1. Preamble

This 'Max Bupa Health Pulse' policy is a contract of insurance between You and Us which is subject to payment of full premium in advance and the terms, conditions and exclusions of this Policy. This Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided by You in the Proposal Form and the Information Summary Sheet.

Please inform Us immediately of any change in the address or any other changes affecting You or any Insured Person which would impact the benefits, terms and conditions under this Policy.

In addition, please note the list of exclusions is set out in Section 7 of this Policy.

2. Definitions & Interpretation

For the purposes of interpretation and understanding of this Policy, We have defined, in Section 12, some of the important words used in the Policy which will have the special meaning accorded to these terms for the purposes of this Policy. For the remaining language and words used, the usual meaning as described in standard English language dictionaries shall apply. The words and expressions defined in the Insurance Act 1938, IRDA Act 1999, regulations notified by the IRDAI and circulars and guidelines issued by the IRDAI, together with their amendment shall carry the meanings given therein.

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

3. Benefits available under the Policy

The benefits available under this Policy are described below.

a. The Policy covers Reasonable and Customary Charges incurred towards medical treatment taken by the Insured Person during the Policy Period for an Illness, Injury or condition as described in the sections below and contracted or sustained during the Policy Period. The benefits listed in the sections below will be payable subject to the terms, conditions and exclusions of this Policy and the availability of the Sum Insured and any sub-limits for the benefit as maybe specified in the Policy Schedule.
b. The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment are mentioned in Annexure II.All the benefits (including optional benefits) which are available under the Policy along with the respective limits / amounts applicable based on the Sum Insured have been summarized in the Product Benefit Table in Annexure III.
c. All claims under the Policy must be made in accordance with the process defined under Section 8 (Claim Process & Requirements).
d. All claims paid under any benefit except for those admitted under Section 3.9 (Pharmacy and Diagnostic Services), Section 3.12 (Health Check-up), Section 4.1 (Personal Accident Cover), Section 4.2 (Critical Illness Cover), Section 4.3 (e-Consultation) and Section 4.4 (Hospital Cash) shall reduce the Sum Insured for the Policy Year in which the Insured Event in relation to which the claim is made has been occurred, unless otherwise specified in the respective section. Thereafter only the balance Sum Insured after payment of claim amounts admitted shall be available for future claims arising in that Policy Year.

3.1 Inpatient Care

What is covered:
We will indemnify the Medical Expenses incurred for one or more of the following due to the Insured Person's Hospitalization during the Policy Period following an Illness or Injury:

i. Room Rent: Room boarding and nursing charges during Hospitalization as charged by the Hospital where the Insured Person availed medical treatment;
ii. Medical Practitioners' fees, excluding any charges or fees for Standby Services;
iii. Investigative tests or diagnostic procedures directly related to the Insured Event which led to the current Hospitalization;
iv. Medicines, drugs as prescribed by the treating Medical Practitioner related to the Insured Event that led to the current Hospitalization;
v. Intravenous fluids, blood transfusion, injection administration charges, allowable consumables and/or enteral feedings;
vi. Operation theatre charges;
vii. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
viii. Intensive Care Unit Charges.

Conditions - The above coverage is subject to fulfillment of following conditions:

a. The Hospitalization is for Medically Necessary Treatment and advised in writing by a Medical Practitioner.
b. If the Insured Person is admitted in a Hospital room where the room category opted or Room Rent incurred is higher than the eligibility as specified in the Policy Schedule, then We shall be liable to pay only a pro-rated portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula:
(eligible Room Rent limit / Room Rent actually incurred) * total Associated Medical Expenses

Associated Medical Expenses shall include Room Rent, nursing charges, Medical Practitioners' fees and operation theatre charges

c. We will pay the visiting fees or consultation charges for any Medical Practitioner visiting the Insured Person only if:
i. The Medical Practitioner's treatment or advice has been specifically sought by the Hospital; and
ii. The visiting fees or consultation charges are included in the Hospital's bill

