CUSTOMER INFORMATION SHEET

(Description is illustrative and not exhaustive)

S. NO	TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
1	**Product Name**	**Group Health Insurance**	
2	**What am I covered for**	**Following are covered as basic cover up to the limit specified in the policy schedule**	Scope of Cover
		1. Room, Board & Nursing Charges	
		2. Medical Practitioner and Specialists Fees	
		3. Anesthesia, Blood, Oxygen, Operation Theatre charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, prosthesis/internal implants and any medical expenses incurred which is integral part of the operation	
		4. Pre-hospitalisation Expenses	
		5. Post-hospitalisation Expenses	
		6. Day Care Expenses	
		7. Non Network Hospitalisation Co-pay	
		8. Domiciliary Hospitalisation	
		Following are covered as add on up to the limits specified in policy schedule, if you have paid the additional premium for these covers	
		1. Ambulance Expenses Cover	Endorsements
		2. Annual Medical Checkup Cover	
		3. Maternity Benefit Extension with waiting period of 9 months	
		4. Maternity Benefit Extension without waiting period of 9 months	
		5. New born cover from day one	
		6. Critical Illness Cover	
		7. Pre-existing Disease Exclusion waiver.	
		8. First year exclusion waiver	
		9. First 30 day exclusion waiver	
		10. Coverage for Ayurvedic Medicine	
		11. Coverage for Homeopathic and Unani system of medicine	
		12. Exclusion of Domiciliary Hospitalisation	
		13. Exclusion of Pre and Post hospitalisation cover	
		14. Coverage for Outpatient expenses	
		15. Coverage for Dental Expenses	
		16. Corporate Buffer	
		17. Coverage for Congenital Internal Diseases	
		18. Voluntary Co-pay option	
		19. Enhancement of Room Rent Sub-limits.	
		20. Family Floater Cover.	
		Note: Insurer's Liability in respect of all claims admitted during the period	

		of insurance shall not exceed the Sum Insured for the Insured person as mentioned in the schedule.	
3	**What are the major Exclusions in the policy**	i. Any hospital admission primarily for investigation / diagnostic purpose	Exclusions
		ii. Pregnancy, infertility, congenital/genetic conditions,	
		iii. Non-allopathic medicine,	
		iv. Treatment taken outside India.	
		v. Circumcision, sex change surgery ,cosmetic surgery & plastic surgery,	
		vi. refractive error correction, hearing impairment correction, corrective & cosmetic dental surgeries,	
		vii. Organ donor expenses,	
		viii. Substance abuse, self-inflicted injuries, STDs and HIV / AIDS,	
		ix. Hazardous sports, war, terrorism, civil war or breach of law,	
		x. Any kind of service charge, surcharge, admission fees, registration fees levied by the hospital.	
		(Note: the above is a partial listing of the policy exclusions. Please refer to the policy clauses for the full listing).	
4	**Waiting period**	1. Initial waiting period: 30 days for all illnesses (not applicable on renewal or for accidental injuries)	Exclusions
		2. Specific waiting period: 12 months for some diseases	
		3. Pre-existing diseases: Covered after 48 months unless otherwise provided	
5	**Payout basis**	Indemnity basis for covered expenses up to specified limits	Scope of Cover
6	**Cost sharing**	In case of a claim, this policy requires you to share the following costs: 10% of each claim as co-payment in case of non network hospitalisation	Scope of Cover
7	**Renewal Conditions**	This Policy may be renewed by mutual consent every year and in such event, the renewal premium shall be paid to Insurer on or before the date of expiry of the Policy or of the subsequent renewal thereof. However Insurer shall not be bound to give notice that such renewal premium is due. Also Insurer may exercise Insurer's option not to renew the policy on grounds of fraud misrepresentation, or suppression of any material fact either at the time of taking the Policy or any time during the currency of the earlier policies. A Grace Period of 30 days is allowed for renewal of the policy. This will be counted from the day immediately following the premium due date during which a payment can be made to renew or continue the Group Health Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-existing diseases. The continuity of coverage for all the covers under the expiring policy will be subject to receiving appropriate premium for the same. Coverage is not available for the period for which no premium is received and Insurer has no liability for the claims arising during this period.	Conditions (Condition no. 16)
8	**Renewal Benefits**	Nil	
9	**Cancellation**	In case of any fraud, misrepresentation, or suppression of any material fact either at the time taking the Policy or any time during the currency of the earlier policies, Insurer may at any time cancel this policy by sending the Insured 15 days notice by registered letter, at the Insured's last	Conditions (Condition no. 13)

known address and in such event Insurer shall refund to the Insured a pro-rata' premium for unexpired period of Insurance subject to no claim has occurred up to date of cancellation. Insurer shall, however, remain liable for any claim which arose prior to the date of cancellation. The Insured may at any time cancel this policy by giving a written notice to the insurer and in such event Insurer shall allow refund of premium at Insured's short period rate only (table given here below) provided no claim has occurred up to the date of cancellation.

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

b. **External Congenital Anomaly -** Congenital anomaly which is in the visible and accessible parts of the body.

"**Critical Illness**" means an illness, sickness or a disease or a corrective measure like Cancer of specified severity, Open Chest CABG, Aorta Graft Surgery, Open Heart Replacement or Repair of Heart Valves, Stroke Resulting in Permanent Symptoms, First Heart Attack – Of Specified Severity, Kidney Failure Requiring Regular Dialysis, Primary Pulmonary Arterial Hypertension, Major Organ/ Bone Marrow Transplant, Multiple Sclerosis with Persisting Symptoms, Coma of Specified Severity, Total Blindness and Permanent Paralysis of Limbs all all as defined in Scope of Cover & Benefits section of this **Policy**.

