will be based only on the information and documentation provided by the Insured Person that will be shared with the Medical Practitioner.

c. This benefit can be availed only once by an Insured Person during a Policy Year for the same Specified Illness or planned Surgery.

d. By seeking the Second Medical Opinion under this Benefit the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.

e. The Insured Person is free to choose whether or not to obtain the Second Medical Opinion, and if obtained then whether or not to act on it in whole or in part.

f. The Second Medical Opinion under this Benefit shall be limited to defined criteria and not be valid for any medico legal purposes.

g. We do not assume any liability and shall not be deemed to 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.

4. Policy Value Added Benefits

Note: The following benefits shall be available only if the Insured Person is eligible to receive the benefits as per the Insured Person's Plan in the Product Benefits Table and as specified in the Schedule of Insurance Certificate in the Policy Year preceding the current Policy.

All claims for any benefits under the Policy must be made in accordance with the process defined under Section 9 (Claim process & Requirements).

4.1 Loyalty Additions

a. For an Individual Policy or Family Floater Policy, if the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable), each Policy Year We will increase the Sum Insured applicable under the Policy by 10% of the Base Sum Insured of the immediately preceding Policy Year subject to the percentage limit specified in the Schedule of Insurance Certificate. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the Sum Insured.

b. For a Family First Policy, if the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable), each Policy Year We will increase the Sum Insured applicable under the Policy by 10% of the Base Sum Insured of each individual Insured Person only and the increase shall not apply to the Floater Sum Insured stated in the Schedule of Insurance Certificate as applicable under the Policy. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the Sum Insured.

c. If the Insured Person in the expiring Policy is covered under an Individual Policy and has an accumulated Loyalty Addition in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family Floater Policy, then We shall not provide any credit for the accumulated Loyalty Addition to the Family Floater Policy.

d. If the Insured Person in the expiring Policy is covered under an Individual Policy and has an accumulated Loyalty Addition in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family First Policy, then the accumulated Loyalty Addition to be carried forward for credit in the Renewing Policy would be the accumulated Loyalty Addition for that Insured Person only.

e. If the Insured Persons in the expiring Policy are covered under a Family First Policy and have an accumulated Loyalty Addition for each Insured Person in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family Floater Policy with same or higher Base Sum Insured, then the accumulated Loyalty Addition to be carried forward for credit in the Renewing Policy would be the least of the accumulated Loyalty Addition amongst all the Insured Persons.

f. If the Insured Persons in the expiring Policy are covered under a Family First Policy and have an accumulated Loyalty Addition for each Insured Person in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on an Individual Policy with same or higher Base Sum Insured, then the accumulated Loyalty Addition to be carried forward for credit in the Renewing Policy would be the accumulated Loyalty Addition for that Insured Person.

g. If the Insured Persons in the expiring Policy are covered on a Family Floater Policy and such Insured Persons Renew their expiring Policy with Us by splitting the Floater Sum Insured stated in the Schedule of Insurance Certificate in to two or more floater / individual / Family

First Policy, then We shall not provide any credit of the accumulated Loyalty Addition to the split Policy.

h. In case the Base Sum Insured under the Policy is reduced at the time of Renewal, the applicable accumulated Loyalty Addition shall also be reduced in proportion to the Base Sum Insured.

i. In case the Base Sum Insured under the Policy is increased at the time of Renewal, the applicable accumulated Loyalty Addition shall be carried forward.

Note: For expiring policies where the option to receive vouchers has already been selected and availed, the vouchers shall continue to be valid until their period of expiry. However, **Renewal** of such **Policy** shall be eligible for an increase in the **Sum Insured** only.

4.2 Health Checkup

If the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable), then the Insured Person may avail a health check-up, only for Diagnostic Tests, up to a sub-limit as per the Plan applicable to the Insured Person as specified in the Product Benefits Table on Cashless Facility basis provided that:

a. Health check-up will be arranged only at Our empanelled Service Providers.

b. The Insured Person will not be eligible to avail a health check-up in the first Policy Year in which he/she is covered as an Insured Person under the Policy.

c. Any unutilized test or amount cannot be carry forwarded to the next Policy Year.

Note – In case of silver plan, a pre-defined set of tests can be availed by the Insured Person. A list of eligible tests is attached in Annexure – V.

5. Optional Benefits

The following optional benefits shall apply under the Policy as per the plan in the Product Benefits Table and as specified in the Schedule of Insurance Certificate and shall apply to all Insured Persons only if such optional benefits are selected by You. These optional benefits can be selected only at the time of issuance of the First Policy or at Renewal by You. 'Hospital Cash' and 'Enhanced Geographical Scope for International coverage' benefits can be added to the Policy on payment of the corresponding additional premium. If a loading applies to the premium for the main Policy, such loading will also apply to the premium for any optional benefits selected.

The Optional Benefits cover Reasonable and Customary Charges incurred towards the medical treatment taken by the Insured Person during the Policy Period for an Illness, Injury or conditions described in the sections below, if it is contracted or sustained by an Insured Person during the Policy Period.

All claims for any benefits under the Policy must be made in accordance with the process defined under Section 9 (Claim process & Requirements).

5.1 Hospital Cash

If We have accepted an Inpatient Care Hospitalization claim under Section 2.1 (Inpatient Care), We will pay the Hospital Cash amount specified in the Product Benefits Table up to a maximum 30 days of Hospitalization during the Policy Year for the Insured Person for each continuous period of 24 hours of Hospitalization from the first day of Hospitalization provided that:

a. The Insured Person has been admitted in a Hospital for a minimum period of 48 hours continuously.

b. We will not make any payment under this option for Section 2.6 (Domiciliary Hospitalization), Section 2.7 (Maternity Benefit) and Section 2.8 (New Born Baby).

5.2 Enhanced Geographical Scope for International Coverage

Notwithstanding anything contrary to the terms and conditions specified therein, geographic coverage for the benefits set out in Section 3.3.1 (Emergency Medical Evacuation – outside the geographical boundaries of India), Section 3.4 (Emergency Hospitalization – outside the geographical boundaries of India) and Section 3.5 (Specified Illness cover – outside the geographical boundaries of India) is extended to include USA & Canada.

6. Claim Cost Sharing Options

The following claim cost sharing options shall apply under the Policy as per the plan in the Product Benefits Table and as specified in the Schedule of Insurance Certificate and shall apply to all Insured Persons only if such options are selected by You. These claim cost sharing options can be selected only at the time of issuance of the First Policy or at Renewal by You.

6.1 Co-payment

The Insured Person will bear a predetermined percentage of the admissible claim amounts subject to the Co-payment option chosen by You irrespective of the Age of the Insured Person and the number of claims made. Co-payment will not apply to any claim under section 3.6 (Second Medical Opinion), Section 4.2 (Health Checkup) and Section 5.1 (Hospital Cash).

6.2 Annual Aggregate Deductible

The Insured Person shall bear on his/her own account an amount equal to the Deductible specified in the Schedule of Insurance Certificate for any and all admissible claim amounts We assess to be payable by Us in respect of all claims made by that Insured Person under the Policy for a Policy Year. It is agreed that Our liability to make payment under the Policy in respect of any claim made in that Policy Year will only commence once the Deductible has been exhausted.

It is further agreed that:

a. The provisions in Section 6.1 on Co-payment (if opted) will apply to any amounts payable by Us in respect of a claim made by the Insured Person after the Deductible has been exhausted.

b. Deductible will not apply to any claim under Section 3.6 (Second Medical Opinion), Section 4.2 (Health Checkup) and Section 5.1 (Hospital Cash).

7. Waiting Periods

All the Waiting Periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if an enhanced Sum Insured is applied, the Waiting Periods would apply afresh to the extent of the increase in Sum Insured only.

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

7.1 Pre-existing Diseases:

All Pre-existing Diseases shall not be covered until 24 months of continuous coverage have elapsed since the inception of the First Policy with Us for Insured Persons to whom the Gold and Platinum Plans are applicable and until 48 months of continuous coverage have elapsed since the inception of the First Policy with Us for Insured Persons to whom the Silver Plan is applicable.

No benefits shall be paid for any Pre-existing Disease unless such Pre-existing Disease is stated in the Proposal and specifically accepted by Us and endorsed thereon.

7.2 Initial Waiting Period (30 days):

All the benefits under the Policy and any treatment taken unless the treatment needed is the result of an Accident that occurs during the Policy Period will be subject to a Waiting Period of 30 days since the inception of the First Policy with Us.

7.3 Specific Waiting Periods:

For all Insured Persons who are above 45 years of Age as on the date of inception of the First Policy with Us, the medical conditions and/or surgical treatment listed below will be subject to a Waiting Period of 24 months unless the condition is directly caused by cancer (as defined in Section 12.76.a) or an Accident and will be covered in the third Policy Year as long as the Insured Person has been insured continuously under the Policy without any break:

a. Pancreatitis and Stones in Biliary and Urinary System,

b. Cataract, Glaucoma and other disorders of lens, disorders of Retina,

c. Hyperplasia of Prostate, Hydrocele and spermatocele,

d. Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, PCOD, or any condition requiring dilation and curettage or Hysterectomy,

e. Hemorrhoids, Fissure or Fistula or Abscess of anal and rectal region,

f. Hernia of all sites,

g. Osteoarthritis, Systemic Connective Tissue disorders, Dorsopathies,

Spondylopathies, inflammatory Polyarthropathies, Arthrosis such as RA, Gout, Intervertebral Disc disorders,

h. Chronic kidney disease and failure,

i. Diabetes and its related complications,

j. Varicose veins of lower extremities,

k. Disease of middle ear and mastoid including Otitis Media, Cholesteatoma, Perforation of Tympanic Membrane,

l. All internal or external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump,

m. Ulcer, Erosion and Varices of Upper Gastro Intestinal Tract,

n. Tonsils and Adenoids, Nasal Septum and Nasal Sinuses,

o. Internal Congenital Anomaly.

If the Insured Person is suffering from the above Illness/condition as a Pre-existing Diseases or a condition under Personal Waiting Periods at the time of inception of the First Policy with Us, any claim in respect of that Illness/condition shall not be covered until 48 months of continuous coverage have elapsed since the inception of the First Policy with Us for Insured Persons to whom the Silver Plan is applicable.

Note: For all Renewing Insured Persons for whom the First Policy document states that this Specific Waiting Period applies only above 60 years of Age, the terms of the Specific Waiting Period as set out in the First Policy document (including the list of relevant medical conditions and surgical conditions as set out below) shall continue to apply until any Waiting Period has expired. The medical conditions and/or surgical treatments applicable to First Policies issued earlier are as follows:

a. Stones in the urinary system (eg kidney/bladder)

b. Stones in billiary system (eg gall stones)

c. Cataract

d. BPH - Benign prostatic hypertrophy

e. Mennoraghia, Fibromyoma, Uterine prolapse including any condition requiring Hysterectomy.

f. Piles (Haemorrhoids)

g. Hernia (Inguinal/umbilical and gastric)

h. Degenerative disorders of knee/hip

i. Chronic renal failure or end stage renal failure

j. Retinopathy

k. Diabetes and related treatments

7.4 Personal Waiting Periods:

Conditions specified for an Insured Person under Personal Waiting Period in the Schedule of Insurance Certificate will be subject to a Waiting Period of 24 months from the inception of the First Policy with Us and will be covered from the commencement of the third Policy Year as long as the Insured Person has been insured continuously under the Policy without any break.

8. Permanent Exclusions

A permanent exclusion will be applied on any medical or physical condition or treatment of an Insured Person, if specifically mentioned in the Schedule of Insurance Certificate and has been accepted by You. This option will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

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

8.1 Ancillary Hospital Charges

Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, RMO charges, night charges, registration, documentation and filing, surcharges. Service charges levied by the Hospital shall not be covered.

8.2 Hazardous Activities

Any claim relating to Hazardous Activities.

8.3 Artificial life maintenance:

Artificial life maintenance, including life support machine used to sustain a person, who has been declared brain dead, as demonstrated by:

a. Deep coma and unresponsiveness to all forms of stimulation; or

b. Absent pupillary light reaction; or

c. Absent oculovestibular and corneal reflexes; or

d. Complete apnea.

8.4 Autoimmune Disorders

Screening, counseling, treatment or complications related to autoimmune diseases.