3.2 Pre-hospitalization Medical Expenses

What is covered:
We will indemnify, on Reimbursement basis only, the Insured Person's Pre-hospitalization Medical Expenses incurred in respect of an Illness or Injury.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. We have accepted a claim under Section 3.1 (Inpatient Care) or Section 3.4 (Day Care Treatment) or Section 3.5 (Domiciliary Hospitalization) or Section 3.15 (Modern Treatments)
b. Pre-hospitalization Medical Expenses are incurred for the same condition for which We have accepted the Inpatient Care, Day Care Treatment or Domiciliary Hospitalization or Modern Treatments claim.
c. The expenses are incurred after the inception of the First Policy with Us. If any portion of these expenses is incurred before the inception of the First Policy with Us, then We shall be liable only for those expenses incurred after the commencement date of the First Policy, irrespective of the initial waiting period.
d. Pre-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is prescribed in writing by the treating Medical Practitioner as Medically Necessary Treatment and is directly related to the same condition that led to Hospitalization.
e. Any claim admitted under this Section 3.2 shall reduce the Sum Insured for the Policy Year in which In-patient Care or Day Care Treatment or Domiciliary Hospitalization or Modern Treatments claim has been incurred.

Sub-limit:

a. We will pay above mentioned Pre-hospitalization Medical Expenses only for period up to 30 days immediately preceding the Insured Person's admission for Inpatient Care or Day Care Treatment or Domiciliary Hospitalization or Modern Treatments.

3.3 Post-hospitalization Medical Expenses

What is covered:

We will indemnify, on Reimbursement basis only, the Insured Person's Post-hospitalization Medical Expenses incurred following an Illness or Injury.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. We have accepted a claim under Section 3.1 (Inpatient Care) or Section 3.4 (Day Care Treatment) or Section 3.5 (Domiciliary Hospitalization) or Section 3.15 (Modern Treatments).
b. Post-hospitalization Medical Expenses are incurred for the same condition for which We have accepted the Inpatient Care or Day Care Treatment or Domiciliary Hospitalization or Modern Treatments claim.
c. The expenses incurred shall be as advised in writing by the treating Medical Practitioner.
d. Post-hospitalization Medical Expenses incurred on physiotherapy will also be payable provided that such physiotherapy is prescribed in writing by the treating Medical Practitioner as Medically Necessary Treatment and is directly related to the same condition that led to Hospitalization.
e. Any claim admitted under this Section 3.3 shall reduce the Sum Insured for the Policy Year in which In-patient Care or Day Care Treatment or Domiciliary Hospitalization or Modern Treatments claim has been incurred.

Sub-limit:

a. We will pay Post-hospitalization Medical Expenses only for period up to 60 days immediately following the Insured Person's discharge from Hospital or Day Care Treatment or Domiciliary Hospitalization or Modern Treatments.

3.4 Day Care Treatment

What is covered:

We will indemnify the Medical Expenses incurred on the Insured Person's Day Care Treatment during the Policy Period following an Illness or Injury. List of Day Care Treatments which are covered under the Policy are provided in Annexure IV.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. The Day Care Treatment is advised in writing by a Medical Practitioner as Medically Necessary Treatment.
b. Only those Day Care Treatments are covered that are mentioned under list of Day Care Treatments under Annexure IV.
c. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections 3.2 and 3.3 above.

What is not covered:
OPD Treatment and Diagnostic Services costs are not covered under this benefit.

3.5 **Domiciliary Hospitalization**

What is Covered:
We will indemnify on Reimbursement basis only, the Medical Expenses incurred for the Insured Person's Domiciliary Hospitalization during the Policy Period following an Illness or Injury.

Conditions - The above coverage is subject to fulfilment of following conditions:
a. The Domiciliary Hospitalization continues for at least 3 consecutive days in which case We will make payment under this benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization;
b. The treating Medical Practitioner confirms in writing that the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital OR the Insured Person satisfies Us that a Hospital bed was unavailable.
c. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections 3.2 and 3.3 above.

3.6 **Alternative Treatments**

What is covered:
We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalization for Inpatient Care during the Policy Period on treatment taken under Ayurveda, Unani, Siddha and Homeopathy.

Conditions - The above coverage is subject to fulfilment of following conditions:
a. The treatment should be taken in AYUSH Hospital:
b. Pre-hospitalization Medical Expenses incurred for up to 30 days immediately preceding the Insured Person's admission and Post-hospitalization Medical Expenses incurred for up to 60 days immediately following the Insured Person's discharge will also be indemnified under this benefit, provided that these Medical Expenses relate only to Alternative Treatments and not Allopathy.

c. Section 7.28 of the Permanent Exclusions (other than for Yoga) shall not apply to the extent this benefit is applicable.