"Critical Illness Benefit" means the amount specified in the Schedule, which is the maximum amount for which Insurer may be liable to make payment for any or all Critical Illnesses covered subject to terms & conditions under this Policy and as stated in the Policy Schedule.

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

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

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

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

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

a. undertaken under General or Local Anesthesia in a **Hospital/Day care centre** in less than 24 hrs because of technological advancement, and

b. which would have otherwise required a **Hospitalisation** of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

all minimum criteria as under

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

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

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

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

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

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

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

"Domiciliary Hospitalisation" 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.

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

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

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

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

"Family" means and includes Insured Person/Insured Person's legal Spouse, Insured Person's legal & dependent children, Insured Person's legal & dependent siblings and dependent parents or dependent parents-in-law.

"**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.

"Group" means any association of persons who assemble together with a commonality of purpose or engaging in a common economic activity like employees of a company. Non-employer-employee groups, like employee associations, holders of credit cards issued by a specific company, customers of a particular business where insurance is offered as an add on benefit, borrowers of a bank, professional associations or societies may also be treated as a group. However, an association of persons coming together with a purpose of availing an insurance cover, will not be treated as a group for the purpose of this policy.

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

a. has qualified nursing staff under its employment round the clock;

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

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

d. has a fully equipped operation theatre of its own where surgical procedures are carried out.

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

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

"Insured" means the group of persons/Corporate/organization/institution/firm/society/ other entity engaged in any trade or business in India on whose name the Policy is issued named as Insured in the Schedule.

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

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

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

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

"Maternity expenses" shall include—

a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).

b. expenses towards lawful medical termination of pregnancy during the policy period.

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

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

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

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

a. is required for the medical management 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.

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

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

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

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

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

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

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

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

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

"Policy" means the complete documents consisting of the Policy wording, Schedule and Endorsements and attachments if any.

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

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

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

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

b. The In-patient Hospitalization claim for such Hospitalization is admissible by the insurance company.

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

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

b. The In-patient Hospitalization claim for such Hospitalization is admissible by the insurance company.

"Proposal" means application form which the Insured duly fills in and signs for this Insurance and any other information Insured provides in the said form or otherwise to Insurer.

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

"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 .

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

"Renewal" means the terms on which the contract of insurance can be renewed on mutual consent with a

provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

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

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

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

"Sum Insured" means the specified amount mentioned in the schedule to this policy which represents the Insurers maximum liability for any or all claims under this policy during the currency of the policy subject to terms and conditions.

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

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

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

SCOPE OF COVER

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

1. **Room, Board & Nursing** Charges as provided by the hospital: up to 1% of the Sum Insured max Rs.1500/- for Normal Room per day. If admitted into Intensive Care Unit up to 2% of the Sum Insured per day max Rs.2500/-. In case the insured opts for a higher room category than his eligibility the same can be covered upon specific acceptance by the insurer or **Administrator**. In such a case all incremental Expenses pertaining to room rent, medical practitioners / specialists fees and other incidental Expenses to be borne by the insured.
2. **Medical Practitioner and Specialists Fees**.
3. Anesthesia, Blood, Oxygen, Operation Theatre charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, prosthesis/internal implants and any medical expenses incurred which is integral part of the operation
4. **Pre-hospitalisation Expenses** - Insurer shall pay for expenses as defined in the policy and incurred 30 days prior to the date of admission into the hospital
5. **Post-hospitalisation Expenses** - Insurer shall pay for expenses as defined in the policy and incurred 60 days after the date of discharge from the hospital.

6. **Day Care Expenses** - Insurer shall pay for Day Care expenses incurred on advanced technological surgeries and procedures requiring less than 24 hours of hospitalisation as per the attached list and subject to the condition that prior approval is obtained by the **Insured Person/Insured** from the **Administrator/Insurer** for such a **Day Care Procedure/Expense.**

7. **Non Network Hospitalisation Co-pay:** For all admissible claims where treatment is taken at hospitals which are not in the list of network providers empanelled by the **Company/Administrator**, insured person shall bear 10% of the eligible admissible claim as per terms of insurance or shall bear a % of the eligible admissible claim as stipulated in the schedule for the said purpose.

8. **Domiciliary Hospitalisation**- Insurer will cover Reasonable and Customary Charges towards Domiciliary Hospitalisation exceeding 3 days as defined in definition subject to 20% of the Basic Sum Insured or a maximum of up to Rs.20000, whichever is lesser, however domiciliary **Hospitalisation** benefits shall not cover:-

   i. Expenses incurred for pre and post domiciliary hospitalisation treatment or

   ii. Expenses incurred for treatment for any of the following **Disease**s

      a. Asthma
      b. Bronchitis
      c. Chronic Nephritis and Nephritic Syndrome
      d. Diarrhea and all type of Dysenteries including Gastro-enteritis
      e. Diabetes Mellitus and Insipidus
      f. Epilepsy
      g. Hypertension
      h. Influenza, Cough and Cold
      i. All Psychiatric or Psychosomatic Disorders
      j. Pyrexia of unknown Origin for less than 10 days
      k. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharingitis
      l. Arthritis, Gout and Rheumatism

EXCLUSIONS

We will not pay for any expenses incurred by Insured Person in respect of claims arising out of or howsoever related to any of the following and for any of the coverages offered under the policy including add on covers:

1. Pre existing Diseases Exclusion:

Benefits will not be available for any condition, ailment or injury or related condition(s) for which Insured has been diagnosed, received medical treatment, had signs and / or symptoms, prior to inception of Insured Person's first group health Policy, until 48 consecutive months have elapsed, after the date of inception of the first group health Policy with **Insurer**.

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

with Insurer.

This Exclusion shall also apply to the extent of the amount by which the limit of indemnity has been increased if the Policy is a renewal of the Health Insurance Policy with Insurer without break in cover. This exclusion shall also apply to any additional health Policy that the Insured has purchased from Us.

