Activ Health Policy Terms and Conditions

Section A. PREAMBLE

This Policy has been issued on the basis of the Disclosure to information norm, including the information provided by You in respect of the Insured Persons in the Proposal Form and any other details submitted in relation to the Proposal Form. This Policy is a contract of insurance between You and Us which is subject to the receipt of premium in full and the terms, conditions and exclusions of this Policy.

Key Notes:
The terms listed in Section D (Definitions) and which have been used elsewhere in the Policy in Initial Capital letters shall have the meaning set out against then in Section D, wherever they appear in the Policy.

Section B. BENEFITS UNDER THE POLICY

Section I: Basic Covers:
The Benefits listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the applicable Plan as specified in the Policy Schedule.

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

Benefits under this Section are subject to the terms, conditions and exclusions of this Policy and the availability of the Sum Insured and subject always to any sub-limits for the Benefit as specified in the Policy Schedule.

All claims must be made in accordance with the procedure set out in Section C(C). Claims paid under this Section will impact the Sum Insured and eligibility for Cumulative Bonus.

(a) In-patient Hospitalization:
What is covered
We will cover the Medical Expenses for one or more of the following arising out of an Insured Person's Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period:
(1) Room Rent and other boarding charges;
(2) Intensive Care Unit charges;
(3) Operation theatre expenses;
(4) Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
(5) Qualified Nurses charges;
(6) Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
(7) Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized
(8) Anaesthesia, blood, oxygen and blood transfusion charges;
(9) Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Conditions
The Hospitalization is medically necessary and follows the written advice of a Medical Practitioner.
Sub-limits
For Essential Plan, treatment-wise sub-limits will apply as below, these limits are applicable per Policy Year.

	Disease Category	Zone I	Zone II	Zone III
1	Cataract (including cost of lens) per eye	Rs 40,000	Rs 30,000	Rs 20,000
2	Angioplasty (including cost of stent)	Rs 3,00,000	Rs 2,50,000	Rs 2,00,000
3	Knee replacement (including revision Surgery)	Rs 3,00,000	Rs 2,50,000	Rs 2,00,000
4	Hip replacement (including revision Surgery)	Rs 3,00,000	Rs 2,50,000	Rs 2,00,000
5	Cholecystectomy (open or lap)	Rs 60,000	Rs 45,000	Rs 35,000
6	Lap / open / vaginal hysterectomy (with / without Salpigo-oophorectomy)	Rs 60,000	Rs 45,000	Rs 35,000

(b) Pre – hospitalization Medical Expenses:
What is covered
We will cover on a reimbursement basis, the Insured Person's Pre-hospitalization Medical Expenses incurred in respect of an Illness or Injury that occurs during the Policy Period.
Conditions
(i) We have accepted a claim for In-patient Hospitalization under Section B(I)(a) above;
(ii) The date of admission to Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to Any One Illness.

(c) Post – hospitalization Medical Expenses:
What is covered
We will cover on a reimbursement basis, the Insured Person's Post-hospitalization Medical Expenses incurred following an Illness or Injury that occurs during the Policy Period.
Conditions
(i) We have accepted a claim for In-patient Hospitalization under Section B(I)(a) above;
(ii) The date of discharge from Hospital for the purpose of this Benefit shall be the date of the Insured Person's last discharge from Hospital in relation to Any one Illness.

(d) Day Care Treatment:
What is covered
We will cover the Medical Expenses incurred on the Insured Person's Day Care Treatment during the Policy Period following an Illness or Injury that occurs during the Policy Period. The list of such Day Care Treatment is mentioned in Annexure IV.

Conditions
(I) The Day Care Treatment is Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
(ii) The Medical Expenses are incurred, including for any procedure which requires a period of specialized observation or care after completion of the procedure undertaken by an Insured Person as Day Care Treatment.
(iii) If We have accepted a claim under this Benefit, We will also cover the Insured Person's Pre-hospitalization and Post-hospitalization Medical Expenses in accordance with Section B(I)(b) and (c) above.

What is not covered
OPD treatment is not covered under this Benefit.

Any one Illness means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
Post-hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:
i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and
ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

Day Care Treatment means medical treatment, and/or *surgical procedure* which is:
i. undertaken under General or Local Anaesthesia in a *hospital/day care centre* in less than 24 hrs because of technological advancement, and
ii. which would have otherwise required hospitalization of more than 24 hours.
Treatment normally taken on an out-patient basis is not included in the scope of this definition.

(e) Domiciliary Hospitalization:

What is covered
We will cover the Medical Expenses incurred for the Insured Person's Domiciliary Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period.

Conditions
(i) The Domiciliary Hospitalisation continues for at least 3 consecutive days in which case We will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalisation;
(ii) The treating Medical Practitioner confirms in writing that Domiciliary Hospitalization was medically necessary and the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital OR the Insured Person satisfies Us that a Hospital bed was unavailable;
(iii) If a claim is accepted under this Benefit then We shall not pay any Post-hospitalization Medical Expenses, but will accept a claim for Pre-hospitalization Medical Expenses subject to the terms and conditions of Section B(I)(b) above.

What is not covered
We shall not be liable to pay for any claim in connection with:
(1) Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
(2) Arthritis, gout and rheumatism;
(3) Chronic nephritis and nephritic syndrome;
(4) Diarrhea and all type of dysenteries, including gastroenteritis;
(5) Diabetes mellitus and insipidus;
(6) Epilepsy;
(7) Hypertension;
(8) Psychiatric or psychosomatic disorders of all kinds;
(9) Pyrexia of unknown origin.

(f) Road Ambulance Cover:

What is covered
We will cover the costs incurred up to the limits as specified in the Policy Schedule, on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period.

Coverage shall also be provided under the below circumstances, if the Medical Practitioner certifies in writing that:
(i) it is medically necessary to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.
(ii) it is medically necessary to transfer the Insured Person to another Hospital during the course of Hospitalization due to lack of super speciality treatment in the existing Hospital.

Conditions
(I) The Ambulance/ healthcare service provider is registered;
(ii) We have accepted a claim for In-patient Hospitalization under Section B(I)(a) above;

What is not covered
Any expenses in relation to transportation of the Insured Person from Hospital to the Insured Person's residence are not payable under this Benefit.

Domiciliary Hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a *hospital* but is actually taken while confined at home under any of the following circumstances:
i) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
ii) the patient takes treatment at home on account of non-availability of room in a hospital.

(g) Organ Donor Expenses:

What is covered
We will cover the Medical Expenses incurred for an organ donor's treatment for the harvesting of the organ donated.

Conditions
(i) The donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;
(ii) The organ transplant is medically necessary for the Insured Person as certified by a Medical Practitioner;

What is not covered
(1) Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
(2) Screening expenses of the organ donor.
(3) Any other Medical Expenses as a result of the harvesting from the organ donor.
(4) Costs directly or indirectly associated with the acquisition of the donor's organ.
(5) Transplant of any organ/tissue where the transplant is experimental or investigational.
(6) Expenses related to organ transportation or preservation.
(7) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

(h) Reload of Sum Insured:

What is covered
Once in the Policy Year, We will provide for a 100% reload of the Sum Insured specified in the Policy Schedule, in case available Sum Insured inclusive of earned Cumulative Bonus (if any) is insufficient as a result of previous claims in that Policy Year. Reload of Sum Insured will be available only once during a Policy Year.

Conditions

(i) A claim will be admissible under this Benefit only if the claim is admissible under In-patient Hospitalization under Section B(I)(a) or Day Care Treatment under Section B(I) (d).
(ii) The reload of Sum Insured shall not apply to the first claim in the Policy Year unless related to an Injury due to a road traffic Accident where the claim amount exceeds the Sum Insured.
(iii) The reload of Sum Insured shall be available only for future claims and not in relation to any Illness/ Injury (including its complications) for which a claim has been admitted for the Insured Person during that Policy Year.
(iv) The reload of Sum Insured shall not be available for any claims under Section B(II) (Additional Benefits), Section B(III) (Value Added Benefits) and Section B(IV) (Optional Covers).
(v) The reloaded Sum Insured will not be considered while calculating the Cumulative Bonus.
(vi) In case of an Individual Policy, reload is available to each Insured Person and can be utilised by Insured Persons who stand covered under the Policy before the Sum Insured was exhausted.
(vii) If the Policy is issued on a floater basis, the reload of Sum Insured will be available on a floater basis for all Insured Persons in the family.
(viii) If the reload of Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.
(ix) During a Policy year, any single claim amount payable, (except a claim against road traffic Accident), subject to admissibility of claim, shall not exceed the sum of:
  (1) The Sum Insured
  (2) Cumulative Bonus (if earned)
(x) During a Policy Year, the aggregate claim amount payable, subject to admissibility of the claim, shall not exceed the sum of:
  (1) The Sum Insured
  (2) Cumulative Bonus (if earned)
  (3) Reloaded Sum Insured
  (4) HealthReturns™ (please refer to HealthReturns™ clause under Section B(III)(s) for details)
  (5) Optional Covers
  (6) Chronic Management Program
  (7) Additional Benefits

Please refer to the Annexure II 'Illustration of Benefits' Section D, for details on this benefit.

(I) Mandatory Co-payment (Applicable for Essential Plan only)

A mandatory Co-payment as specified in the Policy Schedule shall apply to all payable claims amount in respect of an Insured Person.

Conditions

For persons who have opted for a 'Waiver of Mandatory Co-payment' this Co-payment will not apply.

(j) Co-payment for treatment in a Higher Zone

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

Applicable Zone	Treatment taken at	Co-payment applicable
Zone II	Zone I	10%
Zone III	Zone II	15%
Zone III	Zone I	25%

(k) Co-payment for treatment in a Higher room category

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

Plan	Eligible Room Category	Room Category at which treatment taken	Co-payment applicable
Essential	General/ Economy Ward	Shared Room	15%
	General/ Economy Ward	Single Private Room	25%
	General/ Economy Ward	Any Room	50%
	Shared Room	Single Private Room	15%
	Shared Room	Any Room	40%
	Single Private Room	Any Room	25%
Enhanced	Shared Room	Single Private Room	15%
	Shared Room	Any Room	40%
	Single Private Room	Any Room	25%

Conditions applicable to benefits (i) (j) (k) above,

Under Essential Plan: wherever applicable Co-payment percentages under (i) (j) (k) shall apply in conjunction.
Under Enhanced Plan: wherever applicable Co-payment percentages under (j) (k) shall apply in conjunction
Note: Please refer to the Annexure II 'Illustration of Benefits', Section B for details on the applicable Co-payment under each Plan.

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

(l) Benefit for Hospital Room Choice

What is covered

This Benefit is available to the Insured Person if he/she chooses to take admission in a Hospital room category that is lower than the eligible room category for that Insured Person. For this purpose the eligible room category shall be as specified in the Policy Schedule.
Under this Benefit, We will apply the percentage amounts (as specified under Column E of the below table) on payable claims. The amount so arrived will be credited as HealthReturns™ in respect of that Insured Person. Such credits shall be made once the claim has been settled.

Opted Plan (A)	Opted Plan (B)	Eligible Room Category (C)	Room Category at which treatment taken (D)	Benefit applicable as a % of payable claims (E)
Essential	Zone I	Shared Room	General/ Economy Ward	10%
		Single Private Room	General/ Economy Ward	20%
		Single Private Room	Shared Room	10%

	Zone II & III	Shared Room	General/ Economy Ward	5%
		Single Private Room	General/ Economy Ward	15%
		Single Private Room	Shared Room	5%
Enhanced	Zone I	Single Private Room	Shared Room	10%
		Any Room	Shared Room	30%
		Any Room	Single Private Room	20%
	Zone II & III	Single Private Room	Shared Room	5%
		Any Room	Shared Room	25%
		Any Room	Single Private Room	15%

Conditions

(i) This Benefit will only be invoked for Medical Expenses arising under Section B(I)(a) of the Policy.
(ii) The maximum amount under this Benefit shall be restricted to the difference between the Balance Sum Insured (including Cumulative Bonus, if any) and the payable claims amount.

Please refer to Illustration in Section A (2) (Case 3) of Annexure II 'Illustration of Benefits'

Section II: Additional Benefits

The Benefits listed below are in-built additional Policy benefits and shall be available to all Insured Persons in accordance with the applicable Plan as specified in the Policy Schedule.

Benefits under this Section are subject to the terms, conditions and exclusions of this Policy.
Claims under this Section will not impact the Sum Insured or the eligibility for Cumulative Bonus.

(m) **Cumulative Bonus:**

What is covered

We shall apply a Cumulative Bonus at such rates as specified in the Table of Benefits on the Sum Insured of the expiring Policy as specified for Section B(I) in the Policy Schedule provided that If the Insured Person(s) has not made any claim under Section B(I) in a Policy Year, and has successfully Renewed the Policy with Us continuously and without any break. The Cumulative Bonus shall not exceed, 100% of the Sum Insured on the Renewed Policy and such accumulated Cumulative Bonus will not be reduced for claims made in the future, unless utilised.

Conditions

(i) If the Policy is a Family Floater Policy, then Cumulative Bonus will accrue only if no claims have been made in respect of the Insured Persons in the expiring Policy Year. Cumulative Bonus which is accrued during the claim free Policy Year will only be available to those persons who were insured in such claim free Policy Year and continue to be insured in the subsequent Policy Year.
(ii) Cumulative Bonus will not be accumulated in excess of the percentage applicable under the Plan in force for the Insured Person as stated in the Policy Schedule.
(iii) Wherever the earned Cumulative Bonus is used for payment of a claim during a particular Policy Year, the balance, if any, will be carried forward to the next Policy Year.
(iv) Cumulative Bonus will be not be added if the Policy is not Renewed with Us by the end of the Grace Period.
(v) If the Policy Period is two or three years, any Cumulative Bonus that has accrued for the first/second Policy Year will be credited at the end of the first/second Policy Year as the case may be and will be available for any claims made in the subsequent Policy Year.
(vi) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater Policy basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest among all the Insured Persons.
(vii) If the Insured Persons in the expiring Policy are covered on a Family Floater Policy basis and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater Policies/Individual Policies then the Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
(viii) If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be reduced in the same proportion to the Sum Insured.
(ix) If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
(x) The Cumulative Bonus is provisional and is subject to revision if a claim is made in respect of the expiring Policy Year, which is notified after the acceptance of Renewal premium. Such awarded Cumulative Bonus shall be withdrawn only in respect of the expiring year in which the claim was admitted.
(xi) In case of Family Floater Policies, children attaining Age 25 years at the time of Renewal will be moved out of the Family Floater Policy into an Individual Policy. However, all continuity benefits for such Insured Person on the Policy will remain intact. Cumulative Bonus earned on the Policy will stay with the Insured Person(s) covered under the original Policy.

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

(n) Health Check-up Program

What is covered

Each Insured Person above 18 years of Age on the Start date may avail a comprehensive health check-up in a Policy Year in accordance with the table below:

Essential	Enhanced
Age band < 45 years	
Health Assessment™ - MER (includes BP, BMI, HWR and smoking status) Fasting Blood Sugar Total Cholesterol	Health Assessment™ - MER (includes BP, BMI, HWR and smoking status) Fasting Blood Sugar Total Cholesterol
Urine Routine	Urine Routine
CBC with ESR	CBC with ESR
S. Creatinine	S. Creatinine

S. Albumin	S. Albumin
SGPT	SGPT
Thyroid Stimulating Hormone	Thyroid Stimulating Hormone
ECG	ECG
Age band 45 to 55 years	
Health Assessment™ - MER (includes BP, BMI, HWR and smoking status) Fasting Blood Sugar Total Cholesterol	Health Assessment™ - MER (includes BP, BMI, HWR and smoking status) Fasting Blood Sugar Total Cholesterol
Urine Routine	Urine Routine
CBC with ESR	CBC with ESR
S. Creatinine	S. Creatinine
S. Albumin	S. Albumin
SGPT	SGPT
Thyroid Stimulating Hormone	Thyroid Stimulating Hormone
ECG	Tread Mill Test (if < 55 years), 2D Echo (55 years or older)
	PSA (males only)
	Cervical Pap Smear (females only)
Age band > 55 years	
Health Assessment™ - MER (includes BP, BMI, HWR and smoking status) Fasting Blood Sugar Total Cholesterol	Health Assessment™ - MER (includes BP, BMI, HWR and smoking status) Fasting Blood Sugar Total Cholesterol
Urine Routine	Urine Routine
CBC with ESR	CBC with ESR
S. Creatinine	S. Creatinine
S. Albumin	S. Albumin
SGPT	SGPT
Thyroid Stimulating Hormone	Thyroid Stimulating Hormone
ECG	Tread Mill Test (if < 55 years), 2D Echo (55 years or older)
	PSA (males only)
	Cervical Pap Smear (females only)

Reference
MER - Medical Examiner's Report stamped and signed by an MD physician,
BMI - Body Mass Index,
HWR – Hip waist ratio
CBC - Complete Blood Count,
ESR – Erythrocyte sedimentation rate
ECG – Electrocardiogram,
S.Creat - Serum Creatinine,

Conditions

(i) The health check-ups will be arranged by Us only at Our Network Providers;
(ii) You can also avail the applicable tests according to your Age band and claim a reimbursement upto Rs 1000 under Essential Plan. Under Enhanced plan, you can claim a reimbursement upto Rs 1000 for Age band '< 45 years', and upto Rs 2500 for Age bands '45 to 55' and '> 55 years'.
(iii) The Insured Person will be eligible to avail a health check-up every Policy Year.
(iv) For calculation of Healthy Heart Score™ , tests under Health Assessment™ namely - MER (including BP, BMI, HWR and smoking status), Fasting Blood Sugar, Total Cholesterol will have to be carried out at one go (together) and at least once every Policy Year.
(v) Apart from the tests under Health Assessment™ mentioned under point iii) Insured Persons shall be entitled to avail the tests under the Health check-up program in one instance or at separate times during the Policy Year provided that the same test cannot be repeated during the same Policy Year.
(vi) If the Insured Person who has a covered chronic condition, has already undergone tests under Chronic Management Program within three months from date of availing this Benefit, then those specific tests shall not be permitted to be repeated under the Health Check-up Program in the same Policy Year.
(vii) Section C(A) (Permanent Exclusion 7), is not applicable in respect of coverage under this Benefit.
(viii) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider in relation to the health check-up.