3.7 **Living Organ Donor Transplant**

What is covered:
We will indemnify the Medical Expenses incurred for a living organ donor's treatment as an Inpatient for the harvesting of the organ donated.

Conditions - The above coverage is subject to fulfilment of following conditions:
a. The donation conforms to the Transplantation of Human Organs Act 1994 and any amendments thereafter and the organ is for the use of the Insured Person.
b. The organ transplant is certified in writing by a Medical Practitioner as Medically Necessary Treatment for the Insured Person.
c. We have accepted the recipient Insured Person's claim under Section 3.1 (Inpatient Care).

What is not covered:
a. Stem cell donation whether or not it is Medically Necessary Treatment except for Bone Marrow Transplant.
b. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
c. Screening or any other Medical Expenses related to the organ donor, which are not incurred during the duration of Insured Person's Hospitalization for organ transplant.
d. Transplant of any organ/tissue where the transplant is Unproven/Experimental Treatment or investigational in nature.
e. Expenses related to organ transportation or preservation.
f. Any other medical treatment or complication in respect of the donor which is directly or indirectly consequence to harvesting.

3.8 **Emergency Ambulance**

What is covered:
We will indemnify the costs incurred, on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury.

Conditions: The above coverage is subject to fulfilment of following conditions:
a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is injured or is ill to a Hospital where appropriate medical treatment can be obtained or;
b. The medical condition of the Insured Person requires immediate ambulance services from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Hospitalization.
c. This benefit is available for only one transfer per Hospitalization.
d. The ambulance service shall be offered by a healthcare or ambulance Service Provider.
e. We have accepted a claim under Section 3.1 (Inpatient Care) above.
f. We will cover expenses up to the amount specified in Your Policy Schedule.

What is not covered:
The Insured Person's transfer to any Hospital or diagnostic centre for evaluation purposes only.

3.9 **Pharmacy and Diagnostic Services**

What is covered:
You may purchase medicines or avail diagnostic services from Our Service Provider through Our website or mobile application.

Conditions - The above coverage is subject to fulfilment of following conditions:
a. The cost for the purchase of the medicines or for availing diagnostic services shall be borne by You.
b. Further it is made clear that purchase of medicines from Our Service Provider is Your absolute discretion and choice.

3.10 **No Claim Bonus**

What is covered:
a. If the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year in the 2 year / 3 year Policy Period respectively (if applicable) and no claim has been made in the immediately preceding Policy Year, then for every claim free Policy Year, We will increase the Sum Insured applicable under the Policy by 10% of the Base Sum Insured of the immediately preceding Policy Year subject to a maximum of 100% of the Base Sum Insured. There will be no change in the sub-limits of any benefit due to increase in Sum Insured under this benefit.
b. If a claim has been made in the immediately preceding Policy Year, We will not increase or decrease the Sum Insured due to this benefit for the Policy Year. Whereas, if a reported claim has been denied by Us, the Insured Persons will be eligible for this benefit.

Conditions - The above coverage is subject to fulfilment of following conditions:
a. If the Insured Person in the expiring Policy is covered under an Individual Policy and has an accumulated No Claim Bonus in the expiring Policy under this benefit, and such expiring Policy is Renewed with Us on a Family Floater Policy, then We will provide the credit for the accumulated No Claim Bonus to the Family Floater Policy.
b. If the Insured Persons in the expiring Policy are covered on a Family Floater Policy and such Insured Persons Renew their expiring Policy with Us by splitting the Floater Sum Insured stated in the Policy Schedule in to two or more floater / individual Policy, then We will provide the credit of the accumulated No Claim Bonus to the split Policy.
c. In case the Base Sum Insured under the Policy is reduced at the time of Renewal, the applicable accumulated No Claim Bonus shall also be reduced in proportion to the Base Sum Insured. The maximum reduction in the accumulated No Claim Bonus shall be limited to 50% of the accumulated No Claim Bonus. Post reduction in the Base Sum Insured and the accumulated No Claim Bonus, if the accumulated No Claim Bonus is equal to or more than 100% (200%, if Enhanced No Claim Bonus is opted) of the revised Base Sum Insured, then there will be no further increase in the accumulated No Claim Bonus upon Renewal of such Policy.
d. In case the Base Sum Insured under the Policy is increased at the time of Renewal, the applicable accumulated No Claim Bonus shall also be increased in proportion to the Base Sum Insured. The maximum increase in the accumulated No Claim Bonus shall be limited to 50% of the accumulated No Claim Bonus. Post increase in the Base Sum Insured and the accumulated No Claim Bonus, if the accumulated No Claim Bonus is equal to or more than 100% (200%, if Enhanced No Claim Bonus is opted) of the revised Base Sum Insured, then there will be no further increase in the accumulated No Claim Bonus upon Renewal of such Policy.
e. This benefit is not applicable for Optional benefits (if opted for) such as Personal Accident Cover, Critical Illness Cover, e-Consultation and Hospital Cash.