8.5 Behavioral, Neurodevelopmental and Neurodegenerative Disorders:

Medical services for behavioral, neurodevelopmental delays and disorders such as:

a. Disorders of adult personality including gender related problems, gender change;

b. Disorders of speech and language including stammering, dyslexia;

c. All Neurodegenerative disorders including Dementia, Alzheimer's disease and Parkinson's disease.

8.6 Circumcision:

Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

8.7 Complementary & Alternative Medicine:

Any form of Complementary & Alternative Medicine.

8.8 Conflict & Disaster:

Treatment for any Illness or Injury resulting directly or indirectly from nuclear or chemical contamination, war or act of war, riot, revolution, chemical or biological disaster, radiation of any kind, acts of terrorism or any similar event (other than natural disaster or calamity), if one or more of the following conditions apply:

a. The Insured Person puts himself in danger by entering a known area of conflict where active fighting or insurrections are taking place;

b. The Insured Person was an active participant in the above mentioned acts or events of a similar nature;

c. The Insured Person displayed a blatant disregard for personal safety.

8.9 External Congenital Anomaly, Hereditary or Genetic Disorders:

Screening, counseling or treatment related to external Congenital Anomaly, Hereditary or Genetic Disorders.

8.10 Convalescence & Rehabilitation:

Hospital accommodation when it is used solely or primarily for any of the following purposes:

a. Any services related to Complementary & Alternative Medicine provided for the purpose of Convalescence, Rehabilitation and Respite Care other than for receiving eligible treatment of a type that normally requires a stay in Hospital.

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

c. Hospice care - Any services for people who are terminally ill to address medical, physical, social, emotional and spiritual need.

8.11 Cosmetic and Reconstructive Surgery:

a. Any treatment undergone purely for cosmetic or psychological reasons to improve appearance, unless such treatment is Medically Necessary as a part of reconstructive procedure related to cancer or treatment for Injury resulting from Accidents or burns, and is required to restore functionality.

b. Gynaecomastia, Abdominoplasty, blepharoplasty, mammoplasty, Chemical Peel, Rhinoplasty, Otoplasty, Liposuction and Lipectomy will not be payable even in case of Accident or burn or cancer.

8.12 Dental/oral treatment:

Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and Gingiva except for Inpatient Hospitalization due to an Accident.

8.13 Eyesight & Optical Services:

Any treatment to correct refractive errors of the eye, unless required as the result of an Accident. We will not pay for routine eye examinations, contact lenses, spectacles or laser eye sight correction.

8.14 Experimental/Investigational or Unproven Treatment:

a. Services including device, treatment, procedure or pharmacological regimens which are considered as experimental, investigational or unproven.

b. Medical Devices, Vascular or Coronary Stents: Biodegradable (bioresorbable, bioabsorbable) polymer drug eluting stents will be considered as experimental and investigational for all purpose.

c. Stem Cell Transplant: Any stem cell transplant other than for Bone Marrow Transplant.

8.15 HIV, AIDS, and related complex:

Any condition directly or indirectly caused by or associated with Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), including any condition that is related to HIV or AIDS.

8.16 Hospitalization not justified:

Admission solely for the purpose of Physiotherapy, evaluation, investigations, diagnosis or observation services or not consistent with standard treatment guidelines (as defined by Clinical Establishments (Registration and Regulation) Act 2010 and amendments thereafter) or Evidence Based Clinical Practices.

8.17 Inconsistent, Irrelevant or Incidental Diagnostic procedures:

Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the current diagnosis and treatment even if the same requires confinement at a Hospital.

8.18 Mental and Psychiatric Conditions:

Treatment related to symptoms, complications and consequences of mental Illness, mood disorders, psychotic and non-psychotic disorders such as:

a. Intentional self inflicted Injury or attempted suicide by any means.

b. Depression, anxiety, dissociative or stress-related disorders.

8.19 Non-Medical Expenses:

a. Items of personal comfort and convenience.

i. Personal attendant or beauty services, cosmetics, toiletry items, guest services and similar incidental expenses or services.

ii. Issue of medical certificate and examinations as to suitability for employment or travel or any other such purpose.

iii. Any charges incurred to procure any treatment/Illness related documents pertaining to any period of Hospitalization/Illness.

iv. Intra Ocular Lens: Any of the following classes of intraocular lens implants for any indication, including aphakia such as Multifocal IOL, Presbyopia or Astigmatism Correcting IOL, Phakic IOL, Pseudoaccommodating IOL.

b. External or Ambulatory Devices

i. External and or durable medical/non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD or infusion pump.

ii. Ambulatory devices such as walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, diabetic foot wear, glucometer /thermometer and similar items and also any medical equipment which is subsequently used at home.

c. Visiting Charges:

Any travelling charge for visiting consultant.

8.20 Obesity and Weight Control Programs:

Services including medical treatment and Surgical Procedures and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

8.21 Off- label drug or treatment:

Use of pharmaceutical drugs for an unapproved indication or in an unapproved age group, dosage, or route of administration as regulated and approved by Central Drugs Standard Control Organization (CDSCO).

8.22 Puberty and Menopause related Disorders:

Treatment for any symptoms, Illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing.

8.23 Reproductive medicine & other Maternity Expenses: Any assessment or treatment method for:

a. Birth Control

Any type of contraception, sterilization, abortions, voluntary termination of pregnancy (except under Maternity Expenses for Medical Termination of Pregnancy (MTP) as governed by MTP Act 1971 under Section 2.7 above) or family planning;

b. Assisted Reproduction

Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI, Gestational Surrogacy;

c. Sexual disorder and Erectile Dysfunction.

Treatment of any sexual disorder including impotence (irrespective of the cause) and sex changes or gender reassignments or erectile dysfunction;

d. Any costs or expenses related to pregnancy, complications arising from pregnancy or medical termination of pregnancy except to the extent covered under Section 2.7 (Maternity Benefit) if applicable.

8.24 Robotic Assisted Surgery, Light Amplification by Stimulated Emission of Radiation (LASER) & Light based Treatment:

Any invasive or non invasive procedures in which a robotic surgical system or light based measure is used either in conjugation with base procedure or alone and liability will be based on the agreed tariff rate or Reasonable and Customary Charges for the base procedure including but not limited to Cyberknife, Da Vinci, Laser Ablation, Femto second laser.

8.25 Sexually transmitted Infections & diseases:

Screening, prevention and treatment for sexually related infection or disease including but not limited to Genital Warts, Syphilis, Gonorrhea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.

8.26 Sleep disorders:

Treatment for any conditions related to disturbance of normal sleep patterns or behaviors such as Sleep apnea, snoring, etc.

8.27 Substance related and Addictive Disorders:

Treatment and complications related to disorders of intoxication, dependence, abuse, and withdrawal caused by drugs and other substances such as alcohol, opiods or nicotine.

8.28 Traffic Offences & Unlawful Activity:

Any condition occurring either as a result of breach of law with criminal intent or/and violation of traffic rules.

8.29 Treatment received outside India:

Any treatment or medical services received outside India except for treatment undertaken under Section 3.3.1 (Emergency Medical Evacuation – outside the geographical boundaries of India), Section 3.4 (Emergency Hospitalization – outside the geographical boundaries of India) and Section 3.5 (Specified Illness cover – outside the geographical boundaries of India).

8.30 Unrecognized Physician or Hospital:

a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central council of Homeopathy or by relevant authorities in the area or country where the treatment is taken.

b. Treatment or Medical Advice related to one system of medicine provided by a Medical Practitioner of another system of medicine.

c. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.

d. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India or any other country

where treatment takes place, or is an unrecognized Hospital listed by Us on Our website or Policy document

e. Treatment or services received in health hydros, nature cure clinics or any establishment that is not a recognized Hospital or healthcare facility.

8.31 Generally Excluded Expenses

Any costs or expenses specified in the list of expenses generally excluded at Annexure IV.

9. Claims Process & Requirements

The fulfillment of the terms and conditions of this Policy (including realization of full premium in advance by the due dates mentioned in the Schedule of Insurance Certificate) in so far as they relate to anything to be done or complied 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.

9.1 Claims Administration:

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:

a. 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 or failure to follow such directions, advice or guidance.

b. If requested by Us and at Our cost, the Insured Person must submit himself or herself to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary.

c. We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.

d. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

e. It is hereby agreed and understood that no change in the Medical Record provided under the Medical Advice information, by the Hospital or the Insured Person to Us or Our Service Provider during the period of Hospitalization or after discharge by any means of request will be accepted by Us. Any decision on request for acceptance of change will be at Our discretion.

9.2 Claims Procedure: On the occurrence or the 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:

a. For Availing Cashless Facility: Cashless Facility can be availed only at Our Network Providers. The complete list of Network Providers is available on Our website and at Our branches and can also be obtained by contacting Us over the telephone. In order to avail Cashless Facility, the following process must be followed:

i. Process for Obtaining Pre-Authorization

A. For Planned Treatment:

We must be contacted to pre-authorize Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider.

B. In Emergencies

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

All final authorization requests, if required, shall be sent at least six hours prior to the Insured Person's discharge from the Hospital.

Each request for pre-authorization must be accompanied with completely filled and duly signed pre-authorization form including all of the following details:

I. The health card We have issued to the Insured Person at the time of inception of the Policy supported with KYC document;

II. The Policy Number;

III. Name of the Policyholder;

IV. Name and address of Insured Person in respect of whom the request is being made;

V. Nature of the Illness/Injury and the treatment/Surgery required;

VI. Name and address of the attending Medical Practitioner;

VII. Hospital where treatment/Surgery is proposed to be taken;

VIII. Date of admission;

IX. First and any subsequent consultation paper / Medical Record since beginning of diagnosis of that treatment/Surgery.

If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.

When We have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim, applicable Deductibles / Co-payment and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.

Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, Hospital and locations, match with the details of the actual treatment received. For cashless Hospitalization, We will make the payment of the amount assessed to be due, directly to the Network Provider.

We reserve the right to modify, add or restrict any Network Provider for Cashless Facility in Our sole discretion. Before availing Cashless Facility, please check the applicable updated list of Network Providers.

ii. Reauthorization

Cashless Facility will not be provided where re-authorization is not requested for either change in the line of treatment or in the diagnosis or for any procedure carried out on the incidental diagnosis/finding.

b. For Reimbursement Claims:

For all claims for which Cashless Facility have not been pre-authorized or for which treatment has not been taken at a Network Provider, We shall be informed of the claim along with the following details within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier:

i. The Policy Number;

ii. Name of the Policyholder;

iii. 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. Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

9.3 Claims Documentation: We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense within 30 days of the Insured Person's discharge from Hospital (in the case of Pre-hospitalization Medical Expenses and Hospitalization Medical Expenses) or within 30 days of the completion of the Post-hospitalization Medical Expenses period (in the case of Post-hospitalization Medical Expenses). For those claims for which the use of Cashless Facility has been authorised, We will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:

a. Claim form duly completed and signed by the claimant.

Please provide mandatorily following information if applicable

i. Current diagnosis and date of diagnosis;

ii. Past history and first consultation details;

iii. Previous admission/Surgery if any.

b. KYC Document: Of Insured Person in case of cashless claim and Proposer in case of Reimbursement claim.

i. Self attested copy of valid Age proof (passport / driving license / PAN card / class X certificate / birth certificate);

ii. Self attested copy of identity proof (passport / driving license / PAN card / voter identity card);

iii. Recent passport size photograph.

c. Cancelled cheque/ bank statement / copy of passbook mentioning account holder's name, IFSC code and account number printed on it of Policyholder / nominee (in case of death of Policyholder).

d. Original discharge summary.

e. Additional documents required in case of Surgery/Surgical Procedure.

i. Original surgical notes;

ii. Pre Anesthesia check up report (PAC);

iii. Bar code sticker and invoice for implants and prosthesis (if used);

iv. Indoor case paper/OT notes (if required).

f. Original final bill from Hospital with detailed break-up and paid receipt.

g. Room tariff of the entitled room category (in case of a Non-Network provider): duly signed and stamped by the Hospital in which treatment is taken.