2. Exclusions applicable to first 30 days of cover from commencement of Policy:

Insurer shall not be liable to make any payment under this Policy in connection with or in respect of Insured Person's hospitalisation due to sickness / illness, as stated in this Section, arising within the first 30 days of the commencement of the Period of Insurance. However, this exclusion will not apply to hospitalization for an Accidental Bodily Injury occurring during the policy period. This Exclusion shall apply also to the extent of the amount by which the limit of indemnity has been increased if the Policy is a renewal of the Health Insurance Policy with Insurer without break in cover.

3. Exclusions applicable to first year of cover from commencement of the Policy, from the following Diseases / Illness and its related complications unless an add on cover waiving this exclusion is purchased by payment of additional premium to Us:

i. Any types of gastric or duodenal ulcers;

ii. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty;

iii. Surgery on all internal or external tumor /cysts/nodules/polyps of any kind including breast lumps;

iv. All types of Hernia and Hydrocele;

v. Anal Fissures, Fistula and Piles;

vi. Cataract;

vii. Benign Prostatic Hypertrophy;

viii. Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus;

ix. Hypertension, Heart Disease and related complications;

x. Diabetes and related complications;

xi. Non infective Arthritis, Treatment of Spondylosis / Spondylitis, Gout & Rheumatism;

xii. Surgery of Genitourinary tract;

xiii. Calculus Diseases;

xiv. Sinusitis, nasal disorders and related disorders;

xv. Surgery for prolapsed intervertebral disc unless arising from accident;

xvi. Vertebro-spinal disorders (including disc) and knee conditions;

xvii. Surgery of varicose veins and varicose ulcers;

xviii. Chronic Renal failure;

xix. Medical Expenses incurred in connection with joint replacement surgery due to Degenerative condition, Age related osteoarthritis and Osteoporosis unless such Joint replacement surgery unless necessitated by Accidental Bodily Injury.

This Exclusion shall apply also to the extent of the amount by which the limit of indemnity has been increased if

the Policy is a renewal of the Group Health Insurance Policy with Insurer without break in cover for at least 1 year.

4. Treatment outside India.

5. Epidemics recognized by WHO or/and Indian government. Government screening programs, etc

6. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.

7. Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons/materials.

8. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or, as may be necessitated due to an accident

9. Cosmetic or aesthetic treatments of any description, treatment or surgery for change of life/ gender, Lasik treatment for refractive error. Any form of plastic surgery (unless necessary for the treatment of Illness or accidental Bodily Injury).

10. The cost of spectacles, contact lenses, hearing aids, crutches, wheelchairs, dentures, artificial teeth and all other external appliances ,and/or devices unless specifically covered.

11. Expenses incurred on Items for personal comfort like television, telephone, etc. incurred during hospitalization and which have been specifically charged for in the hospitalisation bills issued by the hospital.

12. External medical equipment of any kind used at home as post hospitalisation care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition.

13. Dental treatment or surgery of any kind unless required as a result of Accidental Bodily Injury to natural teeth requiring hospitalization treatment.

14. Convalescence, general debility, “Run-down” condition, rest cure, Congenital external illness/ disease/ defect.

15. All kinds of Congenital Internal disease/ illness/ defects.

16. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/ activity that is against law with a criminal intent.

17. Any complications arising out of or ailments requiring treatment due to use or abuse of any substance, drug or alcohol and treatment for de-addiction.

18. Any condition directly or indirectly caused by or associated with Human Immunodeficiency Virus or Variant/mutant viruses and or any syndrome or condition of a similar kind commonly referred to as AIDS.

19. Venereal disease or any sexually transmitted disease or sickness.

20. Treatment arising from or traceable to pregnancy childbirth, miscarriage, abortion or complications of any of this, including caesarian section. However, this exclusion will not apply to abdominal operation for extra uterine pregnancy (Ectopic Pregnancy), which is proved by submission of Ultra Sonographic Report and certification by Gynecologist that it is life threatening.

21. Any fertility, sub fertility or assisted conception operation or sterilization procedure and related treatment.

22. Vaccination or inoculation except as part of post-bite treatment for animal bite.

23. Vitamins, tonics, nutritional supplements unless forming part of the treatment for injury or disease as certified by the attending Medical Practitioner.

24. Surgery to correct Deviated Nasal septum and hypertrophied turbinate unless necessitated by an accidental body injury and proved to our satisfaction that the condition is a result of an accidental injury.

25. Treatment for any mental illness or psychiatric or psychological ailment / condition.

26. Medical Practitioner's home visit Expenses during pre and post hospitalization period, Attendant Nursing Expenses.

27. Outpatient Diagnostic, Medical and Surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.

28. Any treatment required arising from Insured's participation in any hazardous activity including but not limited to all forms of skiing, scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc unless specifically agreed by the Insurer.

29. Genetic disorders and stem cell implantation / surgery/storage.

30. Expenses incurred at Hospital primarily for diagnosis irrespective of 24 hours hospitalization . This would also include stay in a hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner, which ordinarily can be given without hospitalization.

31. Treatments in health hydro, spas, nature care clinics and the like.

32. Treatments taken at any institution which is primarily a rest home or convalescent facility, a place for custodial care, a facility for the aged or alcoholic or drug addicts or for the treatment of psychiatric or mental disorders; even if the institution has been registered as a hospital with the Appropriate Authorities

33. Treatment with alternative medicines like ayurvedic, homeopathy, unani, acupuncture, acupressure, osteopath, naturopathy, chiropractic, reflexology and aromatherapy unless specifically covered under the policy.