3.11 **Re-fill Benefit**

What is covered:
If the Base Sum Insured and accumulated No Claim Bonus (if any) has been partially or completely exhausted due to claims made and paid or accepted as payable, for any Illness / Injury during the Policy Year under Section 3, then We will provide a Re-fill amount of maximum up to 100% of the Base Sum Insured (excluding No Claim Bonus) which may be utilized for claims arising in that Policy Year, subject to the conditions mentioned below.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. The Re-fill amount may be used for only subsequent claims in respect of the Insured Person and shall not be for any Illness / Injury (including its complications or follow up) for which a claim has been paid or accepted as payable in the current Policy Year for the same Insured Person.
b. For Family Floater Policies, the Re-fill amount will be available on a floater basis to all Insured Persons in that Policy Year.
c. If the Re-fill amount is not utilized in whole or in part in a Policy Year, it cannot be carried forward to any extent in any subsequent Policy Year.
d. The maximum liability for a single claim after applying Re-fill benefit shall not be more than Base Sum Insured and accumulated No Claim Bonus (if any).

3.12 **Health Check-up**

What is covered:

If the Policy is Renewed with Us without a break or if the Policy continues to be in force for the 2nd Policy Year and 3rd Policy Year in the 2 year or 3 year Policy Period respectively (if applicable), then the Insured Person may avail a health check-up, each Policy Year starting from 2nd Policy Year, on Cashless Facility basis.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. Health check-up will be arranged only at Service Providers empanelled with Us.
b. Health check-up shall be available to Insured Person covered as adult under the Policy.
c. The Insured Person will not be eligible to avail a health check-up in the first Policy Year in which he/she is covered as an Insured Person under the Policy.
d. Any unutilized Health Check-up cannot be carry forwarded to the next Policy Year.
e. The tests covered under this benefit are Complete Blood Count, Urine Routine, ESR, HBA1C, S Cholesterol, Sr. HDL, Sr LDL and Kidney Function Test.

3.13 **Mental Disorders Treatment**

What is covered:

We will indemnify the expenses incurred by the Insured Person for Inpatient treatment for Mental Illness up to the limit as specified in Your Policy Schedule.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. Mental Disorders Treatment is only covered where patient is diagnosed by a qualified psychiatrist and / or referred to a clinical psychologist for further treatment.
b. The Hospitalization is for Medically Necessary Treatment and prescribed in writing by a registered mental health specialist, psychiatrist or clinical psychologist.
c. The treatment should be taken in Hospitals having registration under the Clinical Establishments (Registration and Regulation) Act, 2010 and complies with the following minimum criteria:
    i. Has qualified psychiatric doctor who is registered with respective medical council;
    ii. Has dedicated mental therapy sections;
    iii. Maintains daily records of patients.
d. Pre-hospitalization Medical Expenses incurred for up to 30 days, if falling within the Policy Period, immediately preceding the Insured Person's admission and Post-hospitalization Medical Expenses incurred for up to 60 days, if falling within the Policy Period, immediately following the Insured Person's discharge will also be indemnified under this benefit.

What is not covered:

a. The condition which is not clinically significant or is related to anxiety, bereavement, relationship or academic problems, acculturation difficulties or work pressure.
b. Treatment related to intentional self inflicted Injury or attempted suicide by any means.
c. Treatment and complications related to disorders of intoxication, dependence, abuse, and withdrawal caused by drugs and other substances such as alcohol, opiods or nicotine.