(In case You are unable to submit such document, then We shall consider the Reasonable and Customary Charges of the Insured Person's eligible room category of Our Network Provider within the same geographical area for identical or similar services.)

h. Original bills of pharmacy/medicines purchased, or of any other investigation done outside Hospital with reports and requisite prescriptions.

i. Copy of death certificate (in case of demise of the Insured Person).

j. For Medico-legal cases (MLC) or in case of Accident

i. MLC/First Information Report (FIR) copy attested by the concerned Hospital / police station (if applicable);

ii. Original self-narration of incident in absence of MLC / FIR.

k. Original first consultation paper (in case Illness is diagnosed for the first time).

l. Original laboratory investigation, diagnostic & pathological reports with supporting prescriptions.

m. Original X-Ray/ MRI / ultrasound films and other radiological investigations.

*In the event of the **Insured Person's** death during **Hospitalization,** written notice accompanied by a copy of the post mortem report (if any) shall be given to **Us** regardless of whether any other notice has been given to **Us.***

9.4 Claims Assessment & Repudiation:

a. At Our discretion, We may investigate claims to determine the validity of a claim. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals/entities that are authorized 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 set out above. In case of any suspected fraud, the last "necessary" document shall include the receipt of the investigation report from Our investigator/representatives. 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.

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 Schedule of Insurance Certificate or Your legal heirs or legal representatives holding a valid succession certificate.

d. If a claim is made which extends in to two Policy Periods, then such claim shall be paid taking into consideration the available Sum Insured in these Policy Periods including the Deductible for each Policy Period. Such eligible claim amount will be paid to the Policyholder/Insured Person after deducting the extent of premium to be received for the Renewal/due date of premium of the Policy, if not received earlier.

e. All admissible claims under this Policy shall be assessed by Us in the following progressive order:-

i. If a room has been opted in a Hospital for which the Room Rent or room category is higher than the eligible limit as applicable for that Insured Person as specified in the Schedule of Insurance Certificate, then the Associated Medical Expenses payable shall be pro-rated as per the applicable limits in accordance with Section 2.1c.

ii. The Deductible (if applicable) shall be applied to the aggregate of all claims that are either paid or payable under this Policy. Our liability to make payment shall commence only once the aggregate amount of all claims payable or paid exceeds the Deductible.

iii. Co-payment (if applicable) shall be applicable on the amount payable by Us as specified in the Schedule of Insurance Certificate.

f. The claim amount assessed in Section 9.4 e above would be deducted from the amount mentioned against each benefit and Sum Insured as specified in the Schedule of Insurance Certificate.

9.5 Delay in Claim Intimation:

If the claim is not notified to Us within the stipulated time as mentioned in the above sections, 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.

9.6 Claims process for Sections 3 & 4

9.6.1 For Section 3.3 (Emergency Medical Evacuation)

a. In the event of an Emergency, Our Service Provider shall be contacted immediately on the helpline number specified in the Insured Person's health card.

b. Our Service Provider will evaluate the necessity for evacuation of the Insured Person and if the request for Medical Evacuation is approved, the Service Provider shall pre-authorise the type of travel that can be utilized to transport the Insured Person and provide information on the Hospital that may be approached for medical treatment of the Insured Person.

c. If the Service Provider pre-authorises the Medical Evacuation of the Insured Person by means of Air Transportation through an air ambulance or commercial flight whichever is best suited, the Service Provider shall also arrange for the same to be provided to the Insured Person unless there are any logistical constraints or the medical condition of the Insured Person prevents Emergency Medical Evacuation.

d. It is agreed and understood that We shall not cover any claims for Reimbursement of the costs incurred in the evacuation or transportation of the Insured Person or which are not pre-authorized by Our Service Provider.

9.6.2 For Section 3.4 (Emergency Hospitalization - outside the geographical boundaries of India)

a. The health card We provide will enable the Insured Person to access medical treatment at any Network Provider outside India, but within those regions specified in the Schedule of Insurance Certificate, on a cashless basis only by the production of the card to the Network Provider prior to admission, subject to the following:

i. In the event of an Emergency, the Insured Person or Network Provider shall call Our Service Provider immediately, on the helpline number specified in the Insured Person's health card, requesting for a pre-authorization for the medical treatment required.

ii. Our Service Provider will evaluate the request and the eligibility of the Insured Person under the Policy and call for more information or details, if required. Our Service Provider will communicate directly to the Hospital whether the request for pre-authorization has been approved or denied.

iii. If the pre-authorization request is approved, Our Service Provider will directly settle the claim with the Hospital. Any additional costs or expenses incurred by or on behalf of the Insured Person beyond the limits pre-authorized by the Service Provider shall be borne by the Insured Person.

iv. It is agreed and understood that We shall not cover any claims for Reimbursement of the costs incurred in relation to the Hospitalization of the Insured Person while inside or outside India or any claims which are not pre-authorized by Our Service Provider.

9.6.3 For Section 3.5 (Specified Illness Cover – outside the geographical boundaries of India)

a. In the event of the diagnosis of a Specified Illness, the Insured Person should call Us immediately and in any event before the commencement of the travel for treatment overseas on the helpline number specified on in the Insured Person's health card, requesting for a pre-authorization for the treatment.

b. We will evaluate the request and the eligibility of the Insured Person's Policy and call for more information or details, if required.

c. We will communicate directly to the Service Provider and the Insured Person whether the request for pre-authorization has been approved or denied.

d. If the pre-authorization request is approved, Our Service Provider will directly settle the claim with the Hospital. Any additional costs or expenses incurred by or on behalf of the Insured Person beyond the limits pre-authorized by the Service Provider or at any Non-Network Hospital shall be borne by the Insured Person.

e. This benefit is available only as Cashless Facility through pre-authorization by Us.

9.6.4 For Section 3.6 (Second Medical Opinion)

a. In the event of submission of request for Second Medical Opinion, Our Service Provider shall be contacted immediately on the helpline number specified in the Insured Person's health card.

b. Our Service Provider will evaluate the information of the Insured Person and if the request for Second Medical Opinion is approved, the Service Provider will facilitate arrangement as per conditions specified in the Section 3.6

9.6.5 For Section 4.2 (Health Checkup)

a. The Insured Person shall seek appointment by contacting Our Service Provider.

b. Our Service Provider will facilitate Your appointment.

c. Reports of the medical tests can be collected directly from the Service Provider.

10. Portability Option

If You/the Insured Person has exercised the Portability Option at the time of Renewal of Your previous health insurance policy by submitting Your application and the completed Portability form with complete documentation at least 45 days before the expiry of Your previous Policy Period, then the Insured Person will be provided with credit gained for Pre-existing Diseases in terms of Waiting Periods and time bound exclusions up to the existing Sum Insured and cover in accordance with the existing guidelines of the IRDAI provided that:

a. The ported Insured Person was insured continuously and without a break under another Indian retail health insurance policy with any other Indian general insurance company or stand-alone health insurance company or any group/retail indemnity health insurance policy from Us.

b. The Waiting Period with respect to change in Sum Insured or plan shall be taken into account as follows:

i. If the ported Sum Insured is higher than the Sum Insured under the expiring policy, Waiting Periods would be applied on the amount of proposed increase in Sum Insured only, in accordance with the existing guidelines of the IRDAI.

ii. If the ported Sum Insured is lower than the Sum Insured under previous policy then the applicable Waiting Periods would be reduced by the number of months of continuous coverage under the previous policy.

iii. If the proposed Plan is to be changed and not the Sum Insured then the applicable Waiting Periods would be applied as per the proposed plan.

c. In case of different policies and plan in previous years, the Portability Option would be provided for the expiring policy or Plan which is to be ported to Us.

d. The Waiting Period for maternity benefits is not reduced on account of the previous period of insurance coverage even if the previous insurance policy incorporated a Waiting Period for maternity benefits.

e. The Portability Option has been accepted by Us within 15 days of receiving Your Proposal and Portability Form subject to the following:

i. You shall have given Us all additional documentation and/or information that We requested for;

ii. You shall have paid Us the applicable premium in full;

iii. We might have, subject to Our medical underwriting as per Our Board approved underwriting policy, restricted the terms upon which We have offered cover, the decision as to which shall be in Our sole and absolute discretion;

iv. There was no obligation on Us to insure all Insured Persons or to insure all Insured Persons on the proposed terms, even if You have given Us all documentation;

v. We have received necessary details of medical history and claim history from the previous insurance company for the Insured Person's previous health insurance policy through the IRDAI's web portal.

vi. No additional loading or charges have been applied by Us exclusively for porting the Policy.

f. In case You have opted to switch to any other insurer under Portability provisions(Porting Out) and the outcome of acceptance of the Portability request is awaited from the new insurer on the date of Renewal,

i. 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.

ii. If during this extension period a claim has been reported, You shall be required to first pay the balance of the full annual Policy premium. 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 and pay the balance claim amount if any and issue the Policy for the remaining period.

iii. We reserve the right to modify or amend the terms and the applicability of the Portability option in accordance with the provisions of the regulations and guidance issued by the IRDAI as amended from time to time.

11. General Terms and Conditions

11.1 Free Look Provision

a. The free look period shall be applicable at the inception of the Policy and is not applicable and available at the time of Renewal of the Policy or in cases of Portability.

b. You have a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy.

c. If You have any objections to any of the terms and conditions, You may cancel the Policy stating the reasons for cancellation and provided that no claims have been made and the Second Medical Opinion has not been availed under the Policy.

d. We will refund the premium paid by You after deducting the amounts spent on pre-insurance medical check-up (if any), stamp duty charges and proportionate risk premium for the period of cover.

e. Your rights under this Policy will immediately stand extinguished on the free look cancellation of the Policy

11.2 Cancellation/Termination (other than Free Look cancellation)

a. Cancellation by You: You may terminate this Policy by giving 30 days prior written notice to Us. We shall cancel the Policy for the balance of the Policy Period and refund the premium (exclusive of service tax) for the unexpired term as mentioned herein below, provided that no claim has been made and the Second Medical Opinion or health check-up have not been availed under the Policy by or on behalf of any Insured Person:

Policy in-force up to	Policy Period 1 year	Policy Period 2 years
	Refund Premium (%)	Refund Premium (%)
Up to 30 days	75%	87.5%
31 to 90 days	50%	75%
91 to 180 days	25%	62.5%
181 to 365 days	0%	50%
366 to 455 days	Not applicable	25%
456 to 545 days	Not applicable	12%
Exceeding 545 days	Not applicable	0%

b. Automatic Cancellation:

i. Individual Policy:

The Policy shall automatically terminate in the event of death of the Insured Person.

ii. For Family Floater Policies and Family First Policies:

The Policy shall automatically terminate in the event of the death of all the Insured Persons.

iii. Refund:

A refund in accordance with the table in Section 11.2 (a) shall be payable if there is an automatic cancellation of the Policy provided that no claim has been made and the Second Medical Opinion or health check-up have not been availed under the Policy by or on behalf of any Insured Person.

c. Cancellation by Us: We may terminate this Policy during the Policy Period by sending 30 days prior written notice to Your address shown in the Schedule of Insurance Certificate without refund of premium (for cases other than non cooperation) if:

i. You or any Insured Person or any person acting on behalf of either has acted in a dishonest or fraudulent manner under or in relation to this Policy; and/or

ii. You or any Insured Person has not disclosed the material facts or misrepresented in relation to the Policy; and/or

iii. You or any Insured Person has not co-operated with Us. In such cases, premium will be refunded on pro-rata basis provided that no claim has been filed under the Policy by or on behalf of any Insured Person; and/or

iv. You fail or refuse to pay or refund any amount You owe Us.

For avoidance of doubt, it is clarified that no claims shall be admitted and/or paid by Us and the Second Medical Opinion and health check-up cannot be availed during the notice period.

11.3 Loading on Premium

a. Based on Our discretion, upon the disclosure of the health status of the persons proposed for insurance and declarations made in the Proposal or Insurance Summary Sheet, We may apply a risk loading on the premium payable (excluding statutory levies and taxes) or Special Conditions on the Policy. The maximum risk loading applicable shall not exceed more than 350% of the premium.

b. These loadings will be applied from inception date of the First Policy including subsequent Renewal(s) with Us.

c. We may apply a specific personal Waiting Period on a medical condition/ailment depending on the past history or additional Waiting Periods on Pre-existing Diseases as part of the special conditions on the Policy.