(o) Recovery Benefit (Available for Enhanced Plan only)

What is covered

If the Insured Person is Hospitalized during the Policy Period for treatment of an Injury suffered due to an Accident where Hospitalisation continues for at least 10 consecutive days, then We will pay the lump sum amount specified in the Policy Schedule. This Benefit amount will not reduce the Sum Insured.

Conditions

This benefit is over and above the Sum Insured and is available only once per Insured Person, per Policy Year irrespective of Individual Policy or Family Floater Policy.

(p) Second E-Opinion on Critical Illnesses

What is covered

If an Insured Person is diagnosed with a Critical Illness during the Policy Period, the Insured Person may at his/her sole discretion choose to avail a E- opinion from Our panel of Medical Practitioners.

For the purpose of this Benefit, Critical Illness shall mean the following:

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

2. **MYOCARDIAL INFARCTION (First Heart Attack of specified severity)**
   - I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
     - i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
     - ii. New characteristic electrocardiogram changes
     - iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
   - II. The following are excluded:
     - i. Other acute Coronary Syndromes
     - ii. Any type of angina pectoris
     - iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. **OPEN CHEST CABG**
   - I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
   - II. The following are excluded:
     - i. Angioplasty and/or any other intra-arterial procedures

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

5. **COMA OF SPECIFIED SEVERITY**
   - I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
     - i. no response to external stimuli continuously for at least 96 hours;
     - ii. life support measures are necessary to sustain life; and
     - iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
   - II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

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

7. **STROKE RESULTING IN PERMANENT SYMPTOMS**
   - I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.
   - II. The following are excluded:
     - i. Transient ischemic attacks (TIA)
     - ii. Traumatic injury of the brain
     - iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. **MAJOR ORGAN/BONE MARROW TRANSPLANT**
   - I. The actual undergoing of a transplant of:
     - i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
     - ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
   - II. The following are excluded:
     - i. Other stem-cell transplants
     - ii. Where only islets of langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

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

10. MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS

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

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

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

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

(i) This Benefit can be availed by the Insured Person only once in the Policy Period for the same Critical Illness.
(ii) It is agreed and understood that the Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.
(iii) Appointments to avail of this Benefit may be availed through Our Website or Our mobile application or through calling Our call centre on the toll free number specified in the Policy Schedule.
(iv) Under this Benefit, We are only providing the Insured Person with access to an E-opinion and We shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.
(v) The opinion provided under this Benefit shall be limited to the covered Critical Illnesses and not be valid for any medico legal purposes.
(vi) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

(q) Worldwide Emergency Assistance Services (Available for Enhanced Plan only)

What is covered

We will provide the Emergency medical assistance as described below when an Insured Person is travelling 150 (one hundred and fifty) kilometres or more away from his/her residential address as mentioned in the Policy Schedule for a period of less than 90(ninety) days.

(1) Emergency Medical Evacuation: When an adequate medical facility is not available in the proximity of the Insured Person, as determined by the Emergency service provider, the consulting Medical Practitioner and the Medical Practitioner attending to the Insured Person, transportation under appropriate medical supervision will be arranged, through an appropriate mode of transport to the nearest medical facility which is able to provide the required care.
(2) Medical Repatriation (Transportation): When medically necessary, as determined by Us and the consulting Medical Practitioner, transportation under medical supervision shall be provided in respect of the Insured Person to the residential address as mentioned in the Policy Schedule, provided that the Insured Person is medically cleared for travel via commercial carrier, and provided further that the transportation can be accomplished without compromising the Insured Person's medical condition.

Conditions

(i) No claims for reimbursement of expenses incurred for services arranged by Insured Person will be allowed unless agreed by Us or Our authorized representative.
(ii) Please call Our call centre with details on the name of the Insured and/ or Policyholder and Policy number, on the toll free number specified in the Policy Schedule for availing this Benefit.

What is not covered

We will not provide services in the following instances:

(1) Travel undertaken specifically for securing medical treatment.
(2) Injuries resulting from participation in acts of war or insurrection.
(3) Commission of an unlawful act(s).
(4) Attempt at suicide.
(5) Incidents involving the use of drugs unless prescribed by a Medical Practitioner.
(6) Transfer of the Insured Person from one medical facility to another medical facility of similar capabilities which provides a similar level of care.
(7) Trips exceeding 90 days from residential address without prior notification to Us.

We will not evacuate or repatriate an Insured Person in the following instances:

(1) Without medical authorization.
(2) With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness which can be treated by local Medical Practitioner and do not prevent the Insured Person from continuing his/her trip or returning home.
(3) With a pregnancy beyond the end of the 28th week and will not evacuate or repatriate a child born while the Insured Person was traveling beyond the 28th week.
(4) With mental or nervous disorders unless Hospitalized.

Section III: Value Added Benefits

The Benefits listed below are in-built value added benefits and shall be available to all Insured Persons in accordance with the applicable Plan as specified in the Policy Schedule. Benefits under this Section are subject to the terms, conditions and exclusions of this Policy.

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

(r) Chronic Management Program (Available for Platinum Plan only)

What is covered

Under the Chronic Management Program, the Insured Person will be entitled to manage Medical Expenses for out-patient treatment of Diabetes, Hypertension, Hyperlipidemia and Asthma, as specified in the Policy Schedule,

(i) Medical Practitioner's consultations;
(ii) Diagnostic test;
(iii) Pharmacy expenses

These services can be availed at Our Network Providers and empanelled service providers (such as Outpatient clinics or Physicians / Diagnostic centres / Pharmacy Stores) on a Cashless basis.

In case the Insured Person wishes to obtain a Medical Practitioner's consultation on a reimbursement basis, then We will reimburse costs as specified in the Policy Schedule or Endorsement Schedule, up to the limit set for each, against original invoices supported with a Medical Practitioner's prescription for management of the medical condition(s). Original invoices of such consultations along with prescription from the Medical Practitioner can be submitted each month. We will settle such claims on a monthly basis.

If the Insured Person wishes to obtain medicines and consumables for the conditions listed on a reimbursement basis, then, we will reimburse costs as specified in the Policy Schedule or Endorsement Schedule, up to the limit set for each, against original invoices supported with a Medical Practitioner's prescription for management of the medical condition(s). Original invoices of medicines and consumables along with prescription from the Medical Practitioner can be submitted each month. We will settle such claims on a monthly basis.

If the Insured Person wishes to conduct the diagnostics tests for the conditions listed on a reimbursement basis, then, We will reimburse costs as specified in the Policy Schedule or Endorsement Schedule, up to the limit set for each, against original invoices for management of the medical condition(s). Original invoices tests along with the test reports done can be submitted each month. We will settle such claims on a monthly basis.

The list of such Network Providers and empanelled service providers will be updated from time to time and can be obtained from Our website or by calling Our call centre. We will assist in scheduling appointments for consultation and diagnostic tests at a time convenient to the Insured Person.
Alternatively the Insured Person may also schedule his/her own appointment themselves by contacting the Network Provider.

In addition, We will also cover the costs of the Insured Person's Alternative Treatment of these conditions, provided that Our prior approval is obtained on case to case basis for such event of treatment.

For ease of understanding broad definitions of covered Chronic conditions are as below:

(i) Asthma is a Chronic condition that affects the airways (bronchi) of the lungs, causing them to constrict (become narrow) when exposed to certain triggers which results in the symptoms of wheezing, coughing, tight chest and shortness of breath.

(ii) Hypertension is the term used to describe a persistent elevated blood pressure, commonly referred to as high blood pressure, and if this chronic disease is not treated appropriately, is a major risk factor for heart disease, stroke, kidney disease and even eye diseases.

(iii) Hyperlipidaemia is a chronic disease that refers to an elevated level of lipids (fats), including cholesterol and triglycerides, in the blood and if not treated appropriately, it is a major risk factor for increased risks of heart disease, heart attacks, strokes and other incidents of disease.

(iv) Diabetes mellitus is a chronic, progressive disease in which impaired insulin production leads to high blood glucose (sugar) levels, and without good self-management and proper treatment, the increased glucose (sugar) in the blood affects and damages every organ in the body, which causes serious health consequences

Eligibility to get benefit under the Chronic Management Program
The Insured Person will be eligible to avail the Benefits under the Chronic Management Program if either of one out of two conditions mentioned below is fulfilled:

1. <u>If the Insured Person has undergone a pre-Policy medical examination carried out before the Policy Start date:</u>
   (i) Based on the declarations and reports of the pre-Policy medical examination, if the Insured Person is found to be suffering from one or more chronic conditions, then We will manage such conditions from day 1 under the Chronic Management Program. In-patient Hospitalization for such conditions will be covered after 90 days from the Start of the Policy.
   (ii) In case the results of the pre-Policy medical examination indicates that the Insured Person does not have any such chronic conditions, then the Insured Person will be covered under the Chronic Management Program for if the Insured Person develops such conditions later in life.
   (iii) In case after the pre-Policy medical examination, the Insured Person is not detected with one or more aforementioned chronic conditions, but gets detected with other medical conditions, then coverage shall follow the general underwriting guidelines as specified in the Board approved underwriting policy.

2. <u>If the Insured Person chooses to undergo a Health Assessment™ carried out post the Start date :</u>
   (i) If the Insured Person did not undergo a pre-Policy medical examination, then to get the benefit under Chronic Management Program, the Insured Person must undergo a Health Assessment™ within 3months from the Start date. Health Assessment™ is a simple health exam that measures the Insured Person on the parameters of MER (including BP, BMI, HWR and smoking status), Fasting Blood Sugar and Total Cholesterol.
   (ii) If the results of the Health Assessment ™ indicate that the Insured Person does not have any of the aforementioned conditions, then the Insured Person will be entitled to avail the benefits under Chronic Management Program, if the Insured Person develops any such conditions later in life, without any waiting period.
   (iii) If the results of this Health Assessment ™ indicate that the Insured Person suffers from any of the aforementioned conditions then the Insured Person shall be entitled to avail the benefits under the Chronic Management Program, after 24 months of waiting period, provided that the detected chronic condition was not a Pre-Existing Disease, no additional premium shall be required to activate the benefits under the Chronic Management Program.
   (iv) If the Insured Person chooses not to undergo a Health Assessment™ within 3 months of the Policy Start date, a waiting period as per the opted plan shall be applicable for Chronic Management Program. After completion of the applicable waiting Period, if in case the Insured Person if found to be suffering from a covered chronic condition (through results of an Health Assessment™) then, We will activate Chronic Management Program, in respect of the Insured Person.
   This shall also be applicable in case of Portability cases that do not undergo Pre-Policy Medical Examination.

Chronic offering in case an Insured Person suffers from a combination of chronic conditions:

1. In case an Insured Person suffers from Diabetes or any combination of any of the covered chronic conditions, namely Diabetes, Asthma, Hypertension and Hyperlipidaemia, then the Insured Person will be charged the premium of a Diabetes plan with additional premium and as applicable for the particular combination. The Insured Person shall be managed under the Chronic Management Program as applicable for the particular combination.
2. In case an Insured Person suffers from Hypertension or any combination of any of the covered conditions apart from Diabetes, namely Hypertension, Asthma and Hyperlipidaemia, and such person does not suffer from Diabetes, then such Insured Person will be charged a premium for Hypertension management plan with additional premium as applicable for the particular combination. The Insured Person shall be managed under the Chronic Management Program as applicable for the particular combination.
3. In case an Insured Person suffers from Hyperlipidaemia, or from Asthma and Hyperlipidaemia , and such Person is not suffering from Diabetes or Hypertension, then the premium for the Hyperlipidaemia plan will be charged with additional premium as applicable for the particular combination. The Insured Person shall be managed under the Chronic Management Program as applicable for the particular combination.
4. In case an Insured Person suffers from Asthma, and such person is not suffering from Diabetes or Hypertension or Hyperlipidaemia or any combination of these, then the premium for the Asthma Chronic plan will be charged. The Insured Person shall be managed under the Asthma Chronic Management Program.

The coverage to the Insured Person under the Chronic Management Program during the Policy Period would be as eligible at the Start date. Any enhancement in the coverage due to further co-morbid conditions acquired by the Insured Person during the Policy Period would be effected only on Renewal subject to payment of additional premium as applicable. At the time of Renewal, no loading will be applied for such co-morbid conditions.

Note: Where an Insured Person purchases a Policy where he/she is suffering from an existing Chronic condition then he/she mandatorily will have to buy the Policy with Premium and loading (as applicable) for such condition. Deletion of coverage under Chronic Management Program for such condition shall not be allowed on subsequent Renewals of the Policy.

Conditions

(i) In order to avail Cashless Facilities benefits under this Program, the Insured Person is required to carry the health identification card issued by Us along with valid identity proof.

(ii) We shall retain the Insured Person's medical reports generated under this Program, subject to receipt of Your consent at the time of enrollment into the program, and a copy of the medical check-up reports shall be sent to You upon Your request.
(iii) In case a Person doesn't have a Chronic condition at the time of the first Health Assessment (done within 3 months of the Start date of the Policy) and eventually gets detected with a Chronic condition within 6 months of the Start date of the Policy or 6 months from the Policy anniversary, then the benefits under Chronic Management Program will be as specified in the Policy Schedule or Endorsement Schedule.
(iv) In case a Person doesn't have a Chronic condition at the time of the first Health Assessment (done within 3 months of the Start date of the Policy) and eventually gets detected with a Chronic condition after 6 months of the Start date of the Policy or after 6 months of the Policy anniversary, then the benefits under Chronic Management Program will be Prorated to such effect as specified in the Policy Schedule or Endorsement Schedule.
(v) In case a member is detected with a Chronic condition before the Start date of the Policy, then the member can only buy a Individual policy type, such member is not eligible for a floater policy.

(s) HealthReturns™

Ways of Earning HealthReturns™

1. Earned by way of a percentage of Premium through Healthy Heart Score™ and Active Dayz™ (Available for Platinum Plan only)

An Insured Person can earn HealthReturns™ by looking after his/her health, complying with Chronic Management Program (if applicable) and being physically active on a regular basis.

Step 1 – Complete Health questionnaire & Health Assessment™ (applicable for each individual Insured Person)- This is not applicable for individuals that have undergone pre-Policy medical examination before issuance of the Policy, for the first Policy Year.

(i) Complete the online health questionnaire through Our website or mobile application. If requested We would assist the Insured Person in completing the questionnaire over a call.
(ii) Undergo a Health Assessment™ that measures MER including BP, BMI, HWR and smoking status, Fasting Blood Sugar and Total Cholesterol. This is listed as a part of 'Health Check up Program' under Section B(II)(n), charges for which are borne by Us once a Policy Year.

Health Assessment ™ can be undertaken at Our Network Providers. An appointment for the medical examination can be scheduled at a time convenient to the Insured Person by calling Our call centre.

Based on the completed Health Assessment™, the Insured Person's test results will be used to calculate the Healthy Heart Score™. The Healthy Heart Score™ will then be used to identify which category the Insured Person's heart health falls in:

- Green: low risk of heart disease compared to peers in the same age and gender group.
- Amber: moderate risk of heart disease compared to peers in the same age and gender group – intervention will be beneficial.
- Red: high risk of heart disease compared to peers in the same age and gender group – immediate intervention is required.

The Healthy Heart Score™ is valid for 12 months, and will automatically be updated based on latest available test result if another Health Assessment™ is completed.

Charges for Health Assessment ™ as a part of 'Health Check up program' are borne by Us once a Policy Year. In case the Insured Person wants to undergo another Health Assessment™ at Our Network Providers, he/she can do so by payment of requisite charges at the Network Providers.

Conditions

For Healthy Heart Score™ to be calculated Health Assessment™ needs to be carried out each Policy Year.

Step 2 – Comply with Chronic Management program

If the Insured Person has been advised to follow specific treatments as part of the Chronic Management Program, then the Insured Person shall receive the monthly HealthReturns™ benefit, as long as the treatment protocols for that month specified by Us are complied with.