Sub-limit:

a. The following disorders / conditions shall be covered only up to 10% of Base Sum Insured or Rs. 50,000, whichever is lower. This sub-limit shall apply for all the following disorders / conditions on cumulative basis.

Disorder / Condition	Description
Severe Depression	Severe depression is characterized by a persistent feeling of sadness or a lack of interest in outside stimuli. It affects the way one feels, thinks and behaves.
Schizophrenia	Schizophrenia is mental disorder, that distorts the way a person thinks, acts, expresses emotions, perceives reality, and relates to others. Schizophrenia result in combination of hallucinations, delusions, and extremely disordered thinking and behavior that impairs daily functioning,
Bipolar Disorder	Bipolar disorder is a mental illness that brings severe high and low moods and changes in sleep, energy, thinking, and behavior. It includes periods of extreme mood swings with emotional highs and lows.
Post traumatic stress disorder	Post-traumatic stress disorder is an anxiety disorder caused by very stressful, frightening or distressing events. It includes flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event.
Eating disorder	Eating disorder is a mental condition where people experience severe disturbances in their eating behaviors and related thoughts and emotions.
Generalized anxiety disorder	Generalized Anxiety Disorder is a mental health disorder characterized by a perpetual state of worry, fear, apprehension, inability to relax.
Obsessive compulsive disorders	Obsessive-compulsive disorder is an anxiety disorder in which people have recurring, unwanted thoughts, ideas or sensations (obsessions) that make them feel driven to do something repetitively (compulsions).
Panic disorders	Panic disorder is an anxiety disorder characterized by reoccurring unexpected panic attacks with sudden periods of intense fear. It may include palpitations, sweating, shaking, shortness of breath, numbness, or a feeling that something terrible is going to happen.
Personality disorders	Personality disorder is a type of mental disorder in which people have a rigid and unhealthy pattern of thinking, functioning and behaving. It includes trouble in perceiving and relating to situations and people.
Conversion disorders	Conversion disorder is a type of mental disorder where mental or emotional distress causes physical symptoms without the existence of an actual physical condition.
Dissociative disorders	Dissociative disorders are mental disorders that involve experiencing a disconnection and lack of continuity between thoughts, memories, surroundings, actions and identity.

ICD codes for the above disorders / conditions are provided in Annexure V.

b. Pre-hospitalization and Post-hospitalization Medical Expenses are also covered within the overall benefit sub-limit as specified above in point (a).

3.14 **HIV / AIDS**

What is covered:

We will indemnify the expenses incurred by the Insured Person, as per the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 and amendments thereafter, for Hospitalization (including Day Care Treatment) due to condition caused by or associated with HIV / AIDS up to the limit as specified in Your Policy Schedule.

Conditions - The above coverage is subject to fulfilment of following conditions:

a. The Hospitalization or Day Care Treatment is Medically Necessary and the Illness is the outcome of HIV / AIDS. This needs to be prescribed in writing by a registered Medical Practitioner.
b. The coverage under this benefit is provided for opportunistic infections which are caused due to low immunity status in HIV / AIDS resulting in acute infections which may be bacterial, viral, fungal or parasitic.
c. The patient should be a declared HIV positive by informed consent by Integrated counseling and testing centre deployed by government of India.
d. This benefit is provided subject to a Waiting Period of 48 months from inception of the cover with Us, with HIV / AIDS covered as a benefit, for the respective Insured Person.

e. Pre-hospitalization Medical Expenses incurred for up to 30 days, if falling within the Policy Period, immediately preceding the Insured Person's admission and Post-hospitalization Medical Expenses incurred for up to 60 days, if falling within the Policy Period, immediately following the Insured Person's discharge will also be indemnified under this benefit.

What is not covered:

a. Health conditions which are chronic and not directly related to the patient's immune status.
b. Lifestyle diseases like diabetes, hypertension, heart diseases and dyslipidemia which are not related to HIV / AIDS would not be covered under this benefit.

Sub-limit:

a. This benefit is covered up to 10% of Base Sum Insured or Rs. 50,000 whichever is lower.
b. Pre-hospitalization and Post-hospitalization Medical Expenses are also covered within the overall benefit sub-limit as specified above in point (a).