11.4 Renewal of Policy

This Policy is Renewable for life however this Policy will automatically terminate at the end of the Policy Period or Grace Period and We are under no obligation to give intimation in this regard.

a. Continuity of Benefits on Timely Renewal:

i. The Benefits under the Policy can be availed continuously after completion of the Policy Period if the Renewal request is made along with the applicable premium on a timely basis.

ii. The Renewal premium is payable on or before the due date and in any circumstances before the expiry of Grace Period, at such rate as may be reviewed and notified by Us before completion of the Policy Period provided that all such changes are approved by IRDAI and in accordance with the IRDAI's rules and regulations as applicable from time to time.

iii. Renewal premium rates for this Policy may be further altered by Us including in the following circumstances:

A. You proposed to add an Insured Person to the Policy

B. You change any coverage provision

C. You change Your residence to different zip code

iv. Renewal premium will alter based on individual Age. The reference of Age for calculating the premium for Family Floater Policies shall be the Age of the eldest Insured Person, and for Family First Policies it shall be the individual Age of each Insured Person of the family.

v. Renewal premium will not alter based on individual claims experience.Renewal premium rates may be changed by Us provided that such changes are approved by IRDAI and in accordance with the IRDAI's rules and regulations as applicable from time to time.

b. Grace Period:

i. If You do not Renew the Policy by the due dates specified in the Schedule of Insurance Certificate, You or any other eligible adult Insured Person may apply to Renew the Policy within the Grace Period of 30 days of the end of the Policy Period subjected to receipt of application and payment of premium from such Insured Person and evidence satisfactory to Us of the agreement of all other Insured Persons and You (except in case of death). If We accept such application and the premium for the Renewed Policy is paid on time, then the Policy shall be treated as having been Renewed without a break in cover.

ii. Any claim made during Grace Period will not be payable under this Policy.

c. Reinstatement:

i. The Policy shall lapse after the expiration of the Grace Period. If the Policy is not Renewed within the Grace Period then We may agree to issue a fresh Policy subject to Our underwriting criteria, as per Our Board approved underwriting policy and no continuing benefits shall be available from the expired Policy.

ii. We will not pay for any Medical Expenses which are incurred happen between the date the Policy expires and the date immediately before the reinstatement date of Your Policy.

iii. If there is any change in the Insured Person's medical or physical condition, We may add exclusions or charge an extra premium from the reinstatement date.

d. Disclosures on Renewal:

You shall make a full disclosure to Us in writing of any material change in the health condition or geographical location 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. Renewal for Insured Persons who have achieved Age 21:

If any Insured Person who is a child and has completed Age 21 years at the time of Renewal, then such Insured Person will have to take a separate policy based on Our underwriting guidelines, as per Our Board approved underwriting policy as he/she will no longer be eligible to be covered under a Family Floater Policy. In such cases, the credit of the Waiting Periods served under the Policy will be passed on to the separate policy taken by such Insured Person.

f. Addition of Insured Persons on Renewal:

Where an individual is added to this Policy (including for New Born Babies added to the Policy under section 2.8), either by way of

endorsement or at the time of Renewal, the Pre existing Disease clause, exclusions and Waiting Periods will be applicable considering such Policy Year as the first year of the Policy with Us.

g. Changes to Sum Insured on Renewal:

i. Wherever the Sum Insured is reduced on any Policy Renewals, the Waiting Periods as defined under Section 7 shall be waived only up to the lowest Sum Insured of the last 48/24 consecutive months as applicable to the relevant Waiting Periods of the Plan opted.

ii. Any enhanced Sum Insured applied on Renewal will not be available for an Illness or Injury already contracted under the preceding Policy Periods. All Waiting Periods as defined in the Policy under Section 7 shall apply afresh for this enhanced limit from the effective date of such enhancement.

h. Renewal Promise:

Renewal of the Policy will not ordinarily be denied other than on grounds of moral hazard, misrepresentation or fraud or non-cooperation by You.

If on the death of some of the Insured Persons during the Policy Period which results in the remaining Insured Persons being ineligible to avail a Family Floater Policy or Family First Policy, on Renewal, We will issue eligible insurance cover to the remaining Insured Persons subject to Our Board-approved underwriting policy.

11.5 Change of Policyholder

a. The Policyholder may be changed only at the time of Renewal. The new Policyholder must be a member of the Insured Person's immediate family. Such change would be solely subject to Our discretion and payment of premium by You. The Renewed Policy shall be treated as having been Renewed without break. The Policyholder may be changed upon request in case of Your death, Your emigration from India or in case of Your divorce during the Policy Period.

b. Any alteration in the plan due to unavoidable circumstances as in case of the Policyholder's death, emigration or divorce during the Policy Period should be reported to Us immediately. Coverage of Benefits in such scenario will be limited to current Policy Year.

c. Renewal of such Policies will be according to terms and conditions of existing Policy.

11.6 Nomination

a. You are mandatorily required at the inception of the Policy, to make a nomination for the purpose of payment of claims under the Policy in the event of Your death.

b. Any change of nomination shall be communicated to Us in writing and such change shall be effective only when an endorsement on the Policy is made by Us.

c. In case of any Insured Person other than You under the Policy, for the purpose of payment of claims in the event of death, the default nominee would be You.

11.7 Obligations in case of a minor

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

11.8 Authorization to obtain all pertinent records or information:

As a Condition Precedent to the payment of benefits, We and/or Our Service Provider shall have the authority to obtain all pertinent records or information from any Medical Practitioner, Hospital, clinic, insurer, individual or institution to assess the validity of a claim submitted by or on behalf of any Insured Person.

In the event of the Insured Person's death, We and/or Our Service Provider may request an examination of the Insured Person's body, for identification purposes, subject to any law of the applicable jurisdiction relating to such examinations.

11.9 Fraudulent claims

If a claim is in any way found to be fraudulent, or if any false statement, or declaration is made or used in support of such a claim, or if any fraudulent means or devices are used by the Insured Person or anyone acting on behalf of the Insured Person or any false or incorrect Disclosure to Information Norms to obtain any benefit under this Policy, then We may reserve the right to re-underwrite or cancel the Policy and all claims being processed shall be forfeited for all Insured Persons and all sums paid under this Policy shall be repaid to Us by You who shall be jointly liable for such repayment.

11.10 Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

11.11 Territorial Jurisdiction

All benefits are available in India only, and all claims shall be payable in India in Indian Rupees only except for benefits and claims under Section 3.3.1 (Emergency Medical Evacuation – outside the geographical boundaries of India), Section 3.4 (Emergency Hospitalization – outside the geographical boundaries of India) and Section 3.5 (Specified Illness cover – outside the geographical boundaries of India).

11.12 Notices

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

a. You/the Insured Person at the address specified in the Schedule of Insurance Certificate or at the changed address of which We must receive written notice.

b. Us at the following address:

Max Bupa Health Insurance Company Limited
B-1/I-2, Mohan Cooperative Industrial Estate
Mathura Road, New Delhi-110044
Fax No.: 1800-3070-3333

c. No insurance agents, brokers or other person/entity is authorized to receive any notice on Our behalf.

d. In addition, We may send You/the Insured Person other information through electronic and telecommunications means with respect to Your Policy from time to time.

11.13 Alteration to the Policy

This Policy constitutes the complete contract of insurance. Any change in the Policy will only be evidenced by a written endorsement signed and stamped by Us. No one except Us can within the permission of the IRDAI change or vary this Policy.

11.14 Revision or Modification

This product/plan may be revised or modified subject to prior approval of the IRDAI. In such case We shall notify You of any such change at least 3 months prior to the date from which such revision or modification shall come into effect, provided it is not otherwise provided by the IRDAI.

11.15 Withdrawal of Product

This product or any variant/plan under the product may be withdrawn at Our option subject to prior approval of IRDAI or due to a change in regulations. In such a case We shall provide an option to migrate to Our other suitable retail products as available with Us and We shall also notify You of any such change at least 3 months prior to the date from which such withdrawal shall come into effect.

11.16 Customer Service and Grievances Redressal:

a. In case of any query or complaint/grievance, You/the Insured Person may approach Our office at the following address:

Customer Services Department
Max Bupa Health Insurance Company Limited
B-1/I-2, Mohan Cooperative Industrial Estate
Mathura Road, New Delhi-110044
Contact No: 1800-3010-3333
Fax No.: 1800-3070-3333
Email ID: customercare@maxbupa.com

b. In case You/the Insured Person are not satisfied with the decision of the above office, or have not received any response within 10 days, You may contact the following official for resolution:

Head – Customer Services
Max Bupa Health Insurance Company Limited
B-1/I-2, Mohan Cooperative Industrial Estate
Mathura Road, New Delhi-110044
Contact No: 1800-3010-3333
Fax No.: 1800-3070-3333
Email ID: customercare@maxbupa.com

c. In case You/the Insured Person are not satisfied with Our decision/resolution, You may approach the Insurance Ombudsman at the addresses given in Annexure I.

d. The complaint should be made in writing duly signed by the complainant or by his/her legal heirs with full details of the complaint and the contact information of the complainant.

e. As per provision 13(3)of the Redressal of Public Grievances Rules 1998,the complaint to the Ombudsman can be made only if the grievance

i. Has been rejected by the Grievance Redressal Machinery of the Insurer;

ii. Within a period of one year from the date of rejection by the insurer;

iii. If it is not simultaneously under any litigation.

12. Definitions & Interpretation

For the purposes of interpretation and understanding of this Policy, We have defined, herein below some of the important words used in the Policy and for the remaining language and the words; they shall have the usual meaning as described in standard English language dictionaries. The words and expressions defined in the Insurance Act 1938, IRDA Act 1999, regulations notified by the IRDAI and circulars and guidelines issued by the IRDAI shall carry the meanings explained therein.

***Note:* Where the context permits, the singular will be deemed to include the plural, one gender shall be deemed to include the other genders and references to any statute shall be deemed to refer to any replacement or amendment of that statute.**

12.1 Accident or Accidental means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

12.2 Age means age last birthday.

12.3 Air Transportation means air conveyance required to transport the Insured Person during a Medical Evacuation.

12.4 Alternative Treatments are forms of treatments other than allopathic treatment or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

12.5 Associated Medical Expenses shall include Room Rent, nursing charges for Hospitalization as an Inpatient excluding private nursing charges, Medical Practitioners' fees excluding any charges or fees for Standby Services, investigation and diagnostics procedures directly related to the current admission, operation theatre charges and Intensive Care Unit charges.

12.6 Base Sum Insured means the amount stated in the Schedule of Insurance Certificate.

12.7 Bone Marrow Transplant is a condition where the Insured Person needs necessary medical treatment to replace malignant or defective bone marrow with normal bone marrow from healthy donors to stimulate the production of formed blood cells.

12.8 Cashless Facility means a facility extended by the insurer to the Insured Person where the payments, of the costs of treatment undergone by the Insured Person in accordance with the Policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization approved.

12.9 Complementary & Alternative Medicine means Alternative Treatments done alone or along with conventional/modern medicine.

12.10 Condition Precedent shall mean a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

12.11 Congenital Anomaly refers to 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.

12.12 Convalescence, Rehabilitation and Respite Care means any care arrangement in a residential setting or in a Hospital or any other healthcare facility like health hydros, nature cure clinics, wellness centre, palliative centre for services related to help the physically or cognitively impaired to achieve or regain their maximum functional potential for mobility, self-care and independent living, although not necessarily complete independence.

12.13 Co-payment is a cost-sharing requirement under a health insurance policy that provides that the Policyholder/insured will bear a specified percentage of the admissible claim amount. A Co-payment does not reduce the Sum Insured.

12.14 Day Care Center means any institution established for Day Care Treatment of Illness and/or Injuries or a medical set-up within a Hospital and which has been registered within the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all the following minimum criteria:

a. has Qualified Nursing staff under its employment;

b. has qualified Medical Practitioner(s) in charge;

c. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

12.15 Day Care Treatment refers to medical treatment, and/or Surgical Procedure which is:

a. undertaken under General or Local Anaesthesia in a Hospital/Day Care Center in less than 24 hrs because of technological advancement, and

b. which would have otherwise required a Hospitalization of more than 24 hours.