Step 3 – Earn Active Dayz™ by being physically active on an ongoing basis

(i) Active Dayz™ encourages and recognises all types of exercise/fitness activities by making use of activity tracking apps, devices and visits to the Fitness centre or yoga centres to track and record the activities members engage in.
(ii) One Active Dayz™ can be earned by:
  (1) completing a Fitness centre or yoga centre activity for a minimum of 30 minutes at Our panel of Fitness or yoga centers, OR;
  (2) Recording 10,000 steps in a day (tracked through Our mobile application or a wearable device linked to the Policy number) OR;
  (3) burning 300 calories in one exercise session per day OR;
  (4) participation in a recognized marathon/ walkathon/ cyclothon or a similar activity which offers a completion certificate with timing
(iii) In order to make it easier for the Insured Person to earn HealthReturns™, We provide two fitness assessments per Policy Year. These fitness assessments will measure the Insured Person's cardiovascular endurance, flexibility, strength, height to weight ratio and body fat percentage.
  The Insured Person will receive fitness assessment results based on his/her measurements.
(iv) The fitness assessment results will be valid for six months and the best of the fitness assessment result and number of Active Dayz™ will be used in a given month to calculate HealthReturns™.

'Active Dayz' can be earned by undertaking any one of the three activities under point (ii) or 'Fitness Assessment' under point (iii).
The Insured Person will earn HealthReturns™ based on the Healthy Heart Score™, the fitness assessment result and the number of Active Dayz™ recorded. HealthReturns™ is accrued on a monthly basis according to the following grid.

No of Active Dayz™ in a calendar month	OR	Fitness Assessment Result*	Healthy Heart Score™		
			Red	Amber	Green
13+		Level 5	6.0%	12.0%	30.0%
10 - 12		Level 4	3.6%	7.2%	18.0%
7 - 9		Level 3	2.4%	4.8%	12.0%
4 - 6		Level 2	1.2%	2.4%	6.0%
0 – 3		Level 1	0%	0%	0%

In order to achieve a particular level of HealthReturn™ You must achieve either the required number of Active Dayz™ or achieve a level (as shown in table above) under Fitness Assessment.

The grid above is calculated on the Monthly Premium. The Insured Person can earn up 30% of their Monthly Premium as HealthReturns™ based on the grid above.

How it works for a Family floater Policy
In case of a family floater policy, each Insured Person would be tracked separately and shall earn HealthReturns™ based on individual performance as per grid of Healthy Heart Score™ and Active dayz™. For the purpose of calculating HealthReturns™, We will allocate the overall premium to the adults in the Policy. The allocation ratio shall be 2:1 for Parents and Other Adults under the Policy. Weightages for allowed family combinations are as described in the table below.
(Family floater policy can cover maximum up to 6 Adults and 3 Children, however, dependent children upto 25 years are not eligible for HealthReturns™).

Family size	Weightage
Self , Spouse and Dependent Children (upto 25 yrs)	1:1:0:0
Self and Spouse	1:1
Self , Spouse and Parents	1:1:2:2
Self , Spouse and parents and Parents in –law	1:1:2:2:2:2

2. **Earned by way of Benefit for Hospital Room Choice (as per Section B(I)(I)).**
If the Insured Person chooses to avail admission in a Hospital room category that is lower than the eligible room category for that Insured Person then, We will apply allocated a percentage of the payable claims amounts into the HealthReturns™ account for the Insured Person

For Gold Plan - Total HealthReturns™ in a Policy Year shall be total of
- Benefit for Hospital Room Choice

For Platinum Plan - Total HealthReturns™ in a Policy Year shall be total of
- Percentage of Premium earned through Healthy Heart Score and Active Dayz™
- Benefit for Hospital Room Choice

Earned HealthReturns™ can be utilized by any covered member under a Policy.

How can one spend HealthReturns™:
Funds under HealthReturns™ may be utilized for:
(i) In-patient Medical Expenses and Day Care Treatment, provided that the Sum Insured, Cumulative Bonus and Reloaded Sum Insured (if applicable) are exhausted during the Policy Year.
(ii) Payment of Co-payment and Deductible (wherever applicable).
(iii) For non payable claims, in case of an In-patient Hospitalization or Day Care Treatment.
(iv) Non-Medical expenses under listed in Annexure I 'Non Medical Expenses' that would not otherwise be payable under the Policy.
(v) Out-patient expenses up to the value of accrued funds, subject to complete utilization of OPD Expenses (if opted under the Policy).
(vi) Alternative Treatments.

Reimbursement claims for (v) and (vi) can be submitted quarterly in a Policy Year.

Alternatively funds can also be utilized to pay premium from 1st Renewal of the Policy.
Funds earned as HealthReturns™, once earned can be carried forward each month/ each Policy Year (as applicable) and as long as the Policy is Renewed with Us in accordance with the Renewal Terms under the Policy.

Permanent Exclusions and Waiting Periods do not apply under this Benefit.
Please refer to Annexure II: Illustration of Benefits, Section A for details on this benefit.
If You wish to know the present value of the funds earned as HealthReturns™, then You may contact Us at our toll free number or through Our website. In any event, We shall send You an updated statement of the funds earned as HealthReturns™ on an Yearly basis or any other notifications/communication required to be sent hereunder on your registered email ID.

(t) Wellness Coach:
What is covered
In order to educate, empower and engage Insured Persons to become more aware of their health and proactively manage it, each Insured Person shall have access to wellness coaching in areas such as:
(i) Weight management
(ii) Activity and fitness
(iii) Nutrition
(iv) Tobacco cessation
These coaches will be available as a chat service on Our mobile application and website or as a call back service.

It is agreed and understood that Our Wellness coaches are not providing and shall not be deemed to be providing any Medical Advice, they shall only provide a suggestion for the Insured Person's consideration and it is the Insured Person's sole and absolute choice to follow the suggestion for any health related advice.

(v) Doctor on call
Upon the Insured Person's request, We shall also provide access to a general Medical Practitioner, available as a chat service on Our mobile application and website or as a call back service.

We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this benefit.

Section IV: Optional Covers

The Benefits listed below are optional additional benefits and shall be available to the Insured Person only if the additional premium has been received and the Benefit is specified to be in force for that Insured Person in the Policy Schedule. Benefits under this Section are subject to the terms, conditions and exclusions of this Policy and in accordance with the applicable Plan as specified in the Policy Schedule.

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

In case of Individual Policy, each individual Insured Person can opt for any of the below optional covers as per their requirements. In case of Family Floater Policy, once selected, the optional covers shall apply to all Insured Persons without any individual selection.

Claims under this Section IV will not impact the Sum Insured unless specified otherwise in the Policy.

(u) OPD Expenses

What is covered

We will cover costs incurred for medically necessary consultations, diagnostic tests and pharmacy expenses on an out-patient basis upto the amount specified in the Table of Benefits and Policy Schedule. Appointments can be scheduled through Our website or the mobile application; You can also call Our contact center toll free number specified in the Policy Schedule for scheduling an appointment.

We will cover the following expenses:

(i) Outpatient consultations by a general Medical Practitioner/ specialist Medical Practitioner where for every consultation, We will cover: up to a maximum of 10% of the limit specified in the Table of Benefits and Policy Schedule for OPD Expenses.
(ii) Out-patient diagnostic tests and/or medicines purchased from a pharmacy as – prescribed by a general Medical Practitioner/ specialist Medical Practitioner in writing up to a maximum of 50% of the limit specified in the Table of Benefits and Policy Schedule for OPD Expenses.
(iii) Outpatient diagnostic procedures in case of road traffic Accident as prescribed by a General Medical Practitioner/ Specialist Medical Practitioner in writing to a maximum of Rs.10,000 over and above the OPD Limit as specified in the Table of Benefits and Policy Schedule

These services can be availed at Our Network Providers and empanelled service providers (such as Outpatient clinics or Physicians / Diagnostic centres / Pharmacy Stores) on a Cashless basis.
Reimbursement claims can be submitted quarterly in a Policy year.

If in a Policy Year an Insured Person does not utilize the complete limit under OPD Expenses, then the unutilized amount will be carried forward to the subsequent Policy Year, if the Policy has been Renewed with Us continuously without any break and shall be available for utilization within 12 months of such carry forward only. However, such carry forward is not applicable for unutilized limit for Road Traffic Accident Diagnostic as specified in the Table of Benefits and Policy Schedule

OPD Bonus on Unutilized OPD Expenses

We will add a OPD Bonus of 5% to the unutilized OPD Expenses at the end of the Policy Year, if OPD Expenses have not been utilized completely by the Insured Person in the expiring Policy Year, provided that:

(i) This OPD Bonus will apply even if claims under other Benefits have been made under the Policy;
(ii) This OPD Bonus will be calculated based on the unutilised OPD Expenses, irrespective of any change in the Sum Insured or OPD Expenses opted in.
(iii) This OPD Bonus on the unutilized OPD Expenses limit shall not apply in case the Policy is not renewed within the Grace Period.
(iv) This OPD Bonus is not applicable on unutilized limit for Road Traffic Accident Diagnostic

Unutilized OPD Expenses along with earned OPD Bonus shall be carried forward to the subsequent Policy Year, if the Policy has been is Renewed with Us continuously without any break and shall be available for utilization within 12 months of such carry forward only. Unutilized OPD Expenses along with earned OPD Bonus shall not be carried forward, if the Policy has not been Renewed with Us continuously without any break.

Permanent exclusions and waiting periods do not apply in respect of this Benefit.

Conditions

Benefits under this Section shall be available on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule for an Individual Policy and Family Floater Policies. The limit for OPD Expenses for each Insured Person(s) covered under this Policy shall remain the same in case of a family floater policy.

(v) Deductible

What is covered

The Deductible specified in the Policy Schedule shall be applicable in each Policy Year on the aggregate of all admissible claims in that Policy Year.
Wherever a Deductible option is selected, such deductible amount will be applied on each Policy Year on the aggregate of all admissible claims in that Policy Year.

Conditions

(i) The Deductible shall not apply on claims under Section B(II), B(III), and B(IV).
(ii) The applicable Deductible shall be applied separately and on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule for an Individual Policy and shall be available on a floater basis for all eligible Insured Persons up to the limits specified in the Policy Schedule for Family Floater Policies.

(w) Maternity Expenses

i. Maternity Expenses:

What is covered

Where Maternity Expenses is opted as an Optional Cover under this Policy, We will cover Maternity Expenses up to the Maternity Sum Insured specified in the Policy Schedule after a waiting period of 48 months from the inception of the 1st Policy where Maternity Expenses option is selected, if Renewed with Us continuously without any break and Maternity Expenses has been opted continuously as an Optional Cover under this Policy, for the delivery of a child and/ or Maternity Expenses related to a Medically Necessary Treatment and lawful medical termination of pregnancy up to a maximum of 2 events including (a) 2 deliveries (including twins) or (b) 2 terminations or (c) 1 delivery (including twins) and 1 termination during the lifetime of an Insured Person between the Ages of 18 years to 45 years where the mother is the Insured Person.

Coverage under this Benefit shall include:

(i) Medical Expenses for a delivery of a child (including caesarean section) or lawful medical termination of pregnancy
(ii) Pre or post natal Maternity Expenses;
(iii) Any claim under this benefit shall not impact the Opted Sum Insured or Cumulative Bonus.
(iv) Ectopic pregnancy shall not be covered under this Benefit, but any claims will be considered under In-patient Treatment under Section B(I)(a);

Conditions

- This benefit is available for You or Your spouse provided You and Your spouse, both are covered under the same Policy for a continues period of 48 months.
- Our maximum liability per pregnancy will be subject to the limits specified in the policy Schedule.

What is not covered

(i) Medical expenses for ectopic pregnancy. However, these expenses will be covered under In-patient Treatment under Section B(I)(a);.
(ii) Any Pre-hospitalization Medical Expenses or Post – hospitalization Medical Expenses under Section B(I)(b) and (c), above will not be covered under this Benefit,
(iii) Any Reloaded Sum Insured will not be available for coverage under this Benefit.

Note: Section C(A) (Permanent Exclusion 27), is not applicable if this Benefit is in force.

ii. New Born Baby Expenses

What is covered

We cover Medical Expenses towards the treatment of the New Born Baby as an In-patient, up to the limit of the Maternity Sum Insured, while

the Insured Person is Hospitalised as an in-patient for delivery, subject to a valid claim being accepted under Maternity Expenses.

(i) This would include in-patient hospitalisation expenses incurred on the New Born Baby while the Insured Person is Hospitalised as an in-patient for delivery.

(ii) Charges incurred on the New Born Baby during and post birth up to 90 days from the date of delivery, within the limits of Maternity Expenses.

(iii) A New Born Baby beyond 90 days can be covered under the Policy by way of an endorsement or at the next Renewal whichever is earlier, on payment of requisite premium.

Conditions

Any Reloaded Sum Insured will not be available for coverage under this Benefit

Maternity Expenses means:

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

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

New Born Baby means baby born during the Policy Period and is aged upto 90 days.

iii. Vaccination Expenses

What is covered

We will cover vaccination expenses listed below of a New Born Baby from birth to until the New Born Baby completes two years.

	Name of Vaccine	Time to be given
1	Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed	6wks, 10wks, 14wks; 16-18months;
2	Varicella Vaccine, live attenuated	15months,
3	Human Rotavirus Vaccine, Live Attenuated	6wks, 10wks, 14wks
4	Combined Measles, Mumps, and Rubella Vaccine (live attenuated)	9months, 15months,
5	BCG Vaccines	At Birth,
6	OPV	At Birth, 6months, 9months
7	Hepatitis B	At Birth, 6wks, 6months.
8	Haemophilus influenzae type b Vaccine (Hib)	6wks, 10wks, 14wks; 16-18months
9	Inactivated Hepatitis A virus Vaccine	12months, 18months.
10	Pneumococcal Polysaccharide and Non-Typeable Haemophilus influenzae (NTHi) Protein D Conjugate Vaccine, Adsorbed	14wks, 15months
11	Typhoid	9-12months, 18-2yrs.
12	IPV	6wks, 10wks, 14wks,

Conditions

i. Coverage will be subject to claims admitted under Maternity Expenses cover and will be up to the limits of Maternity Sum Insured.

ii. Vaccination expenses will be covered only if the Insured Person whose maternity claim has been accepted by Us continues to Renew the Policy with Us during the period. Reimbursement claims for vaccination expenses can be submitted quarterly in a Policy Year.

iii. Section C (A) (Permanent Exclusion 15), is not applicable if this Benefit is in force.

iv. Benefits under this Section shall be available separately and on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule for an Individual Policy and shall be available on a floater basis for all eligible Insured Persons up to the limits specified in the Policy Schedule for Family Floater Policies.

iv. Stem cell preservation

What is covered

We will cover onetime Medical Expenses up to the limit specified in the Policy Schedule towards the harvesting and storage of stem cells of the New Born Baby.

Conditions

i. The harvesting and storage of the stem cells of the New Born Baby is carried out as a preventive measure against possible future Illnesses.

ii. The stem cells of the New Born Baby are preserved in an India based Stem Cell Bank only.

iii. The payment under this Benefit is subject to a valid claim being accepted by Us under Maternity Expenses under section B(IV)(w)(i).

iv. The coverage under this Benefit will be over and above the Maternity Expenses limit, and up to the limits specified in the Policy Schedule and Table of Benefits.

v. We shall be covering stem cell preservation for a maximum upto 2 New Born Baby(s) during the lifetime of an Insured Person.

(x) Hospital Cash Benefit

What is covered

We will pay the Hospital Cash Benefit specified in the Policy Schedule, for each continuous and completed period of 24 hours of Hospitalisation, during the Policy Period for treatment of an Illness or Injury.

This Benefit shall be payable for a maximum limit of 30 days in a Policy Year and 10 days for each claim.

Conditions

(i) A deductible of 24 hours shall apply under this Benefit, thus the benefits shall become payable only after the completion of the first 24 hours of Hospitalization of the Insured Person.

(ii) Benefits under this Section shall be available on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule irrespective of the type of Policy.

(iii) Claim under this Benefit shall be payable only if in-patient claim has been settled by Us under this Policy under Section B(I)(a).

Please refer to the Annexure II 'Illustration of Benefits' for details on Hospital Cash Benefit.

(y) Waiver of Mandatory Co-payment (Applicable for Essential Plan only)

What is covered

If this Benefit is in force, the applicable Mandatory Co-payment under Essential Plan shall not apply on payable claims under the Policy.