3.15 **Modern Treatments:**

What is covered:

a. The following procedures / treatments will be covered either as Inpatient Care or as part of Day Care Treatment as per Section 3.1 and Section 3.4 respectively, in a Hospital :
   i. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
   ii. Balloon Sinuplasty
   iii. Deep Brain stimulation
   iv. Oral chemotherapy
   v. Immunotherapy- Monoclonal Antibody to be given as injection
   vi. Intra vitreal injections
   vii. Robotic surgeries
   viii. Stereotactic radio surgeries
   ix. Bronchical Thermoplasty
   x. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
   xi. IONM - (Intra Operative Neuro Monitoring)
   xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.
b. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections 3.2 and 3.3 within the overall benefit sub-limit.

Special condition applicable for robotic surgeries:

A limit of maximum INR 1 Lac will apply to all robotic surgeries, except the following:

i. Robotic total radical prostatectomy
ii. Robotic cardiac surgeries
iii. Robotic partial nephrectomy
iv. Robotic surgeries for malignancies

4. Optional Benefits

The following optional benefits shall apply under the Policy only if it is specified in the Policy Schedule. Optional benefits can be selected by You only at the time of issuance of the First Policy or at Renewal (unless otherwise specified) on payment of the corresponding additional premium.

The optional benefits 'Personal Accident Cover', 'Critical Illness Cover' and 'Hospital Cash' will be payable (only on Reimbursement basis) if the conditions mentioned in the below sections are contracted or sustained by the Insured Person covered under these optional benefits during the Policy Period.

The applicable optional benefits will be payable subject to the terms, conditions and exclusions of this Policy and subject always to any sub-limits for the optional benefit as specified in the Policy Schedule.

All claims for any applicable optional benefits under the Policy must be made in accordance with the process defined under Section 8 (Claim Process & Requirements).

4.1 Personal Accident Cover

What is covered:
This optional benefit is available either to the Primary Insured Person or Primary Insured Person along with his/her spouse, which is specified in the Policy Schedule.

If the Insured Person covered under this optional benefit dies or sustains any Injury resulting solely and directly from an Accident occurring during the Policy Period at any location worldwide, and while the Policy is in force, We will provide the benefits described below.

4.1.1 Accident Death (AD)

What is covered:
If the Injury due to Accident solely and directly results in the Insured Person's death within 365 days from the occurrence of the Accident, We will make payment of Personal Accident Cover Sum Insured specified in the Policy Schedule. If a claim is made under this optional benefit, the coverage for that Insured Person under the Policy shall immediately and automatically cease. Any claim incurred before death of such Insured person shall be admissible subject to terms and conditions under this Policy.

4.1.2 Accident Permanent Total Disability (APTD)

What is covered:
If the Injury due to Accident solely and directly results in the Permanent Total Disability of the Insured Person which means that the Injury results in one or more of the following conditions within 365 days from the occurrence of an Accident, We will make payment of 125% of the Personal Accident Cover Sum Insured as specified in the Policy Schedule.

1. Loss of use of limbs or sight

The Insured Person suffers from total and irrecoverable loss of:

I. The use of two limbs (including paraplegia and hemiplegia) OR
II. The sight in both eyes OR
III. The use of one limb and the sight in one eye

2. Loss of independent living

The Insured Person is permanently unable to perform independently three or more of the following six activities of daily living.

I. Washing: the ability to maintain an adequate level of cleanliness and personal hygiene.
II. Dressing: the ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are medically necessary.
III. Feeding: the ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available.
IV. Toileting: the ability to manage bowel and bladder function, maintaining an adequate and socially acceptable level of hygiene.
V. Mobility: the ability to move indoors from room to room on level surfaces at the normal place of residence.
VI. Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa.

Conditions - The above coverage is subject to fulfilment of following conditions:

1. The Permanent Total Disability is proved through a disability certificate issued by a Medical Board duly constituted by the Central and/or the State Government; and
2. We will admit a claim under this optional benefit only if the Permanent Total Disability continues for a period of at least 6 continuous calendar months from the commencement of the Permanent Total Disability unless it is irreversible, such as in case of amputation/loss of limbs etc; and

3. If the Insured Person dies before a claim has been admitted under this optional benefit, no amount will be payable under this optional benefit, however We will consider the claim under Section 4.1.1 (Accident Death) subject to terms and conditions mentioned therein; and
4. We will not make payment under Accident Permanent Total Disability more than once in the Insured Person's lifetime for any and all Policy Periods.
5. If a claim under this optional benefit is admitted, then coverage for the Insured Person will immediately and automatically cease under Section 4.1 (Personal Accident Cover) and this optional benefit shall not be applied in respect of that Insured Person on any Renewal thereafter. However, other applicable benefits can be Renewed in respect of the Insured Person.