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

12.16 Deductible is 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.

12.17 Dental Treatment is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and Surgery excluding any form of cosmetic Surgery/implants.

12.18 Diagnostic Tests means investigations, such as X-Ray or blood tests, to determine the cause of symptoms and/or medical conditions.

12.19 Diagnostic Services means a broad range of Diagnostic Tests and exploratory or therapeutic procedures essential for detection, identification and treatment of medical condition.

12.20 Disclosure to Information Norm means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

12.21 Domiciliary Hospitalization means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

a. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

b. the patient takes treatment at home on account of non availability of room in a Hospital.

12.22 Emergency means a serious medical condition or symptom resulting from Illness or Injury which arises suddenly and unexpectedly and requires immediate care and treatment by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

12.23 Evidence Based Clinical Practice means process of making clinical decisions for Inpatient Care using current best evidence in conjugation with clinical expertise.

12.24 Family Floater Policy means a Policy described as such in the Schedule of Insurance Certificate where the family members (two or more) named in the Schedule of Insurance Certificate are insured under this Policy. Only the following family members can be covered under a Family Floater Policy:

a. Insured Person; and/or

b. Insured Person's legally married spouse (for as long as they continue to be married); and/or

c. Insured Person's children who are less than 21 years of Age on the commencement of the Policy Period (maximum 4 children can be covered).

12.25 Family First Policy means a Policy described as such in the Schedule of Insurance Certificate where You and Your family members named in the Schedule of Insurance Certificate are insured under this Policy. Only the following family members can be covered under a Family First Policy:

a. Your legally married spouse for as long as Your spouse continues to be married to You;
b. Son;
c. Daughter-in-law as long as Your son continues to be married to Your Daughter-in-law;
d. Daughter;
e. Son-in-law as long as Your daughter continues to be married to Your Son-in-law;
f. Father;
g. Mother;
h. Father-in-law as long as Your spouse continues to be married to You;
i. Mother-in-law as long as Your spouse continues to be married to You;
j. Grandfather;
k. Grandmother;
l. Grandson;
m. Granddaughter;
n. Brother;
o. Sister;
p. Sister-in-law;
q. Brother-in-law;
r. Nephew;
s. Niece.

12.26 First Policy means the Schedule of Insurance Certificate issued to the Policyholder at the time of inception of the Policy mentioned in the Schedule of Insurance Certificate with Us.

12.27 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.

12.28 Hazardous Activities means any sport or activity, which is potentially dangerous to the Insured Person whether he is trained or not. Such sport/activity includes but is not limited to Insured Persons whilst engaging in speed racing of any kind (other than on foot), professional or competitive sport, bungee jumping, parasailing, ballooning, parachuting, base jumping, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving, snow and ice sports or involving a naval military or air force operation. Insured Person whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular scheduled airline or air charter company.

12.29 Hereditary or Genetic Disorder means any Illness or disorder presented at birth or later in life caused by inheritance of abnormal gene or chromosome by the Insured Person.

12.30 Hospital (within India) means any institution established for Inpatient Care and Day Care Treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

a. has at least 10 Inpatient beds in towns having a population of less than 10,00,000 and at least 15 Inpatient beds in all other places;

b. has Qualified Nursing staff under its employment round the clock;

c. has qualified Medical Practitioner (s) in charge round the clock;

d. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

12.31 Hospital (outside India) means an institution (including nursing homes) established outside India for Inpatient medical care and treatment of sickness and injuries which has been registered and licensed as such with the appropriate local or other authorities in the relevant area, wherever applicable, and is under the constant supervision of a Medical Practitioner. The term Hospital shall not include a clinic, rest home, or convalescent home for the addicted, detoxification centre, sanatorium, old age home.

12.32 Hospitalization or Hospitalized means the admission in a Hospital for a minimum period of 24 Inpatient Care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

12.33 Injury means Accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

12.34 Information Summary Sheet means the information and details provided to Us or Our representatives over the telephone for the purposes of applying for this Policy which has been recorded by Us and confirmed by You.

12.35 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.

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

12.37 Individual Policy means a Policy described as such in the Schedule of Insurance Certificate where the individual named in the Schedule of Insurance Certificate is insured under this Policy.

12.38 Inpatient means the Insured Person's admission for treatment in a Hospital for more than 24 hours for a covered event.

12.39 Inpatient Care means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

12.40 Insured Person means person named as insured in the Schedule of Insurance Certificate.

12.41 IRDAI means the Insurance Regulatory and Development Authority of India.

12.42 LASER & Light based Treatment means a procedure that uses focused light emission or amplification for treatment of medical conditions.

12.43 Maternity Expense shall include:

a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);

b. Expenses towards lawful medical termination of pregnancy during the Policy Period.

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

12.45 Medical Devices are devices intended for internal or external use in the diagnosis, treatment, mitigation or prevention of disease or disorder.

12.46 Medical Evacuation means the transportation of the Insured Person in an Emergency from the place of Insured Person's Hospitalization (required for stabilization) to the Hospital where adequate treatment is available, provided that treatment is not available locally.

12.47 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.

12.48 Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his licence.

Only for the purposes of any claim or treatment permitted to be made or taken outside India in accordance with section 3.3.1 (Emergency Medical Evacuation – outside the geographical boundaries of India), section 3.4 (Emergency Hospitalization – outside the geographical boundaries of India) and Section 3.5 (Specified Illness cover – outside the geographical boundaries of India), Medical Practitioner shall mean a general practitioner, surgeon, anaesthetist or physician who:

a. holds a degree of a recognized institute; and

b. is registered with a Medical Council or equivalent body of the country where the treatment has taken place; and

c. is legally qualified to practice medicine or Surgery in the jurisdiction where he practices.

12.49 Medical Record means the collection of information as submitted in claim documentation concerning a Insured Person's Illness or Injury that is created and maintained in the regular course of management, made by a Medical Practitioners who has knowledge of the acts, events, opinions or diagnoses relating to the Insured Person's Illness or Injury, and made at or around the time indicated in the documentation.

12.50 Medically Necessary treatment is defined as any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

a. is required for the medical management of the Illness or Injury suffered by the insured;

b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

c. must have been prescribed by a Medical Practitioner;

d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

12.51 Medically Stable Condition means the condition of the Insured Person as certified by the treating Medical Practitioner when the Injuries or Illness suffered by the Insured Person have been brought under control or have become resistant to deterioration.

12.52 Network Provider means Hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a Cashless Facility.

Only for the purposes of any claim or treatment permitted to be made or taken outside India in accordance with section 3.3.1 (Emergency Medical Evacuation – outside the geographical boundaries of India), section 3.4 (Emergency Hospitalization – outside the geographical boundaries of India) & section 3.5 (Specified Illness cover – outside the geographical boundaries of India), Network Provider shall mean the Hospitals that are a part of the Service Provider's network, a list of which is available with the Service Provider.

12.53 New Born Baby means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

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

12.55 Non-Network means any Hospital, Day Care Center or other provider that is not part of the network.

12.56 Off-label drug or treatment means use of pharmaceutical drug for an unapproved indication or in an unapproved age group, dosage or route of administration.

12.57 OPD Treatment is one in which the Insured Person 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 Person is not admitted as a day care patient or Inpatient.

12.58 Policy means these terms and conditions, the Schedule of Insurance Certificate (as amended from time to time), Your statements in the Proposal and the Information Summary Sheet and any endorsements attached by Us to the Policy from time to time.

12.59 Policy Period is the period between the inception date and the expiry date of the Policy as specified in the Schedule of Insurance Certificate or the date of cancellation of this Policy, whichever is earlier.

12.60 Policy Year means the period of one year commencing on the date of commencement specified in the Schedule of Insurance Certificate or any anniversary thereof.

12.61 Pre-existing Disease means any condition, ailment or Injury or related condition(s) for which the Insured Person had signs or symptoms, and / or were diagnosed, and / or received Medical Advice/ treatment within 48 months, prior to the first Policy issued by Us.

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

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

b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

12.63 Post-hospitalization Medical Expenses: Medical Expenses incurred immediately after the Insured Person is discharged from the Hospital, provided that:

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

b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

12.65 Product Benefits Table means the Product Benefits Table issued by Us and accompanying this Policy which specifies the Plan applicable, the Benefits available to the Insured Persons and any sub-limits applicable to each Benefit.

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

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

12.68 Reimbursement means settlement of claims paid directly by Us directly to the Policyholder/Insured Person.

12.69 Renewal defines the terms on which the contract of insurance can be Renewed on mutual consent with a provision of Grace Period for treating the Renewal continuous for the purpose of all Waiting Periods.

12.70 Robotic Assisted Surgery refers to a technology used to assist the surgeon in controlling operative field via a terminal and manipulates robotic surgical instruments via a control panel. The use of computers and robotics is intended to enhance dexterity to facilitate microscale operations

12.71 Room Rent means the amount charged by a Hospital for the occupancy of a bed on per day (24 hours) basis and shall include Associated Medical Expenses.

12.72 Schedule of Insurance Certificate means a certificate issued by Us, and, if more than one, then the latest in time. The Schedule of Insurance Certificate contains details of the Policyholder, Insured Persons and the Benefits applicable under the Policy.

12.73 Second Medical Opinion means an alternate evaluation of diagnosis or treatment modalities arranged by Us from a Medical Practitioner related to Specified Illnesses or planned Surgery or Surgical Procedure which the Insured Person has been diagnosed or advised to undergo during the Policy Year. The Second Medical Opinion will be arranged by Us solely on the Insured Person's request.

12.74 Service Provider means any person, organization, institution that has been empanelled with Us to provide services specified under the benefits to the Insured Person.

12.75 Shared Room means a Hospital room with two or more patient beds with or without attached shared bathroom.

12.76 Specified Illness means the following Illnesses or procedures:

a. Cancer:

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

Specific Exclusion: All tumors in the presence of HIV infection are excluded.

b. Myocardial Infarction (Heart Attack):

The death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.

c. Coronary Artery Bypass Graft (CABG):

The actual undergoing of open / keyhole chest Surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked. The diagnosis must be supported by relevant Diagnostic Tests and confirmed by a cardiologist.

d. Major Organ Transplant:

The actual undergoing of a transplant of one or more of the following human organs: heart, lung, liver, kidney, pancreas as a resulted of irreversible end-stage failure of the relevant organ, or human bone marrow using haematopoietic stem cells.

Specific Exclusions: The following are excluded:

i. Other stem-cell transplants

ii. Transplant of islets of Langerhans only

e. Stroke:

Any cerebrovascular incident including infarction of brain tissue, thrombosis in an intracranial vessel, hemorrhage and embolisation from an extra cranial source, which results in neurological sequelae. Transient Ischemic Attacks (TIA) are excluded. Treatment of the neurological sequelae is excluded from the cover if the primary condition is not covered.

f. Surgery of Aorta:

Surgery of aorta including graft, insertion of stents or endovascular repair.

Specific Exclusion: Surgery for correction of an underlying Congenital Anomaly.

g. Coronary Angioplasty:

Procedures done for widening a narrowed or obstructed blood vessel of the heart in which a stent may or may not be inserted into the blood vessel. The same is payable only if the procedure is done subsequent to Myocardial infarction or Anginal attack.

h. Primary Pulmonary Arterial Hypertension:

An abnormal elevation in pulmonary artery pressure with or without any known cause. The disease must be confirmed by cardiac catheterisation.

i. Brain Surgery:

Any brain (intracranial) Surgery required to treat traumatic or non-traumatic conditions.

Specific Exclusion: Surgery for treating Neurocysticercosis.

12.77 Standby Services are services of another Medical Practitioner requested by treating Medical Practitioner and involving prolonged attendance without direct (face-to-face) patient contact or involvement.

12.78 Suite Room means

a. a space available for boarding in a Hospital which contains two or more rooms; Or

b. a space available for boarding in a Hospital which contains an extended living/dining/kitchen area

12.79 Sum Insured:

In case of Individual Policy, Sum Insured means the total of the Base Sum Insured and Loyalty Additions as per Section 4.1 which is Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of the Insured Person.

In case of Family Floater Policy, Sum Insured means the total of the Base Sum Insured and Loyalty Additions as per Section 4.1 which is Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of all Insured Persons.