34. Hospitalization primarily for investigation purposes, diagnosis, x-ray examination, general or routine physical or medical examinations, not incidental to treatment or diagnosis of a covered Disease or Illness or any treatment which is not medically necessary and any preventive treatments, or examinations carried out by a Medical Practitioner.

35. Hospitalization for donation of any body organs by an Insured Person including complications arising from the donation of organs.

36. Treatment for obesity, weight reduction or weight management.

37. Experimental and unproven treatment.

38. Costs of donor screening or treatment including organ extraction, unless specifically covered and specified in the schedule of the policy.

39. Disease / injury illness whilst performing duties as a serving member of a military or police force.

40. Any kind of Service charges, Surcharges, Admission fees / Registration charges etc levied by the hospital.

Conditions

1. Due Care

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

2. Mis-description

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

3. Insured Person

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

4. Premium

The premium payable under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of Insurer signed by a duly authorized official of Insurer. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this policy by the Insured person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of Insurer to make any payment under this policy. No waiver of any terms provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorized official of Insurer.

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

6. **Mechanism for continuity of coverage for Individual members covered under the group insurance:**

In the event of the group policy under which the Insured Person is a covered member and which is being discontinued or not renewed or Insured person leaving the group on account of resignation/termination or otherwise, the Insured Person has the option of taking a standard individual health policy of the Insurer without any benefit of continuity of cover for any additional benefits that the Insured Person may have enjoyed under the group policy and for which additional premium has been charged. In such an event, all the waiting periods as stipulated under the Individual Health policy will be applicable with due adjustment for the Uninterrupted period in completed years for which the Individual was covered under the Group Health policy issued by us. However, any such benefit would be restricted to the maximum of his eligibility of sum insured under the

Individual health policy or the sum insured enjoyed by the individual under the Group Health policy whichever is lower. Also, all the underwriting rules and regulations of our Individual health policy would be applicable for acceptance of such risk.

7. Unhindered access

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

8. Claims Procedures

i. Reimbursement:

a. The Insured Person shall without any delay consult a Doctor and follow the advice and treatment recommended, take reasonable steps to minimize the quantum of any claim that might be made under this Policy and intimation to this effect can be forwarded to insurer accordingly.

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

c. The Insured Person shall submit himself for examination by Insurer's medical advisors as often as may be considered necessary by Insurer. In such an event the Insurer will bear all expenses incurred with the prior approval/permission of the Insurer to the Insured Person for making himself available for the said examinations.

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

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

ii. Cashless:

ADMINISTRATOR will provide the User guide & identity card to insured. User guide will have following details:

a. Contact details of all Administrator offices

b. Website address of **Administrator**

c. List of network providers with their contact details

d. Procedure for availing cashless benefits at Network providers

e. Claim submission guidelines.

iii. Intimation of claims:

a. In the event of Accidental Bodily Injury or Disease / Illness first occurring or manifesting itself during the Policy Period and causing the Insured Person's Hospitalisation, a hospitalization benefit will be payable as per the Policy conditions, that may result in a claim as per Policy terms and condition, then as a condition precedent to Insurer's liability, Insured / Insured person must provide intimation to Insurer immediately and in any event within 48 hours from date of hospitalisation. However, the Insurer at his sole discretion may relax this condition subject to a satisfactory

proof/evidence/justification being produced on the reasons for such a delay beyond the stipulated period. The intimation can be sent by Insured / Insured Person through various modes like email / telephone/ fax/ in person / letter or any other suitable mode.

b. Insured/Insured Person will need to submit the below mentioned documents for the processing of Hospitalisation Claims within 30 days from the date of discharge from the Hospital, however the Insurer at his sole discretion may relax this condition subject to a satisfactory proof/evidence being produced on the reasons for such a delay beyond the stipulated 30 days up to a maximum period of 60 days.

iv. Claims Submission:

Insured / Insured Person will submit the claim documents to the Administrator . Following is the document list for claim submission:

a. Duly filled Claim form,

b. Valid Photo Identity Card

c. Original Discharge card/certificate/ death summary

d. Copies of prescription for diagnostic test, treatment advise, medical references

e. Original set of investigation reports

f. Itemized original hospital bills, original receipts and related original medical expenses receipts, pharmacy bills in original with prescriptions.

v. Claims Processing:

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

vi. Penal Interest Provision :

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

9. Fraud

If Insured Person or any of their family members' makes or progresses any claim knowing it to be false or fraudulent in any way, then the coverage for this Insured Person and his family members will be void and all claims or payments due under it shall be lost and the premium paid shall become forfeited.

10. Nomination and Assignment

This Policy is not assignable and no person(s) other than Insured or Insured's nominee(s) as mentioned in the schedule or legal representatives, wherever is applicable, can claim or sue the Insurer under this policy.

The payment by the Insurer to the Insured, his/her nominee or legal representative of any compensation or benefit under the policy shall in all cases be an effectual discharge to the Insurer.

11. Subrogation

Insured and/or any Insured Persons shall at their own expense do or concur in doing or permit to be done all such acts and things that may be necessary or reasonably required by Insurer for the purpose of enforcing and/or securing any civil or criminal rights and remedies or obtaining relief or indemnity from any other party to which Insurer would become entitled upon Insurer making reimbursement under this Policy, whether such acts or things shall be or become necessary or required before or after our payment. Neither Insured nor any Insured Person shall prejudice these subrogation rights in any manner and shall at your own expense provide Insurer with whatever assistance or cooperation is required to enforce such rights. Any recovery Insurer make pursuant to this clause shall first be applied to the amounts paid or payable by Insurer under this Policy and our costs and expenses of effecting a recovery, where after Insurer shall pay any balance remaining to Insured.

12. Contribution

If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, insured shall have the right to require a settlement of his claim in terms of any of his policies.