Section C. Terms and Conditions

A. Waiting periods and Permanent Exclusions

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by or arising out of or howsoever attributable to any of the following. All waiting periods and permanent exclusions shall apply individually for each Insured Person and claims shall be assessed accordingly.

i. First 30 days waiting period
Any treatment taken during the first 30 days of the commencement of the Policy shall not be covered under the Policy, unless the treatment is required as a result of an Accident that occurs during the Policy Period. This waiting period does not apply for any Insured Person that is accepted under Portability and for subsequent and continuous Renewals of the Policy with Us.

ii. Two Year waiting periods
A waiting period of 24 months from Start date shall apply to the treatment, whether medical or surgical and of the Illness/conditions and their complications mentioned below:

	Body System	Illness	Treatment/ Surgery
1	Eye	Cataract	Cataract Surgery
		Glaucoma	Glaucoma Surgery
2	Ear Nose Throat	Serous Otitis Media	
		Sinusitis	Sinus Surgery
		Rhinitis	Surgery for the nose
		Tonsillitis	Tonsillectomy
		Tympanitis	Tympanoplasty
		Deviated Nasal Septum	Surgery for Deviated Nasal Septum
		Otitis Media	Surgery or Treatment for Otitis Media
		Adenoiditis	Adenoidectomy
		Mastoiditis	Mastoidectomy
		Cholesteatoma	Resection of the Nasal Concha
3	Gynecology	All Cysts & Polyps of the female genito urinary system	Dilatation & Curettage
		Polycystic Ovarian Disease	Myomectomy
		Uterine Prolapse	Uterine prolapsed Surgery
		Fibroids (Fibromyoma)	Hysterectomy unless necessitated by malignancy
		Breast lumps	Any treatment for Menorrhagia
		Prolapse of the uterus	
		Dysfunctional Uterine Bleeding (DUB)	
		Endometriosis	
		Menorrhagia	
		Pelvic Inflammatory Disease	
4	Orthopedic / Rheumatological	Gout	Joint replacement Surgery Surgery for Prolapse of the intervertebral disc
		Rheumatism, Rheumatoid Arthritis	
		Non infective arthritis	
		Osteoarthritis	
		Osteoporosis	
		Prolapse of the intervertebral disc	
		Spondylopathies	
5	Gastroenterology (Alimentary Canal and related Organs)	Stone in Gall Bladder and Bile duct	Cholestectomy / Surgery for Gall Bladder
		Cholecystitis	Surgery for Ulcers (Gastric / Duodenal)
		Pancreatitis	
		Fissure, Fistula in ano, hemorrhoids (piles), Pilonidal Sinus, Ano-rectal & Perianal Abscess	
		Rectal Prolapse	
		Gastric or Duodenal Erosions or Ulcers + Gastritis & Duodenitis	
		Gastro Esophageal Reflux Disease (GERD)	
		Cirrhosis	
6	Urogenital (Urinary and Reproductive system	Stones in Urinary system (Stone in the Kidney, Ureter, Urinary Bladder)	Prostate Surgery
		Benign Hypertrophy / Enlargement of Prostate (BHP / BEP)	
		Hernia, Hydrocele,	Surgery for Hydrocele, Rectocele and Hernia
		Varicocoele / Spermatocoele	Surgery for Varicocoele / Spermatocoele
7	Skin	Skin tumour (unless malignant)	Removal of such tumour unless malignant
		All skin diseases	
8	General Surgery	Any swelling, tumour, cyst, nodule, ulcer, polyp anywhere in the body (unless malignant)	Surgery for cyst, tumour, nodule, polyp unless malignant

		Varicose veins, Varicose ulcers	Surgery for Varicose veins and Varicose ulcers
		Congenital Internal Diseases or Anomalies	

If any of the Illness/conditions listed above are Pre-Existing Diseases, then they will be covered only after the completion of the Pre-Existing Disease Waiting Period described below.

iii. Chronic Management Program Waiting Period

a. Where the Insured Person has under gone a Health Assessment™ (undergone within 3 months from the Policy Start date) and the results of the Health Assessment™ indicate that the Insured Person is suffering from a chronic condition, then a waiting Period of 24 months shall be applicable from the Start date of the Policy in respect of the Insured Person for Chronic Management Program. However Hospitalization related to these conditions will be covered after a Waiting Period as specified in section C (A) (I)

b. If the results of the Health Assessment™ indicate that the Insured Person does not have any of the aforementioned conditions, then the Insured Person will be entitled to avail the benefits under Chronic Management Program, if the Insured Person develops any such conditions later in life, without any waiting period. However Hospitalization related to these conditions will be covered after a Waiting Period as specified in section C (A) (I)

c. In case the Insured Person doesn't undergo a Health Assessment™ within 3 months from the Policy Start date, then a Waiting Period as applicable under the Plan in force is applicable in respect of the Insured Person for Chronic Management Program. However Hospitalization related to these conditions will be covered after a Waiting Period as specified in section C (A) (I)

d. Where the Insured Person has undergone a pre-Policy medical examination and is found to be suffering from a covered chronic condition under the policy, Chronic Management Program shall be available from day 1 for such condition(s). However Hospitalization related to these conditions will be covered after a Waiting Period of 90 days.

iv. Pre-Existing Disease waiting Period

All Pre-Existing Diseases shall not be covered until the time period specified in the Policy Schedule in this regard has elapsed since the inception of the first Policy with Us. In case of Portability, waiting period shall be reduced to the extent of previous Sum Insured and accrued Cumulative Bonus (if earned), and shall not apply to any other additional increased Sum Insured.

Pre-Existing Disease means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter..

v. Maternity Waiting Period

Any treatment arising from or traceable to pregnancy, childbirth including caesarean section will not be covered until 48 months of continuous coverage has elapsed for that particular Insured Person since the inception of the Maternity Expenses Benefit under the Policy for that Insured Person.

vi. Permanent Exclusions:

1. Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, uprising, revolution, insurrection, military or usurped acts, nuclear weapons / materials, chemical and biological weapons, ionizing radiation, contamination by radioactive material or radiation of any kind, nuclear fuel, nuclear waste.
2. An Insured Person committing or attempting to commit a breach of law with criminal intent, intentional self Injury or attempted suicide while sane or insane.
3. Willful or deliberate exposure to danger, intentional self Injury, non adherence to Medical Advice, participation or involvement in naval, military or air force operation, circus personnel, racing in wheels or horseback, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing, bungee jumping, parasailing, ballooning, skydiving, river rafting, polo, snow and ice sports in a professional or semi professional nature.
4. Abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services, or supplies.
5. Weight management programs or treatment in relation to the same including vitamins and tonics, treatment of obesity (including morbid obesity).
6. Treatment for correction of eye sight due to refractive error including routine examination.
7. All routine examinations and preventive health check-ups.
8. Cosmetic, aesthetic and re-shaping treatments and surgeries.
   Plastic Surgery or cosmetic Surgery or treatments to change appearance unless medically necessary and certified by the attending Medical Practitioner for reconstruction following an Accident, cancer or burns.
9. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment); aesthetic or change-of-life treatments of any description such as sex transformation operations.
10. Non allopathic treatment.
11. Conditions for which treatment could have been done on an outpatient basis without any Hospitalization
12. Experimental, investigational or Unproven Treatment devices and pharmacological regimens.
13. Admission primarily for diagnostic purposes not related to Illness for which Hospitalization has been done.
14. Convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care.
15. Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing.
16. Admission for enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
17. Hearing aids, spectacles or contact lenses including optometric therapy, multifocal lens
18. Treatment for alopecia, baldness, wigs, or toupees, and all treatment related to the same.
19. Medical supplies including elastic stockings, diabetic test strips, and similar products.
20. Any expenses incurred on prosthesis, corrective devices external durable medical equipment of any kind, like wheelchairs crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively. Cost of artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively).
21. Psychiatric or psychological disorders, mental disorders (including mental health treatments), Parkinson and Alzheimer's disease, general debility or exhaustion ("rundown condition"), sleep-apnea, stress.
22. Congenital external diseases, defects or anomalies, genetic disorders.
23. Stem cell therapy or Surgery, or growth hormone therapy.
24. Venereal disease, all sexually transmitted disease or Illness including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
25. "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus) including but not limited to conditions related to or arising out of HIV/AIDS such as ARC (AIDS Related Complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis.
26. Complications arising out of Pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or birth (including caesarean section) except in the case of ectopic pregnancy for in-patient only.
27. Treatment for sterility, infertility, sub-fertility or other related conditions and complications arising out of the same, assisted conception, surrogate or vicarious pregnancy, birth control, and similar procedures contraceptive supplies or services including complications arising due to supplying services.

28. Expenses for organ donor screening, or save as and to the extent provided for in the treatment of the donor (including Surgery to remove organs from a donor in the case of transplant Surgery).
29. Admission for Organ Transplant but not compliant under the Transplantation of Human Organs Act, 1994 (amended)
30. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.
31. Dentures and artificial teeth, Dental Treatment and Surgery of any kind, unless requiring Hospitalization due to an Accident.
32. Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose.
33. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.
34. Treatment for developmental problems, learning difficulties eg. Dyslexia, behavioral problems including attention deficit hyperactivity disorder (ADHD).
35. Treatment for Age Related Macular Degeneration (ARMD) , treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.
36. Expenses which are medically not necessary such as items of personal comfort and convenience including but not limited to television (if specifically charged), charges for access to telephone and telephone calls (if specifically charged), food stuffs (save for patient's diet), cosmetics, hygiene articles, body care products and bath additives, barber expenses, beauty service, guest service as well as similar incidental services and supplies, vitamins and tonics unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
37. Treatment taken from a person not falling within the scope of definition of Medical Practitioner.
38. Treatment charges or fees charged by any Medical Practitioner acting outside the scope of license or registration granted to him by any medical council.
39. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, except if pre-approved by Us.
40. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.
41. Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing, including MRD charges (medical records department charges).
42. Non-Medical Expenses including but not limited to RMO charges, surcharges, night charges, service charges levied by the Hospital under any head and as specified in the Annexure for Non- Medical Expenses.
43. Treatment taken outside India
44. Insured Person whilst flying or taking part in aerial activities except as a fare-paying passenger in a regular scheduled airline or air charter company.

B. Underwriting and Loadings

i. We may apply a risk loading on the premium payable (excluding statutory levies and taxes) based on the details of the Insured Persons, including the health status, habits and lifestyle, past medical records, declarations on the Proposal Form and the results of the pre-Policy medical examination.
ii. The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis or medical condition per Insured Person. Loadings will be applied from Start date of the first Policy including subsequent Renewal. There will be no loadings based on individual claims experience.
iii. We will inform You about the applicable risk loading or special condition through a counter offer letter and We will only issue the Policy once We receive your consent and applicable additional premium. In case, You neither accept the counter offer nor revert to Us within 10 working days, We shall cancel Your application and refund the premium paid.
iv. Your Policy shall not be issued unless We receive Your consent.
v. Following loadings may be applied on the Policy for the medical conditions listed below if they are accepted at the time of underwriting as well as on Renewals.

Conditions/ Ailments	**Amount**
Iron Deficiency Anemia (in absence of Heart complications)	0 to 10%
Smoking	0 to 15%
Benign Prostatic Hyperplasia (BPH)	0 to 10%
Stone/Calculus in the urinary system (including kidney stone, ureteric stone or urinary bladder stone)	0 to 20%
Stones in the gall bladder	0 to 20%
Stones in the biliary system	0 to 20%
Hernia of all types	0 to 20%
Acid peptic disease / Peptic ulcer Disease	0 to 10%
Gastro Esophageal Reflux Disease (GERD)/Reflux esophagitis	0 to 10%
Cataract (not operated)	0 to 15%
Deviated Nasal Septum, Nasal Polyps	0 to 20%
Epilepsy	0 to 15%
Anal fissure	0 to 15%
Fistula-in-ano	0 to 15%
Hemorrhoids (Piles)	0 to 20%
Hydrocele	0 to 20%
Fibroadenoma Breast (non cancerous)	0 to 20%
Fibroids (Uterus)	0 to 15%
Ovarian Cysts	0 to 15%
Poliomyelitis	0 to 5%
Tuberculosis	0 to 15%
Perforated tympanic membrane	0 to 15%
Varicose Veins	0 to 15%

Hyperthyroidism (in absence of heart complications and thyrotoxic crisis)	0 to 15%
Hypothyroidism (in absence of heart complications and Myxoedema)	0 to 15%
Hyperlipidemia (Total Cholesterol > 250 but up to 300 mg/dl)*	0 to 10%
Hyperlipidemia (Serum Trigylcerides > 200 but up to 500 mg/dl)*	0 to 10%
Total Cholesterol > 300 mg/dl (applicable for Gold plan only)	0 to 15%
Serum Triglycerides > 500 mg/dl (applicable for Gold plan only)	0 to 15%
Diabetes Mellitus (applicable for Gold plan only)	0 to 20%
Hypertension (applicable for Gold plan only)	0 to 20%
Asthma (applicable for Gold plan only)	0 to 15%

Note:
a. If the Total Cholesterol is higher than 300 mg/dl, the prospect will be offered a Chronic Management Program for Hyperlipidemia
b. If Serum Triglycerides is higher than 500 mg/dl, the prospect will be offered a Chronic Management Program for Hyperlipidemia
c. If the above two conditions co-exist, the Insured Person will be offered a Chronic Management Program for Hyperlipidemia

C. Claims Administration & Process

The fulfillment of the terms and conditions of this Policy (including payment of premium in full and on time) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the following in relation to claims, shall be conditions precedent to admission of Our liability under this Policy:

(1) On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed.
(2) The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payments that are brought about or contributed to as a consequence of or failure to follow such directions, advice or guidance.
(3) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalisation records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
(4) We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

I. Claims Procedure

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

a. For Availing Cashless Facility

i. Cashless Facilities can be availed only at Our Network Providers. The complete list of Network Providers is available on Our website and at Our branches and can also be obtained by contacting Us over the telephone.
ii. We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities at Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers.

b. Process for Obtaining Pre-Authorisation for Planned Treatment:

(i) We must be contacted to pre-authorise Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Each request for pre-authorisation must be accompanied with all the following details:
(1) The health card We have issued to the Insured Person supported with the Insured Person's KYC documents.
(2) The Policy Number;
(3) Name of the Policyholder;
(4) Name and address of Insured Person in respect of whom the request is being made;
(5) Nature of the Illness/Injury and the treatment/Surgery required;
(6) Name and address of the attending Medical Practitioner;
(7) Hospital where treatment/Surgery is proposed to be taken;
(8) Proposed date of admission.

(ii) If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.
(iii) When we have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim, applicable Deductibles and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.
(iv) The Authorization letter shall be issued to the Network Provider within 24 hours of receiving the complete information.

c. Process to be followed for Availing Cashless Facilities in Emergencies:

(i) We must be contacted to pre-authorise Cashless Facility within 24 hours of the Insured Person's Hospitalization if the Insured Person has been Hospitalized in an Emergency. Each request for pre-authorisation must be accompanied with all the following details:
(1) The health card We have issued to the Insured Person supported with the Insured Person's KYC documents.
(2) The Policy Number;
(3) Name of the Policyholder;
(4) Name and address of Insured Person in respect of whom the request is being made;
(5) Nature of the Illness/Injury and the treatment/Surgery required;
(6) Name and address of the attending Medical Practitioner;
(7) Hospital where treatment/Surgery is proposed to be taken;
(8) Proposed date of admission.

(ii) If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.
(iii) When we have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim, applicable Deductibles and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.
(iv) Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, Hospital and locations, match with the details of the actual treatment received. For Hospitalization where Cashless Facility is pre-authorised by Us, We will make the payment of the amounts assessed to be due directly to the Network Provider.
(v) The Authorization letter shall be issued to the Network Provider within 24 hours of receiving the complete information.

d. For Reimbursement Claims:

(i) For all claims for which Cashless Facilities have not been pre-authorised or for which treatment has not been taken at a Network Provider, We shall be given written notice of the claim along with the following details within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier:
(1) The Policy Number;
(2) Name of the Policyholder;
(3) Name and address of the Insured Person in respect of whom the request is being made;
(4) Health Card, Photo ID, KYC documents
(5) Nature of Illness or Injury and the treatment/Surgery taken;
(6) Name and address of the attending Medical Practitioner;
(7) Hospital where treatment/Surgery was taken;
(8) Date of admission and date of discharge;
(9) Any other information that may be relevant to the Illness/ Injury/ Hospitalization

(ii) If the claim is not notified to Us within the earlier of 48 hours of the Insured Person's admission to the Hospital or before the Insured Person's discharge from the Hospital, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

II. Claims Documentation:

We shall be provided the following necessary information and documentation in respect of all Claims at Your/Insured Person's expense within 30 days of the Insured Person's discharge from Hospital:

(i) Claims for Pre-hospitalisation Medical Expenses and Post Hosptialisation Medical Expenses to be submitted to us within 30 days of the completion of the post hospitalisation treatment

(ii) For those claims for which the use of Cashless Facility has been authorised, We will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:
(1) Duly completed Claim Form
(2) Photo ID & Age Proof
(3) Original Discharge Card / Day Care Summary / Transfer Summary
(4) Original final Hospital Bill with all original Deposit & Final Payment Receipt
(5) Original Invoice with Payment receipt & implant Stickers for all Implants used during Surgeries i.e. Lens Sticker & Invoice in Cataract Surgery, Stent Invoice & Sticker in Angioplasty Surgery.
(6) Treating Medical Practitioner letter stating:
a) Presenting complaints with duration & past history
b) Medical history of Co-morbidities e.g. Hypertension, Heart ailment etc.
c) Treatment detail with name of drugs & route of administration
(7) All previous consultation papers indicating history & treatment details for current ailment
(8) All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription & invoice / bill with receipt from diagnostic center
(9) All Original Medicine / Pharmacy Bills along with Medical Practitioner's prescription
(10) MLC / FIR Copy – in Accidental Cases Only
(11) Copy of Death Summary & Copy Death Certificate (in Death Claims Only)
(12) Treating Medical Practitioner letter stating – in Accidental Cases Only
a) Details of Accident/trauma
b) whether patient was under the influence of alcohol or any intoxicating substance during incident / Accident
(13) Pre & Post Operative Imaging reports – in Accidental Cases Only
(14) Copy of Indoor case papers with nursing sheet detailing medical history of the patient, treatment details, & patient's progress
(15) KYC documents

Additional documents in case of below covers

In case of Contribution claims:

- Photocopy of entire claim document duly attested by previous Insurer or TPA
- Original payment receipts for expenses not claimed/settled by previous insurer
- Discharge voucher/settlement letter by previous insurer

OPD Expenses:

(i) Doctor Consultation
(1) Duly filled claim form
(2) Original prescription from treating general Medical Practitioner / specialist Medical Practitioner
(3) Original invoice and payment receipt

(ii) Diagnostics
(1) Duly filled claim form
(2) Original investigation report(s)
(3) Original invoice and payment receipt
(4) Medical Practitioner's advice for such investigation / diagnostic test
(5) Copy of Police Report in case of Road Traffic Accident

(iii) Pharmacy
(1) Duly filled claim form
(2) Original invoice and payment receipt
(3) Copy of prescription from treating Medical Practitioner

Road Ambulance Cover:

(i) Photocopy of discharge card
(ii) Original Ambulance invoice & paid receipt

Hospital Cash Benefit & Recovery Benefit

(i) Photocopy of all the Hospitalization documents:-Discharge card, indoor case papers will be sought depending upon the requirement to ascertain the genuineness of claim
(ii) Any other document as per the check list for Hospitalization / In patient claims in order to ascertain the genuineness of claim

Vaccination Cover:

(i) Duly filled & signed claim form
(ii) Original Prescription from treating Medical Practitioner
(iii) Original Invoice for Vaccination and payment receipt

Stem cell preservation benefit
(i) Copy of stem cell banking receipt
(ii) Procedure note / confirmation of successful preservation of stem cells

III. Claims Assessment & Repudiation:

(a) At Our discretion, We may investigate claims to determine the validity of a claim. This investigation will be conducted within 15 days of the date of assigning the claim for investigation and not later than 6 months from the date of receipt of claim intimation. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals/entities that are authorised by Us in writing. If there are any deficiencies in the necessary claim documents which are not met or are partially met. We will send a maximum of 3 (three) reminders following which We will send a rejection letter or make apart-payment if we have not received the deficiency documents after 45 days from the date of the initial request for such documents.
(b) We may decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if We observe that such a claim is otherwise valid under the Policy. However documents/ details received beyond such period shall be considered if there are valid reasons for any delay.
(c) We shall settle or repudiate a claim within 30 days of the receipt of the last necessary information and documentation set out above. In case of any suspected fraud, the last "necessary" document will include the receipt of the investigation report from Our investigator/representatives.
(d) Payment for reimbursement claims will be made to You. In the unfortunate event of Your death, We will pay the Nominee named in the Policy Schedule or Your legal heirs or legal representatives holding a valid succession certificate.
(e) In case of delay in payment, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us.
For details on the claims process or assistance during the process, You may contact Us at Our call centre on the toll free number specified in the Policy Schedule or through the website. In addition, We will keep You informed of the claim status and explain requirement of documents. Such means of communication shall include but not be limited to mediums such as letters, email, SMS messages, and information on Our Website.