4.1.3 Accident Permanent Partial Disability (APPD)

What is covered:
If the Injury due to Accident solely and directly results in the Permanent Partial Disability of the Insured Person which is of the nature specified in the table below within 365 days from the occurrence of such Accident, We will make payment under this optional benefit in accordance with the table below:

Conditions - The above coverage is subject to fulfilment of following conditions:
1. The Permanent Partial Disability is proved through a disability certificate issued by a Medical Board duly constituted by the Central and/or the State Government; and
2. We will admit a claim under this optional benefit only if the Permanent Partial Disability continues for a period of at least 6 continuous calendar months from the commencement of the Permanent Partial Disability, unless it is irreversible; and
3. If the Insured Person dies before a claim has been admitted under this optional benefit, no amount will be payable under this optional benefit, however We will consider the claim under Section 4.1.1 (Accident Death) subject to the terms and conditions mentioned therein.
4. If a claim under this optional benefit has been admitted, then no further claim in respect of the same condition will be admitted under this optional benefit.
5. If a claim under this optional benefit is paid and the entire Personal Accident Sum Insured specified in the Policy Schedule does not get utilized, then the balance Personal Accident Cover Sum Insured shall be available for further claims under Section 4.1 (Personal Accident Cover) until the entire Personal Accident Cover Sum Insured is consumed. The Personal Accident Cover Sum Insured specified in the first Policy Schedule shall be a lifetime limit for the Insured Person and once this limit is exhausted, coverage for the Insured Person will immediately and automatically cease under Section 4.1 (Personal Accident Cover) and this optional benefit shall not be applied in respect of that Insured Person on any Renewal thereafter. However, other applicable benefits can be Renewed in respect of the Insured Person.

Permanent Partial Disability Grid		
S. No.	**Nature of Disability**	**% of Personal Accident Cover Sum Insured payable**
1	Loss or total and permanent loss of use of both the hands from the wrist joint	100%
2	Loss or total and permanent loss of use of both feet from the ankle joint	100%
3	Loss or total and permanent loss of use of one hand from the wrist joint and of one foot from the ankle joint	100%
4	Loss or total and permanent loss of use of one hand from the wrist joint and total and permanent loss of sight in one eye	100%
5	Loss or total and permanent loss of use of one foot from the ankle joint and total and permanent loss of sight in one eye	100%
6	Total and permanent loss of speech and hearing in both ears	100%
7	Total and permanent loss of hearing in both ears	50%
8	Loss or total and permanent loss of use of one hand from wrist joint	50%

9	Loss or total and permanent loss of use of one foot from ankle joint	50%
10	Total and permanent loss of sight in one eye	50%
11	Total and permanent loss of speech	50%
12	Permanent total loss of use of four fingers and thumb of either hand	40%
13	Permanent total loss of use of four fingers of either hand	35%
14	Uniplegia	25%
15	Permanent total loss of use of one thumb of either hand	
	a. Both joints	25%
	b. One joint	10%
16	Permanent total loss of use of fingers of either hand	
	a. Three joints	10%
	b. Two joints	8%
	c. One joint	5%
17	Permanent total loss of use of toes of either foot	
	a. All toes- one foot	20%
	b. Great toe- both joints	5%
	c. Great toe- one joint	2%
	d. Other than great toe, one toe	1%

4.2 **Critical Illness Cover**

What is covered:
This optional benefit is available either to the Primary Insured Person or Primary Insured Person along with his/her spouse, which is specified in the Policy Schedule.

If the Insured Person covered under this optional benefit is diagnosed for the first time with any of the following listed Critical Illnesses or if any of the following Critical Illnesses occurs or manifests itself in the Insured Person during the Policy Period for the first time, We will pay the Critical Illness Sum Insured specified in the Policy Schedule provided that the Insured Person survives the Survival Period of 30 days from the diagnosis of the Critical Illness during the Policy Period.