In case of Family First Policy, Sum Insured means the total of the Base Sum Insured for each Insured Person, the Loyalty Additions as per Section 4.1 for each Insured Person and the Floater Sum Insured specified in the Schedule of Insurance Certificate which is Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of each Insured Person. For aforesaid purposes:

a. The Base Sum Insured stated in the Schedule of Insurance Certificate for each Insured Person is available for claims in respect of that Insured Person only, during the Policy Year.

b. If the Base Sum Insured for an Insured Person is exhausted due to payment of claims, then that Insured Person may utilise the Floater Sum Insured stated in the Schedule of Insurance Certificate for any claims arising in that Policy Year. In the event of a claim being admitted from the Floater Sum Insured, the Floater Sum Insured shall stand correspondingly reduced by the amount of claim paid (including 'taxes') or admitted and only the remaining amount of the Floater Sum Insured shall be available for claims arising in that Policy Year in respect of the Insured Persons who have exhausted their Base Sum Insured during that Policy Year.

c. The total of the Base Sum Insured for all Insured Persons, the Loyalty Additions as per Section 4.1 for all Insured Persons and the Floater Sum Insured specified in the Schedule of Insurance Certificate is Our maximum, total and cumulative liability for all claims during a Policy Year in respect of all Insured Persons.

If the Policy Period is 2 years, then the Sum Insured shall be applied separately for each Policy Year in the Policy Period.

12.80 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 of suffering or prolongation of life, performed in a Hospital or Day Care Center by a Medical Practitioner.

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

12.82 Waiting Period means a time-bound exclusion period related to condition(s) specified in the Schedule of Insurance Certificate or the Policy which shall be served before a claim related to such condition(s) becomes admissible.

12.83 We/Our/Us means Max Bupa Health Insurance Company Limited.

12.84 You/Your/Policyholder means the person named in the Schedule of Insurance Certificate who has concluded this Policy with Us.

Benefit Table – Heartbeat Individual and Family Floater - Gold Plan							
Base Sum Insured (in Rs)	**5 lacs**	**7.5 lacs**	**10 lacs**	**15 lacs**	**20 lacs**	**30 lacs**	**50 lacs**
Benefits							
Inpatient care	Covered up to Sum Insured						
Nursing charges for Hospitalization as an inpatient excluding Private Nursing charges							
Medical Practitioners' fees, excluding any charges or fees for Standby Services							
Medicines, drugs and consumables							
Physiotherapy, investigation and diagnostics procedures directly related to the current admission							
Medicines, drugs as prescribed by the treating Medical Practitioner							
Intravenous fluids, blood transfusion, injection administration charges and /or consumables							
Operation theatre charges							
The cost of prosthetics and other devices or equipment if implanted internally during Surgery							
Intensive Care Unit charges							
Room rent	Covered up to Sum Insured (except for Suite or above room category)						
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured						
Post-Hospitalization Medical Expenses (90 days)	Covered up to Sum Insured						
Alternative Treatment	Covered up to Sum Insured						
Day Care Treatment	Covered up to Sum Insured						
Domiciliary Hospitalization	Covered up to Sum Insured						
Maternity Benefit (covered for up to 2 pregnancies or terminations) [1]	Covered up to Rs 40,000	Covered up to Rs 60,000	Covered up to Rs 70,000	Covered up to Rs 75,000	Covered up to Rs 80,000	Covered up to Rs 1,00,000	Covered up to Rs 1,00,000
New Born Baby (covered uptill the end of Policy Year) [1]	Covered up to Sum Insured						
Vaccination of the new born baby	Covered until new born baby completes one year, vaccinations as per annexure						
Living Organ Donor Transplant	Covered up to Sum Insured						
Emergency Ambulance	Network Hospital:Covered up to Sum Insured Non-network Hospital: Covered up to Rs. 2,000 per event						
Policy value added benefits							
Loyalty Additions	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured						
Health Check-up [2]	Annual, Tests covered up to worth Rs 1,250 per Insured Person	Annual, Tests covered up to worth Rs 1,875 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person	Annual, Tests covered up to worth Rs 2,500 per Insured Person
Optional Benefits							
Hospital Cash [3]	Rs 3,000/day						
Claim cost sharing options							
Co-payment	Options of 10% and 20% co-payment						

(1) subject to a continuous coverage of 24 months of that Insured Person since the inception of the first Policy which offers Maternity benefit with Us.

(2) If the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year Policy Period (if applicable)

(3) Hospital Cash - Minimum 48 hrs of continuous hospitalization required. Maximum coverage offered for 30 days/policy year/insured person. Payment made from day one subject to hospitalization claim being admissible.

Policy Tenure - 1 year or 2 year. For 2 year policy 12.5% discount applicable on second year premium

Waiting periods	
Pre - existing conditions	24 months
Initial waiting period	30 days
Specific waiting period	For persons above 45 years of age some conditions would be subject to a 24 months. (Applicable for new business) For all renewing Insured Persons for whom the First Policy document states that this Specific Waiting Period applies only above 60 years of age, the terms of the Specific Waiting Period as set out in the First Policy document (including the list of relevant medical conditions and surgical conditions) shall continue to apply until any Waiting Period has expired.

Annexure II List of covered vaccinations

Time interval	Vaccination to be done (age)	Frequency
Vaccination for first year		
	BCG (From birth to 1 weeks)	1
	OPV (1 week) + IPV1 (6 week,10 weeks)	3
0-3 months		2
	DPT (6& 10 week)	
	Hepatitis-B (0 & 6 week,)	2
	Hib (6 & 10 Week)	2
	Rota (6 & 10 Week)	2
	OPV (6 month) + IPV (14 week)	2
	DPT (14 week)	1
3-6 months	Hepatitis-B (6 month)	1
	Hib (14 week)	1
	Rota (14 week)	1
	MMR (9 Months)	1
9 months	OPV (9 Months)	1
	Typhoid(12 Months)	1
12 months	Hepatitis A (12 Months)	1

PLEASE FAX / SCAN PAGE 1 & 2 ONLY

Request for Cashless Hospitalisation for Medical Insurance Policy

Details of the third party administrator (To be filled in block letters)

a) Name of TPA / Insurance company:

b) Toll free phone number:

c) Toll free FAX:

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient:

b) Gender: Male ☐ Female ☐ c) Age: Years Y Y Month M M d) Date of Birth D D M M Y Y Y Y

e) Contact number: f) Contact number of attending relative

g) Insured card ID number

h) Policy number / Name of corporate i) Employee ID

j) Currently do you have any other Mediclaim / Health insurance ☐ Yes ☐ No Company Name

Give details

k) Do you have a family physician l) Name of the family physician:

m) Contact number, if any (Please complete declaration on the reverse side of this form)

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor b) Contact number

c) Nature of ILLNESS/Disease with presenting complaints

d)Relevant clinical findings

e) Duration of the present ailment ☐☐☐ Days i. Date of first consultation D D M M Y Y Y Y

ii. Past history of present ailment if any

f) Provisional diagnosis:

i. ICD 10 Code:

g) Proposed line of treatment ☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non allopathic treatment

h) If Investigation &/or Medical Management provide details

i) Route of drug administration

i) If Surgical, name of surgery

i. ICD 10 PCS Code:

j) If other treatments provide details

k) How did injury occur

l) In case of accident: i. Is it RTA: ☐ Yes ☐ No ii. Date of injury D D M M Y Y Y Y

iii. Reported to Police ☐ Yes ☐ No iv. FIR No. ☐☐☐

v. Injury/Disease caused due to substance abuse/alcohol consumption ☐ Yes ☐ No

vi.Test conducted to establish this : ☐ Yes ☐ No (If Yes attach reports) l) In case of Maternity: ☐ G ☐ P ☐ L ☐ A

Date of Delivery: D D M M Y Y Y Y

Details of the patient admitted

a) Date of admission D D M M Y Y Y Y b) Time H H M M

c) Is this an emergency / a planned hospitalization event? ☐ Emergency ☐ Planned

d) Expected no. of days stay in hospital: Days e) Room Type:

f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: Rs.

g) Expected cost for investigation + diagnostics Rs. h) ICU Charges Rs.

I) OT Charges Rs. j) Professional fees Surgeon + Anesthetist Fees + consultation Charges Rs.

k) Medicines + Consumables + Cost of Implants (if applicable please specify). Other hospital expenses if any Rs.

l) All inclusive package charges if any applicable Rs.

m) Sum Total expected cost of hospitalization Rs.

Mandatory: Past History of any chronic illness If yes, since (month / year)

☐ Diabetes	M M Y Y Y Y	☐ Heart Disease	M M Y Y Y Y
☐ Hypertension	M M Y Y Y Y	☐ Hyperlipidemias	M M Y Y Y Y
☐ Osteoarthritis	M M Y Y Y Y	☐ Asthma / COPD / Bronchitis	M M Y Y Y Y
☐ Cancer	M M Y Y Y Y	☐ Alcohol or drug abuse	M M Y Y Y Y

☐ Any HIV or STD / Related ailments D D M M Y Y Y Y

Any other Ailment give details

(PLEASE READ VERY CAREFULLY)

DECLARATION

We confirm having read understood and agreed to the Declarations on the reverse of this form

a) Name of the treating doctor SURNAME FIRST NAME MIDDLE NAME

b) Qualification: c) Registration No. with State Code

Hospital Seal
(Must include Hospital ID)

Patient / Insured Name & Signature

(IMPORTANT: PLEASE TURN OVER)

PAGE 3 NOT TO BE FAXED/SCANNED

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA not governed by the terms and conditions of the policy will be paid by me.
4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / TPA
5. I agree and understand that TPA is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

a) Patient's / Insured's Name: _____

b) Contact number: _____ d) Patient's / Insured's Signature: _____

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / insurance company official verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / insurance company within 7 days of the patient's discharge.
3. All non medical expenses , or expenses not relevant to hospitalization or illness, or expenses disallowed in the authorization letter of the TPA / insurance co, or arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. We agree that TPA / insurance company will not be liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal

Doctor's Signature

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

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ANNEXURE FOR PREAUTH CLAIMS

Dear Policyholder,

Please fill the following information along with the cashless form for your medical insurance policy.

Policy No.

Membership Number

Hospital Id
(To be filled by hospital)

DOCUMENT CHECKLIST:

- **I.** Copy of Photo ID, address proof and recent photo of patient. (for Valid proof of documents kindly refer KYC documents list) KYC documents list includes PAN Card/Driving License/Voter Id. Card/Aadhar Card
- **II.** Past illness records (With duration of symptoms) if any
- **III.** First and subsequent consultation paper along with admission note.
- **IV.** Complete medical history along with supporting investigation reports.
- **V.** In case of accident, MLC/FIR copy (if applicable)
- **VI.** Claim consent letter

All documents mentioned above to be submitted along with the completed filled cashless form. Insurer may require further documents to process the request.

Name of the Proposer/insured SURNAME FIRST NAME MIDDLE NAME

Contact No.

Signature

Name of the TPA coordinator SURNAME FIRST NAME MIDDLE NAME

Date: DD MM YYYY

Place:

Signature

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Consent Letter

To,

Date ___/___/___

Medical Superintendent

_____

_____

_____

I, Mr./Ms _____ Age _____ Resident

of_____ State _____ Hereby

give my willful consent to Mr/ Dr _____ of Max Bupa Health

Insurance Company Limited to verify and collect necessary documents/ statements including but not limited to certified copies of medical records from your esteemed hospital for the purpose of settlement of my Insurance claim.

My other relevant details are provided below;

Detail of Insured:-

DOA:-

DOD:-

MRD/ Indoor/ IP No:-

Policy No:-

I request you to provide all the information/ documents as required by Max Bupa Health Insurance Company Ltd.

Name:-

Signature/ Thumb Impression

Witness Name & Signature

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Claim form for health insurance policies other than travel and personal accident - PART A

TO BE FILLED IN BY THE INSURED

(TO BE FILLED IN BLOCK LETTERS)

The issue of this Form is not to be taken as an admission of liability

DETAILS OF PRIMARY INSURED

SECTION A

a) Policy No: b) Sl. No/Certificate No

c) Company/TPA ID No:

d) Name: SURNAME FIRST NAME MIDDLE NAME

e) Address:

City State:

Pin Code Phone No: Email ID:

DETAILS OF INSURANCE HISTORY:

SECTION B

a) Currently covered by any other Mediclaim / Health Insurance: YES NO

b) Date of commencement of first Insurance without break: DD MM YYYY

c) If yes, company name: Policy No.