D. Portability & Continuity Benefits

You can port your existing health insurance Policy from another company to Us, provided that:
(i) You have been covered under an Indian health insurance policy from a non-life insurance company or Health Insurance company registered with IRDAI without any break;
(ii) We should have received Your application for Portability with complete documentation at least 45 days before the expiry of Your present period of insurance;
(iii) If the Sum Insured under the previous Policy is higher than the Sum Insured proposed by You under this Policy, the applicable waiting periods under Section C(A) shall be waived to the extent of the Sum Insured and eligible cumulative bonus, to the extent served under the expiring policy with the previous insurer;
(iv) In case the proposed Sum Insured under Our Policy is more than the insurance cover under the previous policy, then all applicable waiting periods under Sections C(A) shall be applicable afresh to the extent of the amount by which the proposed Sum Insured under this Policy exceed the total of Sum Insured and eligible cumulative bonus under the expiring health insurance policy;
(v) All waiting periods under Section C(A) shall be applicable individually for each Insured Person and claims shall be assessed accordingly.
(vi) Portability benefit will be offered to the extent of previous Sum Insured and accrued cumulative bonus (if earned), and shall not apply to any other additional increased Sum Insured.
(vii) We may subject Your proposal to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be as per Our board approved underwriting policy.
(viii) There is no obligation on Us to insure all the proposed Insured Persons on the proposed terms, even if You have given Us all documentation.
(ix) We should have received the database and claim history from the previous insurance company for Your previous policy.

Portability shall be allowed in the following cases:

(i) All individual health insurance policies issued by non-life insurance companies/ Stand alone Health Insurance companies, including family floater policies.
(ii) Individual members, including the family members covered under any group health insurance policy of a non-life insurance company shallf have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. One year thereafter, he, she shall be accorded the right mentioned in clause (a) above.
The Portability provisions will apply to You, if You wish to migrate from this Policy to any other health insurance policy on Renewals. In case

You have opted to switch to any other insurer under Portability provisions and the outcome of acceptance of the Portability request is awaited from the new insurer on the date of Renewal,

(i) We may upon Your request extend this Policy for a short period of not less than one month at an additional premium to be paid on a pro-rata basis for such short period.
(ii) If during this extension short period a claim has been reported, You shall be required to first pay the full premium so as to make the Policy Period of full 12 calendar months. Our liability for the payment of such claim shall commence only once such premium is received.

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.

E. Free Look Period

(1) The Insured Person will be allowed a period of at least 15 days from the date of receipt of the Policy to review the terms and conditions of the Policy and to return the same if not acceptable.
Health insurance policy contracts with a term of 3 years offered over distance marketing mode shall have a free look period of 30 days from the date of receipt of the Policy.
(2) If the Insured Person has not made any claim during the free look period, the Insured Person shall be entitled to—
(a) A refund of the premium paid less any expenses incurred by Us on medical examination of the Insured Persons and the stamp duty charges or;
(b) where the risk has already commenced and the option of return of the policy is exercised by the Policyholder, a deduction towards the proportionate risk premium for period on cover or;
(c) Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

Free look period shall not be available on Renewals.

F. Fraudulent Claims

If any claim is found to be fraudulent, or if any false declaration is made, or if any fraudulent devices are used by You or the Insured Person or anyone acting on their behalf to obtain any Benefit under this Policy then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons. All sums paid under this Policy shall be repaid to Us by You on behalf of all Insured Persons who shall be jointly liable for such repayment.

G. Material Change

Material information to be disclosed includes every matter that You are aware of, or could reasonably be expected to know, that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk of insurance and if so on what terms. You must exercise the same duty to disclose those matters to Us before the Renewal, or endorsement of the contract and communicate the same to Us in the Change Request form. The policy terms and conditions will not be altered.

H. Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed and stamped by Us.

I. No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder/ Insured Person which is in Our possession and not specifically informed by the Policyholder / Insured Person shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

J. Contribution

In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, each insurer shall make the claim payments independent of payments received under other similar polices.
If two or more policies are taken by an Insured Person during a period from one or more Insurers to indemnify treatment costs, the Policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

1. In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. Claims under other policy/ies may be made after exhaustion of Sum Insured in the earlier chosen policy / policies.
3. If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the Policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where the Insured Person has policies from more than one insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy

K. Zone Classification:

Zone I: Bangalore, Gurgaon, Mumbai, Navi Mumbai, New Delhi, Thane
Zone II: Ahmedabad, Kolkata, Noida, Pune, Hyderabad, Chennai, Chandigarh, Mohali
Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II

Identification of Zone will be based on the city of the proposed Insured Persons.

(a) Persons paying Zone I premium can avail treatment all over India without any Co-payment.
(b) Persons paying Zone II premium
   i. Can avail treatment in Zone II and Zone III without any Co-payment (provided treatment is taken within eligible room category as specified in the Policy Schedule).
   ii. Availing treatment in Zone I will have to bear 10% of each and every claim (provided treatment is taken within eligible room category as specified in the Policy Schedule).
(c) Person paying Zone III premium
   i. Can avail treatment in Zone III, without any Co-payment
   ii. Availing treatment in Zone II will have to bear 15% of each and every claim (provided treatment is taken within eligible room category as specified in the Policy Schedule).
   iii. Availing treatment in Zone I will have to bear 25% of each and every claim (provided treatment is taken within eligible room category as specified in the Policy Schedule).

Note:
- Individual Policy: Your zone is based on the city mentioned in the Proposal form.
- In case of Family Floater Policy, a single Zone shall be applicable to all members covered under the Policy.
  You also have an option of selecting another Zone from the applicable Zone of any of the Insured Persons in the Policy.
- Option to select a Zone higher than that of the actual Zone is available on payment of relevant premium at the time of buying the Policy or at the time of Renewal.
- Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalisation due to an Accident.

L. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

M. Records to be maintained

You or the Insured Person, as the case may be shall keep an accurate record containing all relevant medical records and shall allow Us or our representative(s) to inspect such records. You or the Insured Person as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Period and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy.

N. Cancellation

In case You are not satisfied with the policy or our services, You can request for a cancellation of the policy by giving 15 days' notice in writing. Premium shall be refunded as per table below if no claim has been registered/ made under the Policy and no benefits under the Policy have been availed in full or in part and full premium has been received.

<table>
<tr><td></td><td colspan="3">Refund</td></tr>
<tr><td>In force Period-Up to</td><td>1 Year</td><td>2 Year</td><td>3 Year</td></tr>
<tr><td>1 Month</td><td>75.00%</td><td>85.00%</td><td>90.00%</td></tr>
<tr><td>3 months</td><td>50.00%</td><td>75.00%</td><td>85.00%</td></tr>
<tr><td>6 months</td><td>25.00%</td><td>60.00%</td><td>75.00%</td></tr>
<tr><td>12 months</td><td rowspan="6">NIL</td><td>50.00%</td><td>60.00%</td></tr>
<tr><td>15 months</td><td>30.00%</td><td>50.00%</td></tr>
<tr><td>18 months</td><td>20.00%</td><td>35.00%</td></tr>
<tr><td>24 months</td><td rowspan="3">NIL</td><td>30.00%</td></tr>
<tr><td>30 months</td><td>15.00%</td></tr>
<tr><td>30+ months</td><td>NIL</td></tr>
</table>

You further understand and agree that We may cancel the Policy by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material fact by You without any refund of premium. We may also cancel the Policy with refund of premium in case of non-cooperation by You.

All coverage, benefits, earning on HealthReturns™, shall automatically lapse upon cancellation of the Policy. However, any unclaimed and accrued

HealthReturns™ (from Previous Policy Year/ month) shall be available for a claim over the next 12 month period from the date of cancellation / termination.

O. Endorsements

The Policy will allow the following endorsements during the term of the Policy. Any request for endorsement must be made by You in writing. Any endorsement would be effective from the date of the request as received from You, or the date of receipt of premium, whichever is later.

(i) Non-Financial Endorsements – which do not affect the premium.
   (1) Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)
   (2) Rectification in gender of the Proposer/ Insured Person
   (3) Rectification in relationship of the Insured Person with the Proposer
   (4) Rectification of date of birth of the Insured Person (if this does not impact the premium)
   (5) Change in the correspondence address of the Proposer
   (6) Change/Updation in the contact details viz., Phone No., E-mail Id, alternate contact address of the Proposer etc.
   (7) Change in Nominee Details

(ii) Financial Endorsements – which result in alteration in premium
   (1) Addition of Insured Person (New Born Baby or newly wedded spouse)
   (2) Deletion of Insured Person on Death* or Separation or Policyholder/Insured Person leaving India
   (3) Change in Age/Date of Birth

All endorsement requests may be assessed by Us and if required additional information/documents may be requested.

P. Grace Period

The Policy may be renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable to pay for any claim arising out of an Injury/ Accident/ Condition that occurred during the Grace Period. . The provisions of Section 64VB of the Insurance Act shall be applicable.

All policies Renewed within the Grace Period shall be eligible for continuity of cover.

Q. Renewal Terms

(i) The Policy will automatically terminate at the end of the Policy Period. The Policy is ordinarily renewable on mutual consent for life, subject to realization of Renewal premium.
(ii) The premium payable on Renewal shall be paid to Us on or before the Policy Period end date and in any event before the expiry of the Grace Period. Policy would be considered as a fresh policy if there would be break of more than 30 days between the previous Policy expiry date and current Policy Start date.
(iii) We however shall not be liable for any claim arising out of an ailment suffered or Hospitalisation commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy and such disease/Illness/condition shall be treated as a Pre-Existing Disease.
(iv) Any unutilised funds under HealthReturns™ (from the previous Policy year/ month) will be available for claims during the Grace Period.
(v) You shall not be able to earn HealthReturns™ during the Grace Period.
(vi) In case the Policy is not renewed before the end of the Grace Period, any unutilized funds under HealthReturns™ shall be available for a claim as up to a period of 12 months from the date of expiry of the Policy.
(vii) If the Insured Persons in the expiring Policy are covered in an Individual Policy, and such expiring Policy has been Renewed with Us on a Family Floater Policy basis then the accumulated amount under HealthReturns™ that will be carried forward in such Renewed Policy shall be the total of all the Insured Persons moving out and shall be maintained on an Individual Policy basis.
(viii) If the Insured Persons in the expiring Policy are in a Family Floater Policy and such Insured Persons renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater Policy/ Individual Policies then the accumulated amount under HealthReturns™ shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
(ix) Renewals will not be denied except on grounds of misrepresentation, fraud, non-disclosure of material facts or non-co-operation by You.
(x) Where We have discontinued or withdrawn this product/plan You will have the option to renew under the nearest substitute Policy being issued by Us, however benefits payable shall be subject to the terms contained in such other Policy which has been approved by IRDAI.
(xi) You shall disclose to Us in writing of any chronic condition acquired by any Insured Person at the time of seeking Renewal of this Policy or during the Policy tenure, irrespective of any claim arising or made. If an Insured Person is found to be suffering from a covered chronic condition post any waiting period (if applicable), then We shall manage such conditions under Chronic Management Program as per the terms and conditions laid out under Section B(III) (r).
(xii) We may revise the Renewal premium payable under the Policy or the terms of cover, provided that the Renewal premiums are approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premiums will not alter based on individual claims experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.
(xiii) Alterations like increase/ decrease in Sum Insured or Change in Plan/Product, addition/deletion of Insured Persons (except due to child Birth / Marriage or Death) will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the Proposal Form before the expiry of the Policy. We reserve Our right to carry out underwriting in relation to acceptance of request for changes on Renewal. The terms and conditions of the existing Policy will not be altered.
(xiv) Any enhanced Sum Insured during any Policy Renewals will not be available for an illness, disease, Injury already contracted under the preceding Policy Periods. All waiting periods as mentioned below shall apply afresh for this enhanced limit from the effective date of such enhancement.
(xv) Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned in the Policy Schedule shall be waived only up to the lowest Sum Insured as applicable to the relevant waiting periods of the Plan in force.
(xvi) Where an Insured Person is added to this Policy, either by way of endorsement, all waiting periods under Section C(A) will be applicable considering such Policy Year as the first year of Policy with Us with respect to the Insured Person.
(xvii) Applicable Cumulative Bonus shall be accrued on each Renewal as per eligibility under the plan in force.
(xviii) In case of Family Floater Policies, children attaining 25 years at the time of Renewal will be moved out of the floater into an individual cover. However, all continuity benefits for such Insured Person on the Policy will remain intact. Cumulative Bonus earned on the Policy will stay with the Insured Persons(s) covered under the original Policy.

R. Communications & Notices

Any communication or notice or instruction under this Policy shall be in writing and will be sent to:

(i) The Policyholder's, at the address as specified in the Policy Schedule
(ii) To Us , at the address specified in the Schedule.
(iii) No insurance agents, brokers, other person or entity is authorised to receive any notice on the behalf of Us unless explicitly stated in writing by Us.
(iv) Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

S. Electronic Transactions

You agree to comply with all the terms and conditions of electronic transactions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as the internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through

other means of telecommunication, in respect of this Policy including the monitoring and/or recording of your health status, HealthReturns™, health heart score, policy and/or claim related details, shall constitute legally binding when done in compliance with Our terms for such facilities.

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

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

U. Complete Discharge
We will not be bound to take notice or be affected by any Notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy. The payment made by Us to You/Insured Person or to Your Nominee/Legal Representative or to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete, valid and construe as an effectual discharge in favour of Us.

V. Grievances Redressal Procedure
In case of a grievance, You can contact Us with the details through:
Our website: adityabirlacapital.com
Email: care.healthinsurance@adityabirlacapital.com
Toll Free: 1800 270 7000
Address: Any of Our Branch office or Corporate office
For senior citizens, please contact the respective branch office of the Company or call at 1800 270 7000 or may write an e- mail at seniorcitizen.healthinsurance@adityabirlacapital.com
You can also walk-in and approach the grievance cell at any of Our branches. If in case You are not satisfied with the response then You can contact Our Head of Customer Service at the following email carehead.healthinsurance@adityabirlacapital.com
If You are still not satisfied with Our redressal, You may approach the nearest Insurance Ombudsman. The Contact details of the Ombudsman offices are provided on Our Website.

W. Assignment
The Policy and the benefits under this Policy cannot be assigned in whole or in part.

Section D. DEFINITIONS

1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **Age** or **Aged** is the age as on last birthday, and which means completed years as at the Start date.

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

4. **Any one Illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

5. **Any Room** means a room in a Hospital above a Single Private Room as defined under this Policy.

6. **Ambulance** means a motor vehicle operated by a licenced/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

7. **Annexure** means a document attached and marked as Annexure to this Policy

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

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

10. **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

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

12. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

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

13. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

14. **Day Care Treatment** means medical treatment, and/or *surgical procedure* which is:
    i. undertaken under General or Local Anaesthesia in a *hospital/day care centre* in less than 24 hrs because of technological advancement, and
    ii. which would have otherwise required hospitalization of more than 24 hours.