1. In all such cases where insured opts the settlement of claim under this policy, we will be obliged to settle the claim without insisting on the contribution clause as long as the claim is within the limits of and according to the terms of the policy.
2. If the amount to be claimed exceeds the sum insured under policy issued by us after considering the deductibles or co-pay, the insured shall have the right to choose other insurers by whom the claim to be settled. In such cases, we will settle the claim with contribution clause.
3. Except in benefit policies, in cases where an insured person has policies from other insurer(s) to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the policy.

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

13. Cancellation

In case of any fraud, misrepresentation, or suppression of any material fact either at the time taking the Policy or any time during the currency of the earlier policies, **Insurer** may at any time cancel this policy by sending the Insured 15 days notice by registered letter, at the Insured's last known address and in such event Insurer shall refund to the Insured a pro-rata' premium for unexpired period of Insurance subject to no claim has occurred up to date of cancellation. Insurer shall, however, remain liable for any claim which arose prior to the date of cancellation. The **Insured** may at any time cancel this policy by giving a written notice to the insurer and in such event Insurer shall allow refund of premium at Insured's short period rate only (table given here below) provided no claim has occurred up to the date of cancellation.

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

14. Termination of Policy

This Policy terminates on earliest of the following events-

a. Cancellation of policy by as per the cancellation provision.

b. On the policy expiry date.

15. Arbitration & Conciliation

a. If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole Arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single Arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 Arbitrators, comprising of two Arbitrators and one to be appointed by each of the parties to the dispute/difference and the third Arbitrator to be appointed by such two Arbitrators and the arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliations Act 1996.

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

c. It is expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such Arbitrator/Arbitrators of the amount of the loss shall be first obtained.

d. The law of the arbitration shall be Indian law and the seat of the arbitration and venue for all the hearings shall be within India.

16. Renewal

This Policy may be renewed by mutual consent every year and in such event, the renewal premium shall be paid to Insurer on or before the date of expiry of the Policy or of the subsequent renewal thereof. However Insurer shall not be bound to give notice that such renewal premium is due. Also Insurer may exercise Insurer's option not to renew the policy on grounds of fraud misrepresentation, or suppression of any material fact either at the time of taking the Policy or any time during the currency of the earlier policies.

A Grace Period of 30 days is allowed for renewal of the policy. This will be counted from the day immediately following the premium due date during which a payment can be made to renew or continue the Group Health Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-existing diseases. The continuity of coverage for all the covers under the expiring policy will be subject to receiving appropriate premium for the same. Coverage is not available for the period for which no premium is received and **Insurer** has no liability for the claims arising during this period.

17. Withdrawal of Product

In case of withdrawal of this product insurer will communicate to Insured at least 3 months prior to the withdrawal. Existing policy will continue to remain in force till its expiry, and at the time of renewal, Insured will have option to migrate to insurer's group health insurance products available at that time with continuity benefit, if any.

Disclaimer

If Insurer shall disclaim liability to the Insured for any claim hereunder and if the Insured shall not within 12 calendar months from the date of receipt of the notice of such disclaimer notify Insurer in writing that he does not accept such disclaimer and intends to recover his claim from Insurer then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

18. Geographical limits

All medical/ surgical treatments under this policy shall have to be taken in India and admissible claims thereof

shall be payable in Indian currency.

19. Grievance Redressal Procedure

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

Name, address, e-mail ID and contact number of the Grievance Redressal Officer will appear in the Policy document as well as on Insurer's website.

Further, the Insured may approach the nearest Insurance Ombudsman for redressal of the grievance. List of Ombudsman offices with contact details are attached for ready reference. For updated status, Please refer to website www.irdaindia.org.

Office Details	**Jurisdiction of Office Union Territory,District)**
AHMEDABAD - Office of the Insurance Ombudsman, 2nd floor, Ambica House,Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - **Shri. M. Parshad** Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@gbic.co.in	Karnataka.
BHOPAL - Shri. R K Srivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@gbic.co.in	Madhya Pradesh, Chattisgarh.
BHUBANESHWAR - Shri. B. N. Mishra Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in	Orissa.
CHANDIGARH - Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
CHENNAI - Shri Virander Kumar Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI - Smt. Sandhya Baliga Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in	Delhi.
GUWAHATI - Sh. / Smt. Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri. G. Rajeswara Rao	Andhra Pradesh, Telangana, Yanam and

Office Details	Jurisdiction of Office Union Territory,District)
Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in	part of Territory of Pondicherry.
JAIPUR - Shri. Ashok K. Jain Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.co.in	Rajasthan.
ERNAKULAM - Shri. P. K. Vijayakumar Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@gbic.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA - Shri. K. B. Saha Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@gbic.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW - Shri. N. P. Bhagat Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in	Some Districts of Uttar Pradesh
MUMBAI - Shri. A. K. Dasgupta Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri. Ajesh Kumar Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@gbic.co.in	State of Uttaranchal and some Districts of Uttar Pradesh
PATNA - Shri. Sadasiv Mishra Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@gbic.co.in	Bihar, Jharkhand.
PUNE - Shri. A. K. Sahoo Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure I - Day Care List

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

Microsurgical operations on the middle ear

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

Other operations on the middle & internal ear

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

Operations on the nose & the nasal sinuses

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

Operations on the eyes

22. Incision of tear glands
23. Other operations on the tear ducts
24. Incision of diseased eyelids
25. Excision and destruction of diseased tissue of the eyelid
26. Incision of diseased eyelids
27. Operations on the canthus and epicanthus
28. Corrective surgery for entropion and ectropion
29. Corrective surgery for blepharoptosis
30. Removal of a foreign body from the conjunctiva
31. Removal of a foreign body from the cornea
32. Incision of the cornea
33. Operations for pterygium
34. Other operations on the cornea
35. Removal of a foreign body from the lens of the eye
36. Removal of a foreign body from the posterior chamber of the eye
37. Removal of a foreign body from the orbit and eyeball
38. Operation of cataract