Sum Insured (Rs.)

d) Have you been hospitalized in the last four years since inception of the contract? YES NO Date DD MM YY

Diagnosis:

e) Previously covered by any other Mediclaim / Health insurance : YES NO

f) If yes, Company Name

DETAILS OF INSURED PERSON HOSPITALIZED:

SECTION C

a) Name: SURNAME FIRST NAME MIDDLE NAME

b) Gender: Male Female c) Age: Years YY Month MM d) Date of Birth: DD MM YY

e) Relationship to Primary insured: Self Spouse Child Father Mother Other

(Please Specify)

f) Occupation: Service Self Employed Homemaker Student Retired Other

(Please Specify)

g) Address (if different from above):

City State:

Pin Code: Phone No: Email ID:

DETAILS OF HOSPITALIZATION:

SECTION D

a) Name of Hospital where Admitted:

b) Room Category occupied: Day Care Single occupancy Twin sharing 3 or more beds per room

c) Hospitalization due to: Injury Illness Maternity

d) Date of Injury / Date Disease first detected /Date of Delivery: DD MM YY e) Date of Admission: DD MM YY

f) Time: HH MM g) Date of Discharge: DD MM YY h) Time: HH MM i) If Injury give cause: Self inflicted

Road Traffic Accident Substance Abuse / Alcohol Consumption i. If Medico legal: YES NO

ii. Reported to police: YES NO iii. MLC Report & Police FIR attached: YES NO j) System of Medicine:

DETAILS OF CLAIM:

SECTION E

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses: Rs.

ii. Hospitalization Expenses: Rs.

iii. Post-hospitalization Expenses: Rs.

iv. Health-Check up Cost: Rs.

v. Ambulance Charges: Rs.

vi. Others (code): Rs.

Total **Rs.**

vii. Pre-hospitalization period: Days

viii. Post-hospitalization period: Days

b) Claim for Domiciliary Hospitalization: YES NO (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash: Rs.

ii. Surgical Cash: Rs.

iii. Critical Illness Benefit: Rs.

iv. Convalescence: Rs.

v. Pre/Post hospitalization Lump sum benefit: Rs.

vi. Others Rs.

Total **Rs.**

Claim Documents Submitted- Check List:

- Claim Form Duly signed
- Copy of the Claim intimation if any
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (Including CT/ MRI / USG / HPE)
- Doctor's Prescriptions
- Others

DETAILS OF BILLS ENCLOSED:

SECTION F

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y		Hospital Main Bill	
2		D D M M Y Y		Pre-hospitalization Bills: Nos	
3		D D M M Y Y		Post-hospitalization Bills: Nos	
4		D D M M Y Y		Pharmacy Bills	
5		D D M M Y Y			
6		D D M M Y Y			
7		D D M M Y Y			
8		D D M M Y Y			
9		D D M M Y Y			
10		D D M M Y Y			

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

SECTION G

a) PAN b) Account Number:

c) Bank Name and Branch:

d) Cheque/ DD Payable details: e) IFSC Code:

DECLARATION BY THE INSURED:

SECTION H

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date D D M M Y Y Place Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A
(To be filled in by the insured)

	DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION A - DETAILS OF PRIMARY INSURED		
a)	Policy No.	Enter the policy number	As allotted by the insurance company
b)	Sl. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c)	Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
d)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
e)	Address	Enter the full postal address	Include Street, City and Pin Code

	SECTION B - DETAILS OF INSURANCE HISTORY		
a)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b)	Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c)	Company Name	Enter the full name of the insurance company	Name of the organization in full
	Policy No.	Enter the policy number	As allotted by the insurance company
	Sum Insured	Enter the total sum insured as per the policy	In rupees
d)	Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
	Date	Enter the date of hospitalization	Use mm-yy format
	Diagnosis	Enter the diagnosis details	Open Text
e)	Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f)	Company Name	Enter the full name of the insurance company	Name of the organization in full

	SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a)	Name	Enter the full name of the patient	Surname, First name, Middle name
b)	Gender	Indicate Gender of the patient	Tick Male or Female
c)	Age	Enter age of the patient	Number of years and months
d)	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e)	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f)	Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g)	Address	Enter the full postal address	Include Street, City and Pin Code
h)	Phone No	Enter the phone number of patient	Include STD code with telephone number
i)	E-mail ID	Enter e-mail address of patient	Complete e-mail address

SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) If Injury give cause	Indicate cause of injury	Tick the right option
If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text

SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted Check List	Indicate which supporting documents are submitted	Tick the right option

SECTION F - DETAILS OF BILLS ENCLOSED
Indicate which bills are enclosed with the amounts in rupees

SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full

SECTION H - DECLARATION BY THE INSURED
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.

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CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

(TO BE FILLED IN BLOCK LETTERS)

The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital:

b) Hospital ID: c) Type of Hospital: Network Non Network (If non network fill section E)

d) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

e) Qualification: f) Registration No. with State Code:

g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number: c) Gender: Male Female

d) Age: Years YY Months MM e) Date of birth: DD MM YYYY

f) Date of Admission: DD MM YYYY g) Time: HH MM h) Date of Discharge: DD MM YYYY

i) Time: HH MM j) Type of Admission: Emergency Planned Day Care Maternity

k) If Maternity i. Date of Delivery: DD MM YYYY ii. Gravida Status:

l) Status at time of discharge: Discharge to home Discharge to another hospital Deceased

m)Total claimed amount

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis:			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

c) Pre-authorization obtained: YES NO d) Pre-authorization Number:

e) If authorization by network hospital not obtained, give reason:

f) Hospitalization due to Injury: YES NO I. If Yes, give cause Self-inflicted Road Traffic Accident Substance abuse / alcohol consumption

ii. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: YES NO (If Yes, attach reports)

iii. If Medico legal: YES NO iv. Reported to Police: YES NO v. FIR no.

vi. If not reported to police give reason:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

SECTION D

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

SECTION E

a) Address of the Hospital:

City State:

Pin Code: b) Phone No: d) Hospital PAN:

c) Registration No. with State Code: e) Number of Inpatient beds

f) Facilities available in the hospital: i. OT : ☐ YES ☐ NO ii. ICU : ☐ YES ☐ NO

iii. Others :

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

SECTION F

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: D D M M Y Y Y Y

Place:

Signature and Seal of the Hospital Authority:

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF HOSPITAL		
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether In network or non network hospital	Tick the right option
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number

SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
I) Time	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text

Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/ alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported To Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open Text

SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST
Indicate which supporting documents are submitted

SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
d) Hospital PAN	Enter the permanent account number	As allotted by the Income Tax department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify

SECTION F - DECLARATION BY THE HOSPITAL
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp

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Annexure - Claim Form for reimbursement

Do You Know?

- Non-submission of original bills and receipts is the main reason for delay in claim settlements. Please provide the originals
- Provide your bank details for direct/ Electronic Fund Transfer (EFT) for faster claim settlement.
- To receive updates on your claim status, please provide your mobile no. & E-mail ID
- You can check your claim status at: www.maxbupa.com → Claims → Claims status → Login to check status.

Dear Policyholder,

Please fill the following information along with the reimbursement claim form for your medical insurance policy.

Policy No.

Membership No.

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

Name of Accountholder:

Bank Name:

Branch:

City:

IFSC Code:

Payment option: Cheque ☐ DD ☐ NEFT ☐

***Note:** Please submit a cancelled cheque leaf or a copy of latest bank statement or passbook with accountholder's name, account no., and IFSC code mentioned on it.

CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDAI)

Please submit clear and legible copy of one document (valid and effective as on date of claim submission) each from Part A and Part B and your recent passport size photograph (not more than 6 months old) incase claim amount exceeds Rs 100,000

Photo

Part A **Proof of legal name and any other names used**	i. Pan Card ii. If Pan Card is not available please submit any of the documents mentioned below stating reason for not having Pan Card. a) Passport b) Voter's Identity Card c) Driving License d) Personal Identification and Certification of the employees for your identity. e) Letter issued by Unique identification Authority of India containing details of name address and Aadhar Number f) Job Card issued by NREGA duly signed by an officer of the State Government

Part B **Proof of Residence**	i. Electricity Bill not older than 6 months from the date of claim submission ii. Telephone Bill pertaining to any kind of telephone connection like mobile, landline, wireless etc. Provided it is not older than 6 months from the date of claim submission iii. Ration Card iv. Valid lease agreement along with rent receipts which is not more than 3 months old as a residence proof v. Saving Bank Passbook with details of permanent/ present residence address (updated upto 1 month prior to claim submission document) vi. Statement of saving bank account with details of permanent/ present address (updated upto 1 month prior to claim submission document)

I hereby declare that I have submitted above mentioned documents and recent photograph (not more than 6 months old) for the purpose of claim and the said documents are valid and effective.

Date__/__/____

Signature of Policyholder:

(Please attach copy of a cancelled cheque of your bank for ensuring accuracy of name of the bank, branch name, Account number and IFSC code. If name of the payee is not printed on the cheque leaf please attach copy of the first page of the bank passbook also)

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Consent Letter

To,

Date ___/___/___

Medical Superintendent

_____

_____

_____

I, Mr./Ms _____ Age _____ Resident

of_____ State _____ Hereby

give my willful consent to Mr/ Dr _____ of Max Bupa Health

Insurance Company Limited to verify and collect necessary documents/ statements including but not limited to certified copies of medical records from your esteemed hospital for the purpose of settlement of my Insurance claim.

My other relevant details are provided below;

Detail of Insured:-

DOA:-

DOD:-

MRD/ Indoor/ IP No:-

Policy No:-

I request you to provide all the information/ documents as required by Max Bupa Health Insurance Company Ltd.

Name:-

Signature/ Thumb Impression

Witness Name & Signature

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ANNEXURE IV- LIST OF GENERALLY EXCLUDED ITEMS IN HOSPITALIZATION POLICY

Standard list of expenses generally excluded ("non-medical expenses") in Hospitalization indemnity policies		
S.No.	Items	Recommendations
A	**Toiletries/ cosmetics/ personal comfort or convenience items**	**Payable/Non Payable**
1	Hair removing cream charges	Not payable
2	Baby charges	(unless specified/indicated) Not payable
3	Baby food	Not payable
4	Baby utilities charges	Not payable
5	Baby set	Not payable
6	Baby bottles	Not payable
7	Bottle	Not payable
8	Brush	Not payable
9	Cosy towel	Not payable
10	Hand wash	Not payable
11	Moisturiser paste brush	Not payable
12	Powder	Not payable
13	Razor	Not payable
14	Towel	Not payable
15	Shoe cover	Not payable
16	Beauty services	Not payable
17	Belts/ braces	Essential and should be paid at least specifically for cases who have undergone surgery of thoracic or lumbar spine.
18	Buds	Not payable
19	Barber charges	Not payable
20	Caps	Not payable
21	Cold pack/hot pack	Not payable
22	Carry bags	Not payable
23	Cradle charges	Not payable
24	Comb	Not payable
25	Disposable razor charges (for site for preparation)	Not payable
26	Eau-de-cologne / room fresheners	Not payable
27	Eye pad	Not payable
28	Eye shield	Not payable
29	Email / internet charges	Not payable
30	Food charges (other than patient's diet provided by hospital)	Not payable
31	Foot cover	Not payable
32	Gown	Not payable
33	Leggings	Essential in bariatric and varicose vein surgery and may be considered for at least these conditions where surgery itself is payable.
34	Laundry charges	Not payable
35	Mineral water	Not payable
36	Oil charges	Not payable
37	Sanitary pad	Not payable
38	Slippers	Not payable
39	Telephone charges	Not payable