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

15. **Day Care Centre** - A day care 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 supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under:-
    i) has qualified nursing staff under its employment;
    ii) has qualified medical practitioner/s in charge;
    iii) has fully equipped operation theatre of its own where surgical procedures are carried out;
    iv) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

16. **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.

17. **Dependent Child** means a child (natural or legally adopted or stepchild), who is financially dependent on You does not have his / her independent source of income, is up to the Age of 25 years.

18. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery .

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

20. **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.

21. **Emergency** shall mean a serious medical condition or symptom resulting from Injury or Illness which arises suddenly and unexpectedly, and requires immediate care and treatment by *a Medical Practitioner, generally received within 24 hours of onset* to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an Emergency anymore.

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

23. **Family Floater Policy** means a policy named as a Family Floater Policy in the Policy Schedule under which the family members named as Insured Persons in the Policy Schedule are covered.

24. **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.

25. **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 Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act Or complies with all minimum criteria as under:
i) has qualified nursing staff under its employment round the clock;
ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii) has qualified medical practitioner (s) in charge round the clock;
iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

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

27. **IRDAI** means the Insurance Regulatory and Development Authority of India.

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

(a) Acute condition - Acute condition is a disease, illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery

(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
2. it needs ongoing or long- term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

29. **Individual Policy** means a policy named as an Individual Policy in the Policy Schedule under which one or more persons are covered as Insured Persons.

30. **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.

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

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

33. **Insured Person** means the person(s) named in the Policy Schedule who are covered under this Policy and in respect of whom the appropriate premium has been received.

34. **Maternity Expenses means:**
a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
   i. expenses towards lawful medical termination of pregnancy during the policy period.

35. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow- up prescription.

36. **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.

37. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in *hospital* or part of a stay in hospital which:
    - is required for the medical management of the illness or injury suffered by the insured;
    - must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
    - must have been prescribed by a medical practitioner;
    - must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

38. **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.

39. **Monthly Premium shall** mean the applicable annual premium with respect to the Insured Person(s) split in 12 months in equal proportion only for the purpose of calculation of Benefit(s) under this Policy.

40. **New Born Baby** means baby born during the Policy Period and is aged upto 90 days.

41. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

42. **Non- Network Provider** means any hospital, day care centre or other provider that is not part of the network.

43. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

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

45. **Policy** means this Terms & Conditions document, the Proposal Form, Policy Schedule, Add-On Benefit Details (if applicable) and Annexures which form part of the Policy contract including endorsements, as amended from time to time which form part of the Policy contract and shall be read together.

46. **Policy Period** means the period between the Start date and the expiry date of the Policy as specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.

47. **Policy Year** means a period of 12 consecutive months commencing from the Start date or any anniversary.

48. **Policy Schedule** means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

49. **Pre-Existing Disease** means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.

50. **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person , provided that:
    ii. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
    iii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

51. **Post-hospitalization Medical Expenses** means medical expenses
incurred during pre-defined number of days immediately after the insured person is discharged from the hospital, provided that
    i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and
    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

52. **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.

53. **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.

54. **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.

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

56. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated Medical Expenses.

57. **Single Private Room** means a basic (cheapest) category of Single room in a Hospital with/without air-conditioning facility where a single patient is accommodated and which has an attached toilet (lavatory and bath).

58. **Shared Room** means a basic (cheapest) category of Shared Room in a Hospital with/without air-conditioning with two or three patient beds.

59. **General Ward Or Economy Ward** means a cheapest category Hospital Room in a Hospital with more than three patient beds.

60. **Start date of the Policy** means the inception date of the current Policy Period as specified in the Policy Schedule.

61. **Sum Insured means:**
    i) For an Individual Policy, the amount specified in the Policy Schedule against an Insured Person which is Our maximum, total and cumulative liability for any and all claims arising during a Policy Year in respect of that Insured Person.
    ii) For a Family Floater Policy, the amount specified in the Policy Schedule which is Our maximum, total and cumulative liability for any and all claims arising during a Policy Year in respect of any and all Insured Persons.

62. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner

63. **TPA** means any person who is licensed under the IRDA (Third Party Administrators – Health Services) Regulations 2016 (as may be amended, replaced or modified) by the IRDAI, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.
The updated list of TPAs shall be available on Our website.

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

65. **We/Our/Us** means Aditya Birla Health Insurance Company Limited.

66. **You/Your/Policyholder** means the person named in the Policy Schedule as the policyholder and who has concluded this Policy with Us.

CONTACT DETAILS	CONTACT DETAILS
AHMEDABAD - Shri. / Smt. 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/Smt..... 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/Smt..... 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/Smt..... 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	Andhra Pradesh, Telangana, Yanam and 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	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - Shri/Smt..... 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 / 2514252 / 2514253, Email: bimalokpal.noida@gbic.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - 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.: 020-41312555 Email: bimalokpal.pune@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure 1: List Of Non Medical Expenses

Sr. No.	List Of Non Medical Expenses	
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	MOISTURISER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Not Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and paid specifically for cases that 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 may be considered for at least these conditions where surgery itself is payable.
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable
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	LACTOGEN/ INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling in case of upper arm fractures may be considered.
	ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Not Payable
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Not Payable
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Not Payable. (We should consider only in accident cases; where Dental Surgery is required)
62	HORMONE REPLACEMENT THERAPY	Not Payable
63	HOME VISIT CHARGES	Not Payable
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Not Payable
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT	Not Payable

66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Not Payable
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Not Payable
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Not Payable
69	DONOR SCREENING CHARGES	Not Payable
70	ADMISSION/REGISTRATION CHARGES	Not Payable
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Not Payable
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not Payable
74	STEM CELL IMPLANTATION/ SURGERY	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	Not Payable
77	MICROSCOPE COVER	Payable under OT Charges, not payable separately
78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Not Payable
79	SURGICAL DRILL	Not Payable
80	EYE KIT	Payable under OT Charges, not payable separately
81	EYE DRAPE	Payable under OT Charges, not payable separately
82	X-RAY FILM	Payable under Radiology Charges, not as consumable
83	SPUTUM CUP	Not Payable
84	BOYLES APPARATUS CHARGES	Payable under OT Charges, not payable separately
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Not Payable
86	ANTISEPTIC OR DISINFECTANT LOTIONS	Not Payable
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable
88	COTTON	Not Payable
89	COTTON BANDAGE	Not Payable
90	MICROPORE/ SURGICAL TAPE	Not Payable
91	BLADE	Not Payable
92	APRON	Not Payable
93	TORNIQUET	Not Payable
94	ORTHOBUNDLE, GYNAEC BUNDLE	Not Payable
95	URINE CONTAINER	Not Payable
	ELEMENTS OF ROOM CHARGE	
96	LUXURY TAX	Not Payable. If there is no Policy Exclusion, then Actual Tax Levied by Government is Payable -Part of Room Charge for Sub Limits
97	HVAC	Not Payable
98	HOUSE KEEPING CHARGES	Not Payable
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Not Payable
100	TELEVISION & AIR CONDITIONER CHARGES	Payable - If under room charges not if separately levied
101	SURCHARGES	Not Payable
102	ATTENDANT CHARGES	Not Payable
103	IM IV INJECTION CHARGES	Not Payable
104	CLEAN SHEET	Not Payable
105	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Not payable, Patient diet provided by Hospital is payable
106	BLANKET/WARMER BLANKET	Not Payable

	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	Not Payable--To be Claimed by Patient Post -Hospitalisation where admissible
119	FILE OPENING CHARGES	Not Payable
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
121	MEDICAL CERTIFICATE	Not Payable
122	MAINTAINANCE 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	**Not Payable**
131	WALKING AIDS CHARGES	Not Payable
132	BIPAP MACHINE	Not Payable
133	COMMODE	Not Payable
134	CPAP/ CAPD EQUIPMENTS	Not Payable
135	INFUSION PUMP - COST	Not Payable
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
137	PULSEOXYMETER CHARGES	Not Payable
138	SPACER	Not Payable
139	SPIROMETRE	Not Payable
140	SPO2 PROBE	Not Payable
141	NEBULIZER KIT	Not Payable
142	STEAM INHALER	Not Payable
143	ARMSLING	Not Payable
144	THERMOMETER	Not Payable
145	CERVICAL COLLAR	Not Payable
146	SPLINT	Not Payable
147	DIABETIC FOOT WEAR	Not Payable
148	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150	LUMBO SACRAL BELT	Payable - If Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine.
151	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable -for any ICU patient requiring more than 3 days in ICU, all patient with paraplegia /quadriplegia or for any major illness requiring prolonged hospitalization. (Prevent Bed Sores & DVT)
152	AMBULANCE COLLAR	Not Payable
153	AMBULANCE EQUIPMENT	Not Payable

154	MICROSHEILD	Not Payable
155	ABDOMINAL BINDER	Payable - If Essential and should be paid at least in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.
	ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
156	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\\ \ DISINFECTANTS ETC	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	Not Payable
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES / DIET CHARGES	Not 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 - If prescribed
161	Digestion Gels	Payable - If prescribed
162	ECG ELECTRODES	Payable - Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
163	GLOVES	Payable -Sterilized Gloves Payable. Unstrerilized Gloves not Payable
164	HIV KIT	Payable
165	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable - If prescribed
166	LOZENGES	Payable - If prescribed
167	MOUTH PAINT	Payable - If prescribed
168	NEBULISATION KIT	Payable - If used during hospitalization is payable reasonably
169	NOVARAPID	Payable - If prescribed
170	VOLINI GEL/ ANALGESIC GEL	Payable - If prescribed
171	ZYTEE GEL	Payable - If 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
174	ALCOHOL SWABES	Not Payable
175	SCRUB SOLUTION/STERILLIUM	Not Payable
	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	Payable - Not payable, except for telemedicine consultations where covered by policy
186	OXYGEN MASK	Not Payable
187	PAPER GLOVES	Not Payable
188	PELVIC TRACTION BELT	Not Payable
189	REFERAL DOCTOR'S FEES	Not Payable
190	ACCU CHECK (Glucometery/ Strips)	Not Payable
191	PAN CAN	Not Payable
192	SOFNET	Not Payable
193	TROLLY COVER	Not Payable

194	UROMETER, URINE JUG	Not Payable
195	AMBULANCE	Payable - Ambulance from home to hospital or interhospital shifts is payable/ RTA as specific requirement is payable
196	TEGADERM / VASOFIX SAFETY	Payable - If maximum of 3 in 48 hrs and then 1 in 24 hrs
197	URINE BAG	Payable - where medicaly necessary till a reasonable cost - maximum 1 per 24 hrs
198	SOFTOVAC	Not Payable
199	STOCKINGS	Payable - If Essential for case like CABG etc. where it should be paid.

ANNEXURE II - ILLUSTRATION OF BENEFITS

Section A. Lets look at the ways by which funds under HealthReturns™ can be accmulated

1. By way of percentage of Premium earned through Healthy Heart Score™ and Active Dayz™

Scenario I
A 46 year old individual Amar buys an Individual Platinum Policy with Us on 1st of Jan 2017 on payment of ₹12000 per year (excluding taxes), with Sum Insured 5 Lacs, let's understand how he can earn HealthReturns™1 each month under the Policy under different circumstances. Amar has undergone pre-Policy medical examination due to his Age and is found to have diabetes and is placed on a Chronic Management Program to keep his diabetes condition in control.

Month	1 Jan 2017	1 Feb 2017	1 March 2017
Healthy Heart Score™	Red (Results of the pre-Policy medical examination placed Amar at a Healthy Heart Score 'Red')	Red	Amber (Amar undergoes a Health Assessment to understand his health better and his Health Heart Score™ has now shown improvement)
Adherence to Chronic Management Program	Yes, Amar took regular medication and consultations as per his defined program	Yes, Amar took regular medication and consultations as per his defined program	No
Active Dayz™ (One is eligible to earn 1 Active Day™ for each completed 24 hours)	5 Fitness Centre Visit for at least 30 minutes per day	5 Fitness Centre visits for at least 30 minutes	5 Fitness Centre visits for at least 30 minutes
	10 recordings of 10,000 steps each day (these are on days other than the days on which the Fitness Centre visits were done)	Burning 300 calories in one exercise session per day for 5 days (these are on days other than the days on which the Fitness Centre visits were done)	5 recordings of 10,000 steps each day (these are on days other than the days on which the Fitness Centre visits were done)
	Total Active Dayz™ = 15	Total Active Dayz™ = 10	Total Active Dayz™ = 10
Total HealthReturns™	Based on 15 Active Dayz™ and a Healthy Heart Score ™ 'Red', the Insured member qualifies for 6% HealthReturns™ on monthly premium paid-Thus calculation according to the table I below shall be 6 % * (12000/ 12) = 60 This equals ₹60	Based on 10 Active Dayz™ and a Healthy Heart Score ™ 'Red', the Insured member qualifies for 3.6% HealthReturns™ on monthly premium paid-Thus calculation according to the table I below shall be 3.6 % * (12000/12) = 36 This equals ₹36	Based on 10 Active Dayz™ and a Healthy Heart Score ™ 'Amber, the Insured member should get 7.2% HealthReturns™ on monthly premium paid, But since he doesn't comply with Chronic Management Program in march, so he cannot be eligible to get HealthReturns™ for this month. This equals ₹0

Amar has earned ₹96 as HealthReturns™ by the end of March.

Table 1:
Reference for HealthReturns™ Calculation

No of Active Dayz™ in a calendar month	Fitness Assessment Result*	Healthy Heart Score™ (Calculated Per month)		
		Red	Amber	Green
13+	NA	6.0%	12.0%	30.0%
10 – 12	NA	3.6%	7.2%	18.0%
7 – 9	Level 3	2.4%	4.8%	12.0%
4 – 6	Level 2	1.2%	2.4%	6.0%
0 – 3	Level 1	0%	0%	0%

Table 2: Weights @ Family structure

For a Family Floater Policy, the allocation ratio shall be 2:1 for Parents and Other Adults under the Policy. Weightages for allowed family combinations are as described in the table below

Family size	Weights
Self, Spouse and Dependent Children (upto 25 yrs)	1:1:0:0
Self and Spouse	1:1
Self, Spouse and Parents	1:1:2:2
Self, Spouse and parents and Parents in-law	1:1:2:2:2:2

Secnario II

A 28 year old individual Akbar and his 46 year old father buy a Family Floater Platinum Policy with Us, on 1st of Jan 2017 on payment of ₹12000 per year (excluding taxes), with Sum Insured 5 Lacs on a family floater basis, let's understand how they can earn HealthReturns™ under a family floater Policy

	Akbar		Akbar's Father	
	Akbar wants to understand his health better and wants to get the benefit of HealthReturns™, hence he undergoes a Health Assessment within a month from the date of the Inception of the Policy. Upon evaluation he is found to have diabetes.		Akbar's father undergoes a pre-Policy medical examination due to Age and BMI (as he is overweight) and is found to have Chronic Hypertension, he is placed at a Healthy Heart Score 'Red' 1 Jan 2017	
	Akbar will be eligible for HealthReturns™ but shall not be eligible to get the benefit for Chronic Management Program until 24 months from the date of Inception of the Policy.		He is covered for Hypertension.	
Month	1 Feb 2017	1 March 2017	1 Jan 2017	1 Feb 2017
Healthy Heart Score™	Amber (Based on Health Assessment Akbar is placed at a Healthy Heart Score 'Amber')	Amber	Red (Results of the pre-Policy medical examination placed Ram's father at a Healthy Heart Score 'Red')	Red
Adherence to Chronic Management Program	NA	NA	Yes, Akbar's father took regular medication and consultations as per his defined program	No
Active Dayz™ (One is eligible to earn 1 Active Day™ for each 24 hours from the date of inception of the Policy)	10 Fitness Centre Visits for at least 30 minutes per day 5 recordings of 10,000 steps each day (these are on days other than the days on which the Fitness Centre visits were done)	15 recordings of 100,000 steps each day	10 recordings of 10,000 steps each day	None - as Akbar's father did not do any tracked activity this month.
	Total Active Dayz™ = 15	Total Active Dayz™ = 15	Total Active Dayz™ =10	Total Active Dayz™ = 0
Total HealthReturns™	Based on 15 Active Dayz™ and a Healthy Heart Score ™ 'Amber, the Insured member qualifies for 12% HealthReturns™ on Monthly Premium paid, Thus calculation according to table I & II above shall be 12% x 1/3 x (12000/12) = 40 This equals ₹40	Based on 15 Active Dayz™ and a Healthy Heart Score ™ 'Amber, the Insured member qualifies for 12% HealthReturns™ on Monthly Premium paid, Thus calculation according to table I & II above shall be 12% x 1/3 x (12000/12) = 40 This equals ₹40	Based on 10 Active Dayz™ and a Healthy Heart Score ™ 'Red, the Insured member qualifies for 3.6% HealthReturns™ on Monthly Premium paid, Thus calculation according to table I & II above shall be 3.6% x 2/3 x (12000/12) = 24 This equals ₹24	This equals ₹0
	Akbar has earned ₹80 as HealthRetuns™ by the end of March		Akbar's father has earned ₹24 as HealthReturns™ by the end of Feb	

2. By way of Benefit for Hospital Room Choice

Case 1 - An individual Rohit buys an Enhanced Plan of 8 Lacs in Zone 1 and opts for a Room Category of Any Room.
He gets admitted for a medical condition in a Single Private Room and incurs a claim amount of 1 Lac, let's look at how **Benefit for Hospital Room Choice** will get calculated,
Payable claim Amount = 1 Lac
20 % applicable on the payable claims amount = 20% x 100,000 = ₹20,000
Thus, Benefit for Hospital Room Choice = ₹20,000
This amount will be transferred as HealthReturns™ for that Insured Person, once the main claim has been settled by Us.