Operations on the skin & subcutaneous tissues

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

Operations on the tongue

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

Operations on the salivary glands & salivary ducts

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

Other operations on the mouth & face

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

Operations on the tonsils & adenoids

68. Transoral incision and drainage of a pharyngeal abscess
69. Tonsillectomy without adenoidectomy
70. Tonsillectomy with adenoidectomy
71. Excision and destruction of a lingual tonsil
72. Other operations on the tonsils and adenoids
73. Trauma surgery and orthopaedics
74. Incision on bone, septic and aseptic
75. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
76. Suture and other operations on tendons and tendon sheath
77. Reduction of dislocation under GA
78. Arthroscopic knee aspiration

Operations on the breast

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

Operations on the digestive tract

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

Operations on the female sexual organs

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

Operations on the prostate & seminal vesicles

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

Operations on the scrotum & tunica vaginalis testis

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

Operations on the testes

116. Incision of the testes
117. Excision and destruction of diseased tissue of the testes
118. Unilateral orchidectomy
119. Bilateral orchidectomy
120. Orchidopexy

121. Abdominal exploration in cryptorchidism
122. Surgical repositioning of an abdominal testis
123. Reconstruction of the testis
124. Implantation, exchange and removal of a testicular prosthesis
125. Other operations on the penis

Operations on the spermatic cord, epididymis und ductus deferens

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

Operations on the penis

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

Operations on the urinary system

137. Cystoscopical removal of stones

Other Operations

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

Annexure II

Standard List of Excluded expenses in Hospitalisation indemnity policies

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

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

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

127	WASHING CHARGES	Not Payable
128	MEDICINE BOX	Not Payable
129	MORTUARY CHARGES	Payable upto 24 hrs, shifting charges not payable
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES		
131	WALKING AIDS CHARGES	Not Payable
132	BIPAP MACHINE	Not Payable
133	COMMODE	Not Payable
134	CPAP/ CAPD EQUIPMENTS	Device not Payable
135	INFUSION PUMP - COST	Not Payable
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Device not Payable
137	PULSEOXYMETER CHARGES	Device not Payable
138	SPACER	Not Payable
139	SPIROMETRE	Device not Payable
140	SP 02 PROBE	Not Payable
141	NEBULIZER KIT	Not Payable
142	STEAM INHALER	Not Payable
143	ARMSLING	Not Payable
144	THERMOMETER	Not Payable (paid by patient)
145	CERVICAL COLLAR	Not Payable
146	SPLINT	Not Payable
147	DIABETIC FOOT WEAR	Not Payable
148	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150	LUMBOSACRAL BELT	Essential and should be paid specifically for cases who have undergone surgery of lumbar spine.
151	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia / quadripiegia for any reason and at reasonable cost of approximately Rs 200/ day
152	AMBULANCE COLLAR	Not Payable
153	AMBULANCE EQUIPMENT	Not Payable
154	MICROSHEILD	Not Payable
155	ABDOMINAL BINDER	Essential an d should be paid in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.
ITEMS PA YABLE IF SUPPORTED BY A PRESCRIPTION		
156	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\ DSINFECTANTS ETC	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post hospitalization nursing charges not Payable
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES	Patient Diet provided by hospital is payable
159	SUGAR FREE Tablets	Payable -Sugar free variants of admissable medicines are not excluded
160	CREAMS POWDERS LOTIONS (Toileteries are not payable,only prescribed medical pharmaceuticals payable)	Payable when prescribed
161	Digestion gels	Payable when prescribed
162	ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT o r ICU. For longer stay in ICU, may require a change and at least one set every

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

ENDORSEMENTS

It is hereby agreed that any or all endorsements issued with this Policy or endorsed thereon in shall be expressly subject to the terms and conditions and exclusions of this Policy, except to the extent expressly varied by the endorsement and shall become applicable only upon endorsement and **after our receipt of requisite additional premiums.** All other Policy terms, conditions and exclusions shall remain unchanged.

1. **Ambulance expenses cover:**

It is hereby declared and agreed that we will reimburse 1% of Sum Insured per Person per Policy period up to a maximum of Rs. 1500 towards the utilisation of an ambulance for the Insured Person being transported to the hospital for treatment of the illness/disease/injury and upon producing the bills in original. Ambulance services used are to be of a licensed operator.

All other terms and conditions under the policy remain unaltered.

2. **Annual medical check-up:**

We will reimburse the reasonable and customary charges incurred by an Insured Person for a health check-up at any of the Insurer's empanelled diagnostic centre or at any other diagnostic centre, provided that:

a. The Health Check-up is to be undertaken within the Policy Period,

b. Our maximum liability under this Endorsement will be limited to - 1% of sum insured up to a maximum of Rs. 2500 Per Policy Period.

All other terms and conditions under the policy remain unaltered.

3. **Maternity Benefit Extension with waiting period of 9 months:**

It is hereby declared and agreed that the exclusion No.20 of the "Exclusions" stands deleted and Insurer will reimburse medical expenses up to the limits and sub limits as mentioned in the Schedule against the Insured Persons. Expenses incurred towards the normal baby care after delivery is not covered under this benefit.

Option for Maternity Benefits has to be exercised at the inception of the policy period and no refund is allowable in case of Insured's cancellation of this option during the term of the policy. These Benefits are admissible only if the expenses are incurred in a Hospital as an in-patient in India.

The benefit under this Policy shall be payable after a period of 9 months from the date of inception of the Policy in so far as the period of 9 months applicable for payment of any claim under this benefit. However, Insurer may at its absolute discretion relax the above period of 9 months in case of a medical emergency or accident resulting in delivery, mis-carriage or abortion.