40	Tissue paper	Not payable
41	Tooth paste	Not payable
42	Tooth brush	Not payable
43	Guest services	Not payable
44	Bed pan	Not payable
45	Bed under pad charges	Not payable
46	Camera cover	Not payable
47	Care free	Not payable
48	Cliniplast	Not payable
49	Crepe bandage	Payable only treatment warrant usage
50	Curapore	Not payable
51	Diaper of any type	Not payable
52	Dvd, cd charges	Not payable (However If CD is specifically sought by Insurer/TPA then payable)
53	Eyelet collar	Not payable
54	Face mask	Not payable
55	Flexi mask	Not payable
56	Gause soft	Not payable
57	Gauze	Not payable
58	Hand holder	Not payable
59	Hansaplast/ adhesive bandages	Not payable
60	Lactogen/ infant food	Not payable
61	Slings	Reasonable costs for one sling in case of upper arm fractures may be considered

S. No.	Items	Recommendations
B	**Items Specifically Excluded in Policies**	**Payable/Non Payable**
1	Weight control programs/ supplies/ services	Exclusion in policy unless otherwise specified
2	Cost of spectacles/ contact lenses/ hearing aids etc.,	Exclusion in policy unless otherwise specified
3	Dental treatment expenses that do not require hospitalization	Exclusion in policy unless otherwise specified
4	Hormone replacement therapy	Exclusion in policy unless otherwise specified
5	Home visit charges	Exclusion in policy unless otherwise specified
6	Infertility/ sub-fertility/ assisted conception procedure	Exclusion in policy unless otherwise specified
7	Obesity (including morbid obesity) treatment	Exclusion in policy unless otherwise specified
8	Psychiatric & psychosomatic disorders	Exclusion in policy unless otherwise specified
9	Corrective surgery for refractive error	Exclusion in policy unless otherwise specified
10	Treatment of sexually transmitted diseases	Exclusion in policy unless otherwise specified
11	Donor screening charges	Exclusion in policy unless otherwise specified
12	Admission/registration charges	Exclusion in policy unless otherwise specified
13	Hospitalization for evaluation/ diagnostic purpose	Exclusion in policy unless otherwise specified
14	Expenses for investigation/ treatment irrelevant to the disease for which admitted or diagnosed	Exclusion in policy not payable unless otherwise specified
15	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
16	Stem cell implantation/ surgery & storage	Not payable except bone marrow transplantation where covered by policy

S. No.	Items	Recommendations
C	**Items which form part of Hospital services where separate consumables are not payable but the service is**	**Payable/non payable**
1	Ward and theatre booking charges	Payable under OT charges, not payable separately
2	Arthroscopy & endoscopy instruments	Rental charged by the hospital payable. Purchase of instruments not payable.
3	Microscope cover	Payable under OT charges, not payable separately
4	Surgical blades,harmonic scalpel,shaver	Payable under OT charges, not payable separately
5	Surgical drill	Payable under OT charges, not payable separately
6	Eye kit	Payable under OT charges, not payable separately
7	Eye drape	Payable under OT charges, not payable separately
8	X-ray film	Payable under radiology charges, not as consumable
9	Sputum cup	Payable under investigation charges, not as consumable
10	Boyles apparatus charges	Part of OT charges, not separately
11	Blood grouping and cross matching of donors samples	Part of cost of blood, not payable
12	Antiseptic or disinfectant lotions	Not payable-part of dressing charges
13	Band aids, bandages, sterile injections, needles, syringes	Not payable - part of dressing charges
14	Cotton	Not payable-part of dressing charges
15	Cotton bandage	Not payable-part of dressing charges
16	Micropore/ surgical tape	Not payable-payable by the patient when prescribed, otherwise included as dressing charges
17	Blade	Not payable
18	Apron	Not payable -part of hospital services/disposable linen to be part of OT/ ICU charges
19	Torniquet	Not payable (service is charged by hospitals, consumables cannot be separately charged)
20	Orthobundle, gynaec bundle	Part of dressing charges
21	Urine container	Not payable

S. No.	Items	Recommendations
D	**Elements Of Room Charge**	**Payable/Non Payable**
1	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
2	Hvac	Part of room charge not payable separately
3	House keeping charges	Part of room charge not payable separately
4	Service charges where nursing charge also charged	Part of room charge not payable separately
5	Television & air conditioner charges	Payable under room charges not if separately levied
6	Surcharges	Part of room charge not payable separately. Paid in case of trust hospital if nursing and service charges are to be charged
7	Attendant charges	Not payable - part of room charges
8	IM/ IV injection charges	Part of nursing charges, not payable
9	Clean sheet	Part of laundry/housekeeping not payable separately
10	Extra diet of patient (other than that which forms not payable if it is policy exclusion. Otherwise patient diet provided by part of bed charge)	Hospital is payable

11	Blanket/warmer blanket	Not payable- part of room charges
S. No.	Items	Recommendations
E	**Administrative or Non-medical Charges**	**Payable/Non Payable**
1	Admission kit	Not payable
2	Birth certificate	Not payable
3	Blood reservation charges and ante natal booking charges	Not payable
4	Certificate charges	Not payable
5	Courier charges	Not payable
6	Conveyance charges	Not payable
7	Diabetic chart charges	Not payable
8	Documentation charges / administrative	Expenses not payable
9	Discharge procedure charges	Not payable
10	Daily chart charges	Not payable
11	Entrance pass / visitors pass charges	Not payable
12	Expenses related to prescription on discharge	To be claimed by patient under post -hosp where admissible
13	File opening charges	Not payable
14	Incidental expenses / misc. Charges (not explained)	Not payable
15	Medical certificate	Not payable
16	Maintenance charges	Not payable
17	Medical records	Not payable
18	Preparation charges	Not payable
19	Photocopies charges	Not payable
20	Patient identification band / name tag	Not payable
21	Washing charges	Not payable
22	Medicine box	Not payable
23	Mortuary charges	Payable upto 24 hrs, shifting charges not payable
24	Medico legal case charges (MLC charges)	Not payable

S. No.	Items	Recommendations
F	**External Durable Devices**	**Payable/Non Payable**
1	Walking aids charges	Not payable
2	Bipap machine	Not payable
3	Commode not payable	Not payable
4	CPAP/ CPAD equipments device	Not payable
5	Infusion pump - cost device	Not payable
6	Oxygen cylinder (for usage outside the hospital)	Not payable (in case of post-hospitalization expenses, cost of oxygen prescribed payable, but not the cost of the cylinder)
7	Pulse oxymeter charges device	Not payable
8	Spacer	Not payable
9	Spirometre device	Not payable
10	Spo2 probe	Not payable
11	Nebulizer kit	Not payable
12	Steam inhaler	Not payable
13	Arm sling pouch	Not payable
14	Thermometer	Not payable (paid by patient)

15	Cervical collar	Not payable
16	Splint	Not payable
17	Diabetic foot wear	Not payable
18	Knee braces (long/ short/ hinged)	Not payable
19	Knee immobilizer/shoulder immobilizer	Not payable
20	Lumbo sacral belt	Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine
21	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
22	Ambulance collar	Not payable
23	Ambulance equipment	Not payable
24	Microsheild	Not payable
25	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.

S. No.	Items	Recommendations
G	**Items Payable If Supported By A Prescription**	**Payable/Non Payable**
1	Betadine \ hydrogen peroxide\spirit\detol \savlon\ 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
2	Private nurses charges- special nursing charges	Not payable if policy excludes; post hospitalization nursing charges not payable
3	Nutrition planning charges - dietician charges- diet charges	If policy excludes diet charges - not payable; patient diet provided by hospital is payable
4	Sugar free tablets	Payable -sugar free variants of admissible medicines are not excluded
5	Cream powder lotion (toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
6	Digestive gel/ antacid gel	Payable when prescribed
7	Ecg electrodes	Upto 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
8	Gloves sterilized gloves	Payable / unsterilized gloves not payable
9	Hiv kit	Payable - pre-operative screening
10	Listerine/ antiseptic mouthwash	Payable when prescribed
11	Lozenges	Payable when prescribed
12	Mouth paint	Payable when prescribed
13	Nebulisation kit	If used during hospitalization is payable reasonably
14	Neosprin	Payable when prescribed
15	Novarapid	Payable when prescribed
16	Volini gel/ analgesic gel	Payable when prescribed
17	Zytee gel	Payable when prescribed
18	Vaccination charges	Routine vaccination not payable / post bite vaccination payable

S. No.	Items	Recommendations

H	Part of Hospital's own costs and not payable	Payable/Non Payable
1	AHD	Not payable - part of hospital's internal cost
2	Alcohol swabes	Not payable - part of hospital's internal cost
3	Scrub solution/sterillium	Not payable - part of hospital's internal cost
4	Vaccine charges for baby	Not payable
5	Aesthetic treatment / surgery	Not payable
6	Tpa charges	Not payable
7	Visco belt charges	Not payable
8	Any kit with no details mentioned [delivery kit, not payable orthokit, recovery kit, etc]	Not payable
9	Examination gloves	Not payable
10	Kidney tray	Not payable
11	Mask	Not payable
12	Ounce glass	Not payable
13	Outstation consultant's/ surgeon's fees	Not payable, except for telemedicine consultations where covered by policy
14	Oxygen mask	Not payable
15	Paper gloves	Not payable
16	Pelvic traction belt	Should be payable in case of PIVD requiring traction as this is generally not reused
17	Referral doctor's fees	Not payable
18	Accu check (glucometery/ strips)	Not payable. Pre-hospitalization or post-hospitalization / reports and charts required/ device not payable
19	Pan can	Not payable
20	Sofnet	Not payable
21	Trolly cover	Not payable
22	Urometer, urine jug	Not payable
23	Ambulance	Payable as per the terms of the policy
24	Tegaderm / vasofix safety	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
25	Urine bag	Payable where medically necessary till a reasonable cost maximum 1 per 24 hrs
26	Softovac	Not payable
27	Stockings	Essential for case like CABG etc. Where it should be paid.
28	Additional room charges/bed charges for attendant	Not payable
29	Attender bed charges	Not payable
30	Investigation charges not related to the diagnosis	Not payable
31	Iv fluid infusion charges	As nursing charges included in the room charges
32	Multiple consultation charges not related to diagnosed ailments	Not payable
33	RMO charges not payable if visit charges are applied.	Not payable
34	Psychiatric consultation charges	Not payable
35	Anti-d/rho clone etc-immunisation for rh negative mother carrying rh positive baby	Payable only in first pregnancy provided gravida status is l-0, if it is l-1 not payable.
36	Maternity related consultations	Not payable
37	Maternity related expenses	Not payable
38	Ac charges	Not payable

39	Attendant/ayah/ward boy charges	Not payable
40	Body wash	Not payable
41	Electricity charges (levied by hospital)	Not payable
42	Establishment charges	Not payable
43	File charges	Not payable
44	Gate pass charges	Not payable
45	Home nursing charges	Not payable
46	Insurance processing charges	Not payable
47	Registration charges/fee	Not payable
48	Water charges (levided by hospital)	Not payable
49	Naturopathy treatment charges	Not payable
50	Non-allopathic treatment charges.	Not payable
51	Yoga charges	Not payable
52	Surgery for correction of eye sight like myopia/hypermetropia/amblyopia/ presbiopia/atigmatism/strabismus, etc	Payable only under policies where ped is covered by way of deletion of the exclusion or by way of entitlement after lapse of specified period of claim free duration
53	Room fresheners	Not payable
54	Loban	Not payable
55	Nebulization mask	Not payable
56	One touch sure strip	Not payable
57	Under pads	Not payable
58	Alpha bed/water bed etc.	Not payable
59	Ambulatory devices like walker/crutches/wheel chair etc.	Not payable
60	Instrument charges where no details of procedure/instrument used is given.	Not payable
61	Bili blanket	Not payable
62	Bills not in proper format/not serially numbered and printed bill.	Not payable
63	Charges paid to organ donors	Not payable
64	Credit bills-no cash paid receipt.	Not payable
65	Duplicate bills.	Not payable
66	Health drinks-horlicks, viva, bournvita and protein powder including lactogen	Admissible only to the extent prescribed
67	No bills for claimed amount	Not payable
68	Ultroid system	Not payable
69	RMO charges	RMO charges not payable if visit charges are applied.
70	Service charges	Not payable if nursing charges are paid
71	IV administration charge	Not payable if nursing charges are paid
72	IV fluid administration charge	Not payable if nursing charges are paid
73	Injection charges	Not payable if nursing charges are paid
74	Administrative charge	Not payable if nursing charges are paid