Case 2 - An individual Raman buys an Enhanced Plan of 8 Lacs in Zone 1 and opts for a Room Category of Any Room.
He gets admitted for a medical condition in a Single Private Room and incurs a claim amount of 9 Lac, let's look at how **Benefit for Hospital Room Choice** will get calculated,
Payable claim Amount = 9 lac
20 % applicable on the payable claims amount = 20% x 800,000 = ₹1,60,000
But he will not get this incentive, as payable claim amount is higher than the sum insured.
This, In cases where the claim amount is higher than the Balance Sum Insured, Including Cumulative Bonus (if any), Benefit for Hospital Room Choice is not applicable.

Case 3 - An individual Rakesh buys an Enhanced Plan of 8 Lacs in Zone 1 and opts for a Room Category of Any Room.
He gets admitted for a medical condition in a Single Private Room and incurs a claim amount of 7.5 Lac, let's look at how **Benefit for Hospital Room Choice** will get calculated,
Payable claim Amount = 7.5 lac
'Benefit of Hospital Room Choice' - 20 % applicable on the payable claims amount = 20% x 7,50,000 = Rs 1,50,000
However, he will only get Rs 50,000 as incentive and not the rest of Rs 1 Lac, as the maximum amount under this Benefit shall be restricted to the difference between the Balance Sum Insured (including Cumulative Bonus, if any) and the payable claims amount.

Section B. Lets look at the Co-payment applicable under each Plan

Co-payment applicable for Essential Plan

An Individual Rohan, who lives in Patna (Zone II) buys an Essential Plan with a Shared Room, let's look at how Co-payment will be applicable on the payable claims amount of ₹1 Lac, under Essential plan in different instances as shown below		
I) Mandatory Co-payment (Applicable for Essential Plan only)	A compulsory co-payment of 20% is applicable on each and every payable claims under Essential Plan	Payable claim amount as per Hospital bill = ₹100,000 Co-pay amount paid by Rohan = 20% x 100,000 = ₹20,000 Amount paid by Us = ₹80,000
II) Co-payment for treatment in a Higher Zone	Rohan takes treatment in Mumbai, which is categorized under Zone I, Hence, he will have to bear co-pay's under I, II	- Mandatory Co-pay of 20% - Co-payment for treatment in a Higher Zone of 10% Hence, total co-pay of 30% will be applicable Payable Claim amount as per Hospital bill = ₹100,000 Co-pay amount paid by Rohan = 30% x 100,000 = ₹30,000 Amount paid by Us = ₹70,000
III) Co-payment for treatment in a Higher room category	Rohan takes treatment in a Single Private Room (higher than opted Room Category) in Zone I Hence he will have to bear a co-pay's under I, II, III	- A Mandatory Co-pay of 20% - Co-payment for treatment in a Higher Zone of 10% - Co-payment for treatment in a Higher room category - for Shared Room to Single Private Room is 15% Hence, total co-pay of 45% will be applicable Payable Claim amount as per Hospital bill = ₹100,000 Co-pay amount paid by Rohan = 45% x 100,000 = ₹45,000 Amount paid by Us = ₹55,000

Co-payment applicable for Enhanced plan

An Individual Meera, who lives in Ahemdabad (Zone II) buys an Enhanced Plan with a Single Private Room, let's look at how Co-payment will be applicable on the payable claims amount of ₹1 Lac, under Enhanced plan in different instances as shown below		
I) Co-payment for treatment in a Higher Zone	Meera takes treatment in Mumbai, which is in a Zone I (higher Zone) she will have to bear a co-pay of 10%	- Co-payment for treatment in a Higher Zone of 10% Payable claim amount as per Hospital bill = ₹100,000 Co-pay amount paid by Meera = 10% x 100,000 = ₹10,000 Amount paid by Us = ₹90,000
II) Co-payment for treatment in a Higher room category	Meera takes treatment in a Suite (which is in a room category higher than opted for) in Mumbai (higher Zone than opted at the time of purchase of Policy)	- Co-payment for treatment in a Higher Zone of 10% - Co-payment for treatment in a Higher room category of 25% Hence, total co-pay of 35% will be applicable Payable Claim amount as per Hospital bill = ₹100,000 Co-pay amount paid by Ram = 35% x 100,000 = ₹35,000 Amount paid by Us = ₹65,000

Section C. Let's look at how Hospital Cash Benefit and Recovery Benefit will be applicable under the Policy.

In case an individual Seema opts for an Enhanced Plan of 5 Lacs Sum Insured, and opts for a Hospital Cash Benefit of ₹1000 and gets hospitalized for a treatment of a an Illness for 10 days, lets look at how much of Hospital Cash benefit and recovery benefit she is eligible for.
Hospital Cash Benefit shall be payable for each completed day of Hospitalization, but only after the completion of the first 24 hours of Hospitalization of the Insured Person. Thus 1 day deductible is applicable on this benefit. (This benefit is payable only if the In-patient hospitalization claim is admissible under the Policy.) Days spent in hospital = 10 days Deductible = 1 day Hence Hospital Cash Benefit payable = ₹1000 x 9 days = ₹9,000 Recovery Benefit payable = ₹10,000 lumpsum (Minimum of 1% of Sum Insured i.e 1% of 5 Lacs = ₹15,000 and ₹10,000) Total benefit paid to Seema, once the claim is settled = ₹19,000 (₹ 9,000 + 10,000)

Section D. Let's look at how Reload of Sum Insured is applicable under the Policy.

In case there are two Insured members in an individual Policy, with Sum Insured 5 Lacs each, let's look at how Reload of Sum Insured will apply for each member in the Policy.		
First Policy Year	Seeta	Geeta
Sum Insured	5 Lacs	5 Lacs
1st Claim	6 Lacs due to an Road Traffic Accident	2 Lacs due to a Heart Condition
Will Reload of Sum Insured apply?	Yes, Reload of Sum Insured will be applicable , since it is due to an Accident and the claim amount is more than the opted Sum Insured Opted Sum Insured = ₹5 Lacs Reloaded Sum Insured = ₹5 Lacs Total available Sum Insured = ₹10 Lacs Claim = 6 Lacs Balance Sum Insured for the remaining Policy Year = 4 Lacs (10 Lacs – 6 Lacs)	No, because claim amount is within the Sum Insured limit. Reload of Sum Insured will apply only when the Sum Insured is insufficient for payment of claim. Balance Sum Insured for the Policy Year = 3 Lacs (5 Lacs – 2 Lacs)
2nd Claim	1 Lac due to Asthma	4 Lacs due to a Heart Condition
Will the claim be utilized from Reloaded Sum Insured	Yes, this amount is payable from the Reloaded Sum Insured. This is because a claim for this condition has not been paid for in the current Policy Year.	No, Sum Insured cannot be Reloaded and utilized for any Illness/ Injury (including its complications) for which a claim has been admitted during that Policy Year.
3rd claim	None	4 Lac due to knee replacement Surgery
Will Reload of Sum Insured apply?	Not Applicable	Yes, as this is an unrelated claim event, Sum Insured will be reloaded Balance Sum Insured = 3 Lacs Reloaded Sum Insured = 5 Lacs Total available Sum Insured = 8 Lacs Claim = 4 Lacs Balance Sum Insured for the remaining Policy Year = 4 Lacs (8 Lacs – 4 Lacs)

Section E: Chronic Management Program

An individual Deepak opts for a 2 year term Individual Platinum Policy with Us on 1st of Jan 2017 and he undergoes a pre-Policy medical examination due to his Age and is found to have diabetes. Let's understand what are the terms applicable to his Policy and how he will get covered under Chronic Management Program in case he also develops Hypertension after 1 year of continuing the Policy (1st Jan 2018).	
1 Jan 2017	Deepak pays a premium of Rs 5000, which is the applicable premium for the Diabetes Plan a and a Chronic Management Program for Diabetes is started for management of his condition.
1 Jan 2018	Deepak is diagnosed with Hypertension during his 'Health check-up program' during the year. Question - Can Deepak get coverage for Hypertension under Chronic Management Program during the term of the Policy, prior to renewal? Answer – No, However at renewal of the Policy Deepak can pay an addition premium towards management of his acquired condition of Hypertension and get covered under the chronic management program for Hypertension in addition to Diabetes. Consultations or Diagnostic procedures common to the two conditions would be merged and a single Chronic management program for this combination would be covered.
From renewal Premium - 1st Jan 2019	Deepak gets coverage for both Diabetes and Hypertension under the Chronic Management Program if he chooses to pay the additional for Hypertension.

Annexure IV – List of Day Care Treatments

1	Cardiology Related:
1.	Coronary Angiography
2	Critical Care Related:
	2. Insert Non - Tunnel CV Cath
	3. Insert PICC CATH (Peripherally Inserted Central Catheter)
	4. Replace PICC CATH (Peripherally Inserted Central Catheter)
	5. Insertion Catheter, Intra Anterior
	6. Insertion of Portacath
3	Dental Related:
	7. Suturing Lacerated Lip
	8. Suturing Oral Mucosa
	9. Oral Biopsy In Case Of Abnormal Tissue Presentation
	10. FNAC
4	ENT Related:
	11. Myringotomy With Grommet Insertion
	12. Tymanoplasty (closure Of An Eardrum Perforation reconstruction Of The Auditory Ossicles)
	13. Removal Of A Tympanic Drain
	14. Keratosis Removal Under GA
	15. Operations On The Turbinates (nasal Concha)
	16. Removal Of Keratosis Obturans
	17. Stapedotomy To Treat Various Lesions In Middle Ear
	18. Revision Of A Stapedectomy
	19. Other Operations On The Auditory Ossicles
	20. Myringoplasty (post-aura/endaural Approach As Well As Simple Type-I Tympanoplasty)
	21. Fenestration Of The Inner Ear
	22. Revision Of A Fenestration Of The Inner Ear
	23. Palatoplasty
	24. Transoral Incision And Drainage Of A Pharyngeal Abscess
	25. Tonsillectomy Without Adenoidectomy
	26. Tonsillectomy With Adenoidectomy
	27. Excision And Destruction Of A Lingual Tonsil
	28. Revision Of A Tympanoplasty
	29. Other Microsurgical Operations On The Middle Ear
	30. Incision Of The Mastoid Process And Middle Ear
	31. Mastoidectomy
	32. Reconstruction Of The Middle Ear
	33. Other Excisions Of The Middle And Inner Ear
	34. Incision (opening) And Destruction (elimination) Of The Inner Ear
	35. Other Operations On The Middle And Inner Ear
	36. Excision And Destruction Of Diseased Tissue Of The Nose
	37. Other Operations On The Nose
	38. Nasal Sinus Aspiration
	39. Foreign Body Removal From Nose
	40. Other Operations On The Tonsils And Adenoids
	41. Adenoidectomy
	42. Labyrinthectomy For Severe Vertigo
	43. Stapedectomy Under GA
	44. Stapedectomy Under LA
	45. Tympanoplasty (type IV)
	46. Endolymphatic Sac Surgery For Meniere's Disease
	47. Turbinectomy
	48. Endoscopic Stapedectomy
	49. Incision And Drainage Of Perichondritis
	50. Septoplasty
	51. Vestibular Nerve Section
	52. Thyroplasty Type I
	53. Pseudocyst Of The Pinna - Excision
	54. Incision And Drainage - Haematoma Auricle
	55. Tympanoplasty (Type II)
	56. Reduction Of Fracture Of Nasal Bone
	57. Thyroplasty Type II
	58. Tracheostomy
	59. Excision Of Angioma Septum
	60. Turbinoplasty
	61. Incision & Drainage Of Retro Pharyngeal Abscess
	62. Uvulo Palato Pharyngo Plasty
	63. Adenoidectomy With Grommet Insertion
	64. Adenoidectomy Without Grommet Insertion
	65. Vocal Cord Lateralisation Procedure
	66. Incision & Drainage Of Para Pharyngeal Abscess
	67. Tracheoplasty
5	Gastroenterology Related:
	68. Cholecystectomy And Choledocho-jejunostomy/ Duodenostomy / Gastrostomy / Exploration Common Bile Duct
	69. Esophagoscopy, Gastroscopy, Duodenoscopy With Polypectomy/Removal Of Foreign Body/diathermy Of Bleeding Lesions
	70. Pancreatic Pseudocyst Eus & Drainage
	71. RF Ablation For Barrett's Oesophagus
	72. ERCP And Papillotomy
	73. Esophagoscope And Sclerosant Injection
	74. EUS + Submucosal Resection
	75. Construction Of Gastrostomy Tube
	76. EUS + Aspiration Pancreatic Cyst
	77. Small Bowel Endoscopy (therapeutic)
	78. Colonoscopy, Lesion Removal
	79. ERCP
	80. Colonscopy Stenting Of Stricture
	81. Percutaneous Endoscopic Gastrostomy
	82. EUS And Pancreatic Pseudo Cyst Drainage
	83. ERCP And Choledochoscopy
	84. Proctosigmoidoscopy Volvulus Detorsion
	85. ERCP And Sphincterotomy

	86. Esophageal Stent Placement		134. ERCP - Bile Duct Stone Removal
	87. ERCP + Placement Of Biliary Stents		135. Ileostomy Closure
	88. Sigmoidoscopy W / Stent		136. Colonoscopy
	89. EUS + Coeliac Node Biopsy		137. Polypectomy Colon
	90. UGI Scopy And Injection Of Adrenaline, Sclerosants Bleeding Ulcers		138. Splenic Abscesses Laparoscopic Drainage
			139. UGI Scopy And Polypectomy Stomach
6	General Surgery Related:		140. Rigid Oesophagoscopy For FB Removal
	91. Incision Of A Pilonidal Sinus / Abscess		141. Feeding Jejunostomy
	92. Fissure In Ano Sphincterotomy		142. Colostomy
	93. Surgical Treatment Of A Varicocele And A Hydrocele Of the Spermatic Cord		143. Ileostomy
			144. Colostomy Closure
	94. Orchidopexy		145. Submandibular Salivary Duct Stone Removal
	95. Abdominal Exploration In Cryptorchidism		146. Pneumatic Reduction Of Intussusception
	96. Surgical Treatment Of Anal Fistulas		147. Varicose Veins Legs - Injection Sclerotherapy
	97. Division Of The Anal Sphincter (sphincterotomy)		148. Rigid Oesophagoscopy For Plummer Vinson Syndrome
	98. Epididymectomy		
	99. Incision Of The Breast Abscess		149. Pancreatic Pseudocysts Endoscopic Drainage
	100. Operations On The Nipple		150. Zadek's Nail Bed Excision
	101. Excision Of Single Breast Lump		151. Subcutaneous Mastectomy
	102. Incision And Excision Of Tissue In The Perianal Region		152. Excision Of Ranula Under GA
	103. Surgical Treatment Of Hemorrhoids		153. Rigid Oesophagoscopy For Dilation Of Benign Strictures
	104. Other Operations On The Anus		
	105. Ultrasound Guided Aspirations		154. Eversion Of Sac -unilateral -bilateral
	106. Sclerotherapy, Etc.		
	107. Laparotomy For Grading Lymphoma With Splenectomy / liver / lymph Node Biopsy		
			155. Lord's Plication
	108. Therapeutic Laparoscopy With Laser		156. Jaboulay's Procedure
	109. Appendicectomy With/without Drainage		157. Scrotoplasty
	110. Infected Keloid Excision		158. Circumcision For Trauma
	111. Axillary Lymphadenectomy		159. Meatoplasty
	112. Wound Debridement And Cover		160. Intersphincteric Abscess Incision And Drainage
	113. Abscess-decompression		161. PSOAS Abscess Incision And Drainage
	114. Cervical Lymphadenectomy		162. Thyroid Abscess Incision And Drainage
	115. Infected Sebaceous Cyst		163. Tips Procedure For Portal Hypertension
	116. Inguinal Lymphadenectomy		164. Esophageal Growth Stent
	117. Incision And Drainage Of Abscess		165. Pair Procedure Of Hydatid Cyst Liver
	118. Suturing Of Lacerations		166. Tru Cut Liver Biopsy
	119. Scalp Suturing		167. Photodynamic Therapy Or Esophageal Tumour And Lung Tumour
	120. Infected Lipoma Excision		
	121. Maximal Anal Dilatation		168. Excision Of Cervical Rib
	122. Piles A) Injection Sclerotherapy B) Piles Banding		169. Laparoscopic Reduction Of Intussusception
			170. Microdochectomy Breast
			171. Surgery For Fracture Penis
	123. Liver Abscess- Catheter Drainage		172. Sentinel Node Biopsy
	124. Fissure In Ano- Fissurectomy		173. Parastomal Hernia
	125. Fibroadenoma Breast Excision		174. Revision Colostomy
	126. Oesophageal Varices Sclerotherapy		175. Prolapsed Colostomy- Correction
	127. ERCP - Pancreatic Duct Stone Removal		176. Testicular Biopsy
	128. Perianal Abscess I&d		177. Laparoscopic Cardiomyotomy(Hellers)
	129. Perianal Hematoma Evacuation		178. Sentinel Node Biopsy Malignant Melanoma
	130. UGI Scopy And Polypectomy Oesophagus		179. Laparoscopic Pyloromyotomy(Ramstedt)
	131. Breast Abscess I& D	7	Gynecology Related:
	132. Feeding Gastrostomy		180. Operations On Bartholin's Glands (cyst)
	133. Oesophagoscopy And Biopsy Of Growth Oesophagus		181. Incision Of The Ovary