Claim in respect of delivery for only first two living children and/or operations associated therewith will be considered in respect of any one Insured Person. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.

Expenses incurred in connection with voluntary medical termination of pregnancy are not covered.

Pre-natal and post-natal expenses are not covered unless the same require Hospitalisation and within the meaning of hospitalisation as defined under the standard policy wordings. This benefit is available as a part of Maternity Sublimit.

All other terms and conditions under the policy remain unaltered.

4. **Maternity Benefit Extension without waiting period of 9 months:**

It is hereby declared and agreed that the exclusion No.20 of the "Exclusions" stands deleted and Insurer will reimburse medical expenses up to the limits and sub limits as mentioned in the Schedule against the Insured Persons. Expenses incurred towards the normal baby care after delivery is not covered under this benefit.

Option for Maternity Benefits has to be exercised at the inception of the policy period and no refund is allowable in case of Insured's cancellation of this option during the term of the policy. These Benefits are admissible only if the expenses are incurred in a Hospital as an in-patient in India.

Claim in respect of delivery for only first two living children and/or operations associated therewith will be considered in respect of any one Insured Person. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.

Expenses incurred in connection with voluntary medical termination of pregnancy are not covered.

Pre-natal and post-natal expenses are not covered unless the same require Hospitalisation and within the meaning of hospitalisation as defined under the standard policy wordings. This benefit is available as a part of Maternity Sublimit.

All other terms and conditions under the policy remain unaltered.

5. **New Born Cover from Day One:**

It is hereby declared and agreed that we will cover the new born babies of any Insured Person from the date of birth of the baby, for any disease/sickness/ailment/Injury. The limit opted for this cover is distinct and is not inclusive of the maternity cover limit opted. All other terms and conditions under the policy remain unaltered.

6. **Critical Illness Cover**:

It is hereby declared and agreed that we will reimburse the Reasonable and Customary Charges incurred for the treatment of "Critical Illness" as defined below and under the policy up to an additional Sum Insured limit equal to his/her Basic Sum Insured. This benefit will be available to the insured persons only upon exhaustion of the Basic Sum Insured under the standard hospitalisation benefit available under the policy. All the monetary sub-limits as applicable under the policy would be applicable for this cover also. Provided that

1. The **Insured Person** is first diagnosed as suffering from a Critical Illness during the Policy Period
2. **Critical Illness means –**
    1. Cancer of specified severity,
    2. Open Chest CABG
    3. Aorta Graft Surgery,

4. Open Heart Replacement or Repair of Heart Valves
5. Stroke Resulting in Permanent Symptoms
6. First Heart Attack – Of Specified Severity
7. Kidney Failure Requiring Regular Dialysis
8. Primary Pulmonary Arterial Hypertension,
9. Major Organ/ Bone Marrow Transplant
10. Multiple Sclerosis with Persisting Symptoms
11. Coma of Specified Severity
12. Total Blindness
13. Permanent Paralysis of Limbs

All as defined below only:

1. Cancer

I. A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded -

1. Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
2. Any skin cancer other than invasive malignant melanoma
3. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.....
4. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
5. Chronic lymphocyctic leukaemia less than RAI stage 3
6. Microcarcinoma of the bladder
7. All tumours in the presence of HIV infection.

2. Open Chest CABG

1. The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.
2. The following are excluded:
   i. Angioplasty and/or any other intra-arterial procedures

ii. any key-hole or laser surgery.

3. Aorta Graft Surgery

The actual undergoing of surgery for disease of the aorta needing excision and surgical replacement of a portion of the diseased aorta with a graft. For this definition, aorta means the thoracic and abdominal aorta but not its branches.

Surgery following traumatic injury to the aorta is not covered. Surgery to treat peripheral vascular disease of the aortic branches is excluded even if a portion of the aorta is removed during the operative procedures. Surgery performed using only minimally invasive or intra-arterial techniques such as percutaneous endovascular aneurysm with insertion of a stent graft are excluded.

4. Open Heart Replacement or Repair of Heart Valves

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

5. Stroke Resulting in Permanent Symptoms

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

b. The following are excluded:

   a. Transient ischemic attacks (TIA)

   b. Traumatic injury of the brain

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

6. First Heart Attack – Of Specified Severity

i. The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

   a. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)

   b. new characteristic electrocardiogram changes

   c. elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

ii. The following are excluded:

1. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T
2. Other acute Coronary Syndromes
3. Any type of angina pectoris.

7. Kidney Failure Requiring Regular Dialysis

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

8. Primary Pulmonary Arterial Hypertension

Primary Pulmonary Hypertension is characterized by elevated pulmonary artery pressure with no apparent cause and substantial right ventricular enlargement confirmed by a Cardiologist with the help of investigations including Cardiac Catheterization (cardiac catheterization proving the pulmonary pressure to be above 30 mm of Hg), resulting in permanent irreversible physical impairment of at least Class IV of the New York Heart Association (NYHA) Classification of Cardiac Impairment and resulting in the Insured being unable to perform his / her usual occupation.

The latest NYHA Classification of Cardiac Impairment shall be used. Diagnosis and Treatment – 39th Edition"):

Class I: No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnoea, or angina pain.

Class II: Slight limitation of physical activity. Ordinary physical activity results in symptoms.

Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

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

9. Major Organ/ Bone Marrow Transplant

a) The actual undergoing of a transplant of:

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

   b. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

b) The following are excluded:

   a. Other stem-cell transplants

   b. Where only islets of langerhans are transplanted

10. Multiple Sclerosis with Persisting Symptoms

a. The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

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

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

   iii. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes at least one month apart.

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

11. Coma of Specified Severity

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

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

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

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

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

12. Total Blindness:

Total, permanent and irreversible loss of all sight in both eyes as a result of sickness or accident. Diagnosis has to be confirmed by a specialist (best by an ophthalmologist) and evidenced by specific test results.