	182. Insufflations Of The Fallopian Tubes		233. Motor Cortex Stimulation
	183. Other Operations On The Fallopian Tube		234. Stereotactic Radiosurgery
	184. Dilatation Of The Cervical Canal		235. Percutaneous Cordotomy
	185. Conisation Of The Uterine Cervix		236. Intrathecal Baclofen Therapy
	186. Therapeutic Curettage With Colposcopy / Biopsy / Diathermy / Cryosurgery		237. Entrapment Neuropathy Release
			238. Diagnostic Cerebral Angiography
	187. Laser Therapy Of Cervix For Various Lesions Of Uterus		239. VP Shunt
	188. Other Operations On The Uterine Cervix		240. Ventriculoatrial Shunt
	189. Incision Of The Uterus (hysterectomy)	9	Oncology Related:
	190. Local Excision And Destruction Of Diseased Tissue Of The Vagina And The Pouch Of Douglas		241. Radiotherapy For Cancer
			242. Cancer Chemotherapy
	191. Incision Of Vagina		243. IV Push Chemotherapy
	192. Incision Of Vulva		244. HBI-hemibody Radiotherapy
	193. Culdotomy		245. Infusional Targeted Therapy
	194. Salpingo-oophorectomy Via Laparotomy		246. SRT-stereotactic ARC Therapy
	195. Endoscopic Polypectomy		247. SC Administration Of Growth Factors
	196. Hysteroscopic Removal Of Myoma		248. Continuous Infusional Chemotherapy
	197. D&c		249. Infusional Chemotherapy
	198. Hysteroscopic Resection Of Septum		250. CCRT-concurrent Chemo + RT
	199. Thermal Cauterisation Of Cervix		251. 2D Radiotherapy
	200. Mirena Insertion		252. 3D Conformal Radiotherapy
	201. Hysteroscopic Adhesiolysis		253. IGRT- Image Guided Radiotherapy
	202. Leep		254. IMRT- Step & Shoot
	203. Cryocauterisation Of Cervix		255. Infusional Bisphosphonates
	204. Polypectomy Endometrium		256. IMRT- DMLC
	205. Hysteroscopic Resection Of Fibroid		257. Rotational Arc Therapy
	206. LLETZ		258. Tele Gamma Therapy
	207. Conization		259. FSRT-fractionated SRT
	208. Polypectomy Cervix		260. VMAT-volumetric Modulated Arc Therapy
	209. Hysteroscopic Resection Of Endometrial Polyp		261. SBRT-stereotactic Body Radiotherapy
	210. Vulval Wart Excision		262. Helical Tomotherapy
	211. Laparoscopic Paraovarian Cyst Excision		263. SRS-stereotactic Radiosurgery
	212. Uterine Artery Embolization		264. X-knife SRS
	213. Laparoscopic Cystectomy		265. Gammaknife SRS
	214. Hymenectomy(Imperforate Hymen)		266. TBI- Total Body Radiotherapy
	215. Endometrial Ablation		267. Intraluminal Brachytherapy
	216. Vaginal Wall Cyst Excision		268. Electron Therapy
	217. Vulval Cyst Excision		269. TSET-total Electron Skin Therapy
	218. Laparoscopic Paratubal Cyst Excision		270. Extracorporeal Irradiation Of Blood Products
	219. Repair Of Vagina (Vaginal Atresia)		271. Telecobalt Therapy
	220. Hysteroscopy, Removal Of Myoma		272. Telecesium Therapy
	221. TURBT		273. External Mould Brachytherapy
	222. Ureterocoele Repair - Congenital Internal		274. Interstitial Brachytherapy
	223. Vaginal Mesh For POP		275. Intracavity Brachytherapy
	224. Laparoscopic Myomectomy		276. 3D Brachytherapy
	225. Surgery For SUI		277. Implant Brachytherapy
	226. Repair Recto- Vagina Fistula		278. Intravesical Brachytherapy
	227. Pelvic Floor Repair(Excluding Fistula Repair)		279. Adjuvant Radiotherapy
	228. URS + LL		280. Afterloading Catheter Brachytherapy
	229. Laparoscopic Oophorectomy		281. Conditioning Radiothearpy For BMT
	230. Normal Vaginal Delivery And Variants		282. Nerve Biopsy
8	Neurology Related:		283. Muscle Biopsy
	231. Facial Nerve Glycerol Rhizotomy		284. Epidural Steroid Injection
	232. Spinal Cord Stimulation		285. Extracorporeal Irradiation To The Homologous Bone Grafts

	286. Radical Chemotherapy		329. Corrective Surgery For Entropion And Ectropion
	287. Neoadjuvant Radiotherapy		330. Corrective Surgery For Blepharoptosis
	288. LDR Brachytherapy		331. Removal Of A Foreign Body From The Conjunctiva
	289. Palliative Radiotherapy		332. Removal Of A Foreign Body From The Cornea
	290. Radical Radiotherapy		333. Incision Of The Cornea
	291. Palliative Chemotherapy		334. Operations For Pterygium
	292. Template Brachytherapy		335. Other Operations On The Cornea
	293. Neoadjuvant Chemotherapy		336. Removal Of A Foreign Body From The Lens Of The Eye
	294. Adjuvant Chemotherapy		337. Removal Of A Foreign Body From The Posterior Chamber Of The Eye
	295. Induction Chemotherapy		
	296. Consolidation Chemotherapy		338. Removal Of A Foreign Body From The Orbit And Eyeball
	297. Maintenance Chemotherapy		339. Correction Of Eyelid Ptosis By Levator Palpebrae Superioris Resection (bilateral)
	298. HDR Brachytherapy		
10	Operations On The Salivary Glands & Salivary Ducts:		340. Correction Of Eyelid Ptosis By Fascia Lata Graft (bilateral)
	299. Incision And Lancing Of A Salivary Gland And A Salivary Duct		341. Diathermy/cryotherapy To Treat Retinal Tear
	300. Excision Of Diseased Tissue Of A Salivary Gland And A Salivary Duct		342. Anterior Chamber Paracentesis / Cyclodiathermy / Cyclocryotherapy / Goniotomy Trabeculotomy And Filtering And Allied Operations To Treat Glaucoma
	301. Resection Of A Salivary Gland		
	302. Reconstruction Of A Salivary Gland And A Salivary Duct		343. Enucleation Of Eye Without Implant
	303. Other Operations On The Salivary Glands And Salivary Ducts		344. Dacryocystorhinostomy For Various Lesions Of Lacrimal Gland
11	Operations On The Skin & Subcutaneous Tissues:		345. Laser Photocoagulation To Treat Ratinal Tear
	304. Other Incisions Of The Skin And Subcutaneous Tissues		346. Biopsy Of Tear Gland
	305. Surgical Wound Toilet (wound Debridement) And Removal Of Diseased Tissue Of The Skin And Subcutaneous Tissues		347. Treatment Of Retinal Lesion
		14	**Orthopedics Related:**
	306. Local Excision Of Diseased Tissue Of The Skin And Subcutaneous Tissues		348. Surgery For Meniscus Tear
			349. Incision On Bone, Septic And Aseptic
	307. Other Excisions Of The Skin And Subcutaneous Tissues		350. Closed Reduction On Fracture, Luxation Or Epiphyseolysis With Osteosynthesis
	308. Simple Restoration Of Surface Continuity Of The Skin And Subcutaneous Tissues		
			351. Suture And Other Operations On Tendons And Tendon Sheath
	309. Free Skin Transplantation, Donor Site		352. Reduction Of Dislocation Under GA
	310. Free Skin Transplantation, Recipient Site		353. Arthroscopic Knee Aspiration
	311. Revision Of Skin Plasty		354. Surgery For Ligament Tear
	312. Other Restoration And Reconstruction Of The Skin And Subcutaneous Tissues.		355. Surgery For Hemoarthrosis/pyoarthrosis
			356. Removal Of Fracture Pins/nails
	313. Chemosurgery To The Skin.		357. Removal Of Metal Wire
	314. Destruction Of Diseased Tissue In The Skin And Subcutaneous Tissues		358. Closed Reduction On Fracture, Luxation
			359. Reduction Of Dislocation Under GA
	315. Reconstruction Of Deformity/defect In Nail Bed		360. Epiphyseolysis With Osteosynthesis
	316. Excision Of Bursirtis		361. Excision Of Various Lesions In Coccyx
	317. Tennis Elbow Release		362. Arthroscopic Repair Of Acl Tear Knee
12	Operations On The Tongue:		363. Closed Reduction Of Minor Fractures
	318. Incision, Excision And Destruction Of Diseased Tissue Of The Tongue		364. Arthroscopic Repair Of PCL Tear Knee
			365. Tendon Shortening
	319. Partial Glossectomy		366. Arthroscopic Meniscectomy - Knee
	320. Glossectomy		367. Treatment Of Clavicle Dislocation
	321. Reconstruction Of The Tongue		368. Haemarthrosis Knee- Lavage
	322. Other Operations On The Tongue		369. Abscess Knee Joint Drainage
13	Ophthalmology Related		370. Carpal Tunnel Release
	323. Surgery For Cataract		371. Closed Reduction Of Minor Dislocation
	324. Incision Of Tear Glands		372. Repair Of Knee Cap Tendon
	325. Other Operations On The Tear Ducts		373. ORIF With K Wire Fixation- Small Bones
	326. Incision Of Diseased Eyelids		374. Release Of Midfoot Joint
	327. Excision And Destruction Of Diseased Tissue Of The Eyelid		375. ORIF With Plating- Small Long Bones
	328. Operations On The Canthus And Epicanthus		376. Implant Removal Minor

	377. K Wire Removal		428. Removal Of Vesical Stone
	378. Closed Reduction And External Fixation		429. Excision Sigmoid Polyp
	379. Arthrotomy Hip Joint		430. Sternomastoid Tenotomy
	380. Syme's Amputation		431. Infantile Hypertrophic Pyloric Stenosis Pyloromyotomy
	381. Arthroplasty		432. Excision Of Soft Tissue Rhabdomyosarcoma
	382. Partial Removal Of Rib		433. Mediastinal Lymph Node Biopsy
	383. Treatment Of Sesamoid Bone Fracture		434. High Orchidectomy For Testis Tumours
	384. Shoulder Arthroscopy / Surgery		435. Excision Of Cervical Teratoma
	385. Elbow Arthroscopy		436. Rectal-myomectomy
	386. Amputation Of Metacarpal Bone		437. Rectal Prolapse (delorme's Procedure)
	387. Release Of Thumb Contracture		438. Detorsion Of Torsion Testis
	388. Incision Of Foot Fascia		439. EUA + Biopsy Multiple Fistula In Ano
	389. Partial Removal Of Metatarsal	17	Plastic Surgery Related:
	390. Repair / Graft Of Foot Tendon		440. Construction Skin Pedicle Flap
	391. Revision/removal Of Knee Cap		441. Gluteal Pressure Ulcer-excision
	392. Amputation Follow-up Surgery		442. Muscle-skin Graft, Leg
	393. Exploration Of Ankle Joint		443. Removal Of Bone For Graft
	394. Remove/graft Leg Bone Lesion		444. Muscle-skin Graft Duct Fistula
	395. Repair/graft Achilles Tendon		445. Removal Cartilage Graft
	396. Remove Of Tissue Expander		446. Myocutaneous Flap
	397. Biopsy Elbow Joint Lining		447. Fibro Myocutaneous Flap
	398. Removal Of Wrist Prosthesis		448. Breast Reconstruction Surgery After Mastectomy
	399. Biopsy Finger Joint Lining		449. Sling Operation For Facial Palsy
	400. Tendon Lengthening		450. Split Skin Grafting Under RA
	401. Treatment Of Shoulder Dislocation		451. Wolfe Skin Graft
	402. Lengthening Of Hand Tendon		452. Plastic Surgery To The Floor Of The Mouth Under GA
	403. Removal Of Elbow Bursa	18	Thoracic Surgery Related:
	404. Fixation Of Knee Joint		453. Thoracoscopy And Lung Biopsy
	405. Treatment Of Foot Dislocation		454. Excision Of Cervical Sympathetic Chain Thoracoscopic
	406. Surgery Of Bunion		455. Laser Ablation Of Barrett's Oesophagus
	407. Tendon Transfer Procedure		456. Pleurodesis
	408. Removal Of Knee Cap Bursa		457. Thoracoscopy And Pleural Biopsy
	409. Treatment Of Fracture Of Ulna		458. EBUS + Biopsy
	410. Treatment Of Scapula Fracture		459. Thoracoscopy Ligation Thoracic Duct
	411. Removal Of Tumor Of Arm/ Elbow Under RA/GA		460. Thoracoscopy Assisted Empyaema Drainage
	412. Repair Of Ruptured Tendon	19	Urology Related:
	413. Decompress Forearm Space		461. Haemodialysis
	414. Revision Of Neck Muscle (torticollis Release)		462. Lithotripsy/nephrolithotomy For Renal Calculus
	415. Lengthening Of Thigh Tendons		463. Excision Of Renal Cyst
	416. Treatment Fracture Of Radius & Ulna		464. Drainage Of Pyonephrosis/perinephric Abscess
	417. Repair Of Knee Joint		465. Incision Of The Prostate
15	Other Operations On The Mouth & Face:		466. Transurethral Excision And Destruction Of Prostate Tissue
	418. External Incision And Drainage In The Region Of The Mouth, Jaw And Face		467. Transurethral And Percutaneous Destruction Of Prostate Tissue
			468. Open Surgical Excision And Destruction Of Prostate Tissue
	419. Incision Of The Hard And Soft Palate		469. Radical Prostatovesiculectomy
	420. Excision And Destruction Of Diseased Hard And Soft Palate		470. Other Excision And Destruction Of Prostate Tissue
	421. Incision, Excision And Destruction In The Mouth		471. Operations On The Seminal Vesicles
	422. Other Operations In The Mouth		472. Incision And Excision Of Periprostatic Tissue
16	Pediatric Surgery Related:		473. Other Operations On The Prostate
	423. Excision Of Fistula-in-ano		474. Incision Of The Scrotum And Tunica Vaginalis Testis
	424. Excision Juvenile Polyps Rectum		475. Operation On A Testicular Hydrocele
	425. Vaginoplasty		476. Excision And Destruction Of Diseased Scrotal Tissue
	426. Dilatation Of Accidenta L Caustic Stricture Oesophageal		477. Other Operations On The Scrotum And Tunica Vaginalis Testis
	427. Presacral Teratomas Excision		478. Incision Of The Testes

	479. Excision And Destruction Of Diseased Tissue Of The Testes		
	480. Unilateral Orchidectomy		
	481. Bilateral Orchidectomy		
	482. Surgical Repositioning Of An Abdominal Testis		
	483. Reconstruction Of The Testis		
	484. Implantation, Exchange And Removal Of A Testicular Prosthesis		
	485. Other Operations On The Testis		
	486. Excision In The Area Of The Epididymis		
	487. Operations On The Foreskin		
	488. Local Excision And Destruction Of Diseased Tissue Of The Penis		
	489. Amputation Of The Penis		
	490. Other Operations On The Penis		
	491. Cystoscopical Removal Of Stones		
	492. Lithotripsy		
	493. Biopsy Oftemporal Artery For Various Lesions		
	494. External Arterio-venous Shunt		
	495. AV Fistula - Wrist		
	496. URSL With Stenting		
	497. URSL With Lithotripsy		
	498. Cystoscopic Litholapaxy		
	499. ESWL		
	500. Bladder Neck Incision		
	501. Cystoscopy & Biopsy		
	502. Cystoscopy And Removal Of Polyp		
	503. Suprapubic Cystostomy		
	504. Percutaneous Nephrostomy		
	505. Cystoscopy And "SLING" Procedure.		
	506. TUNA- Prostate		
	507. Excision Of Urethral Diverticulum		
	508. Removal Of Urethral Stone		
	509. Excision Of Urethral Prolapse		
	510. Mega-ureter Reconstruction		
	511. Kidney Renoscopy And Biopsy		
	512. Ureter Endoscopy And Treatment		
	513. Vesico Ureteric Reflux Correction		
	514. Surgery For Pelvi Ureteric Junction Obstruction		
	515. Anderson Hynes Operation		
	516. Kidney Endoscopy And Biopsy		
	517. Paraphimosis Surgery		
	518. Injury Prepuce- Circumcision		
	519. Frenular Tear Repair		
	520. Meatotomy For Meatal Stenosis		
	521. Surgery For Fournier's Gangrene Scrotum		
	522. Surgery Filarial Scrotum		
	523. Surgery For Watering Can Perineum		
	524. Repair Of Penile Torsion		
	525. Drainage Of Prostate Abscess		
	526. Orchiectomy		
	527. Cystoscopy And Removal Of FB		