13. Permanent Paralysis of Limbs

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

7. **Pre-existing Disease Exclusion Waiver:**

It is hereby declared and agreed that the exclusion No.1 of the “Exclusions” stands deleted and Insurer will pay the expenses up to the limits and sub limits as mentioned in the Schedule against the insured persons. All other terms and conditions under the policy remain unaltered.

8. **First year Exclusions Waiver:**

It is hereby declared and agreed that the exclusion No.3 of the "Exclusions" stands deleted and Insurer will pay the expenses up to the limits and sub limits as mentioned in the Schedule against the insured persons. All other terms and conditions under the policy remain unaltered.

9. **First 30 days Exclusion Waiver:**

It is hereby declared and agreed that the exclusion No.2 of the "Exclusions" stands deleted and Insurer will pay the expenses up to the limits and sub limits as mentioned in the Schedule against the insured persons.

All other terms and conditions under the policy remain unaltered.

10. **Coverage for Ayurvedic Medicine:**

It is hereby declared and agreed that Ayurvedic Treatment is limited to 15% of Sum Insured per Policy period or up to a maximum of Rs. 20000, whichever is lower, subject to and for treatment taken as inpatient in a government hospital or in any institute recognised by government and/or accredited by Quality Council of India/National Accreditation Board on Health. The hospitalisation should be for a minimum period of 24 hours for being eligible for the reimbursement.

All other terms and conditions under the policy remain unaltered.

11. **Coverage for Homeopathic and Unani system of medicine:**

It is hereby declared and agreed that Homeopathy and Unani Treatment cover is limited to 10% of Sum Insured per Policy period or up to a maximum of Rs. 15000, whichever is lower, subject to and for treatment taken as inpatient in a government hospital or in any institute recognised by government and/or accredited by Quality Council of India/National Accreditation Board on Health. The hospitalisation should be for a minimum period of 24 hours for being eligible for the reimbursement.

All other terms and conditions under the policy remain unaltered.

12. **Exclusion of Domiciliary Hospitalisation:**

It is hereby declared and agreed that notwithstanding anything to the contrary contained in the within written policy, the coverage under this policy shall exclude any expenses for Domiciliary Hospitalisation. Subject otherwise to the terms and conditions of this policy.

All other terms and conditions under the policy remain unaltered.

13. **Exclusion of Pre and Post Hospitalisation cover**:

It is hereby declared and agreed that notwithstanding anything to the contrary contained in the within written policy, the coverage under this policy shall exclude the expenses arising out of Pre & Post Hospitalisation. Subject otherwise to the terms and conditions of this policy.

All other terms and conditions under the policy remain unaltered.

14. **Coverage for Out Patient Treatment:**

It is hereby declared and agreed that We will cover Outpatient Treatment for the Insured Person, provided that

i. Our maximum liability under this Endorsement for reimbursement of expenses will be limited to a maximum of 2% of the sum insured during the entire policy period. Subject otherwise to the terms and conditions of this policy

All other terms and conditions under the policy remain unaltered.

15. **Coverage for Dental Expenses:**

It is hereby declared and agreed that We will pay/reimburse the Reasonable and Customary charges of any necessary dental treatment during the Policy Period taken from a dentist by an Insured Person and Exclusion No.13 stands deleted for all Insured Persons to this extent, provided that:

i. We will only pay for X-rays, extractions, amalgam or composite fillings, root canal treatments and prescribed drugs for the same, and

ii. We will not pay for any dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for the temporomandibular (jaw) joint, or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer, and

iii. Our maximum liability under this Endorsement will be limited a maximum reimbursement of 2% of the sum insured for the entire policy period.

All other terms and conditions under the policy remain unaltered.

16. Corporate Buffer (Additional Sum Insured for the total Group):

It is hereby declared and agreed that an additional sum insured as stipulated in the schedule of the policy will be available to the Insured which is in addition to the basic sum insured reflected in the policy schedule per person/family.

We will provide a Corporate Floater as stated in the Policy Schedule during the Policy Period subject to the following sub limits:

a. This sum insured will be available for those insured person, who have already exhausted their sum insured limit subject to a per person limit.

b. However, the amount is restricted to coverage as stated in the Policy Schedule of each and every Illness in respect of each and every Insured person or His family (if applicable).

The Corporate Buffer will not be available for Maternity & Non Allopathic Treatment/Claims.

All other terms and conditions under the policy remain unaltered.

17. Coverage for congenital internal Diseases:

It is hereby agreed and declared that Exclusion no: 15 under the policy stands deleted. All other terms and conditions of the policy remain unaltered.

18. Voluntary Co-pay option:

For all admissible claims insured person shall bear ---------% of all eligible and admissible claims as per terms and conditions of insurance and as stated in the policy schedule. All other terms and conditions of the policy remain unaltered.

19. Enhancement of Room rent sub-limits:

It is hereby agreed and declared that Room, Board & Nursing Charges as provided by the hospital/nursing home stands enhanced to ----------% of the Sum Insured max Rs.---------/- for Normal Room per day and up to ----------% of the Sum Insured per day max Rs.----------/- if admitted to Intensive Care Unit. All other terms and conditions of the policy remain unaltered.

20. **Family Floater Cover:**

It is hereby agreed and declared that this policy covers the **Primary Insured** and his **Family** as defined in the policy on a Family Floater basis under which the Policy definition of the Sum Insured shall be replaced with the following:

Sum Insured: means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by the Primary Insured and all Dependents during the Policy Period, except where a particular benefit is expressed to be subject to its own limit in which case that limit, which is subject to the Sum Insured, represents Our maximum liability for any and all claims made by the Primary Insured and all Dependents in respect of that benefit.