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 –
   a. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
   b. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
   c. Malignant melanoma that has not caused invasion beyond the epidermis;
   d. 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
   e. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
   f. Chronic lymphocytic leukaemia less than RAI stage 3

g. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
h. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or be low and with mitotic count of less than or equal to 5/50 HPFs;
i. All tumors in the presence of HIV infection.

2. Myocardial Infarction

(First Heart Attack of specific 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 Neuron 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.

12. Deafness

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

13. End Stage Lung Failure

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
   i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
   ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
   iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
   iv. Dyspnea at rest.

14. End Stage Liver Failure

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

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

15. Loss of Speech

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

II. All psychiatric related causes are excluded

16. Third Degree Burns

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

17. Fulminant Viral Hepatitis

I. A sub-massive to massive necrosis of the liver by any virus, leading precipitously to liver failure.

   This diagnosis must be supported by all of the following:
   i. rapid decreasing of liver size; and
   ii. necrosis involving entire lobules, leaving only a collapsed reticular framework; and
   iii. rapid deterioration of liver function tests; and
   iv. deepening jaundice; and
   v. hepatic encephalopathy.

   Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria

18. Aplastic Anemia

I. Aplastic Anemia is chronic persistent bone marrow failure. A certified hematologist must make the diagnosis of severe irreversible aplastic anemia. There must be permanent bone marrow failure resulting in bone marrow cellularity of less than 25% and there must be two of the following:

i. Absolute neutrophil count of less than 500/mm³
ii. Platelets count less than 20,000/mm³
iii. Reticulocyte count of less than 20,000/mm³

The Insured Person must be receiving treatment for more than 3 consecutive months with frequent blood product transfusions, bone marrow stimulating agents, or immunosuppressive agents or the Insured Person has received a bone marrow or cord blood stem cell transplant. Temporary or reversible Aplastic Anemia is excluded and not covered under this Policy

19. Muscular Dystrophy

I. Muscular Dystrophy is a disease of the muscle causing progressive and permanent weakening of certain muscle groups. The diagnosis of Muscular Dystrophy must be made by a consultant neurologist, and confirmed with the appropriate laboratory, biochemical, histological, and electromyography evidence. The disease must result in the permanent inability of the Insured Person to perform (whether aided or unaided) at least three (3) of the six (6)"Activities of Daily Living".

Activities of Daily Living are defined as:

a. Washing : the ability to maintain an adequate level of cleanliness and personal hygiene
b. Dressing : the ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are Medically Necessary
c. Feeding : the ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available
d. Toileting : the ability to manage bowel and bladder function, maintaining an adequate and socially acceptable level of hygiene
e. Mobility : the ability to move indoors from room to room on level surfaces at the normal place of residence
f. Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa

20. Bacterial Meningitis

I. Bacterial meningitis is a bacterial infection of the meninges of the brain causing brain dysfunction. There must be an unequivocal diagnosis by a consultant physician of bacterial meningitis that must be proven on analysis and culture of the cerebrospinal fluid. There must also be permanent objective neurological deficit that is present on physical examination at least 3 months after the diagnosis of the meningitis infection.

Conditions applicable to 'Critical Illness cover':

a. We will not make payment under Section 4.2 (Critical Illness Cover) more than once in the Insured Person's lifetime for any and all Policy Periods
b. The diagnosis of a Critical Illness must be verified in writing by a Medical Practitioner.
c. The Waiting Periods specified below shall be applicable to the Insured Person and claims shall be assessed accordingly. On Renewal, if the Critical Illness Cover Sum Insured specified in the Policy Schedule is enhanced, the Waiting Periods would apply afresh to the extent of the increase in benefit amount limit, subject to Underwriting Guidelines and in accordance with the existing guidelines of the IRDAI.

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

i. Pre-existing Diseases (Code-Excl01):

a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first Policy with Us.
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the Policy after the expiry of 48 months for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

ii. 90-day Initial waiting period:

a. Expenses related to the treatment of any Illness within 90 days from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months
c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

d. If the Insured Person is diagnosed / undergoes a Surgical Procedure or any medical condition occurs falling under the definition of Critical Illness as specified above that may result in a claim, then We shall be given written notice immediately and in any event within 7 days of the aforesaid Illness/ condition/ Surgical Procedure.
e. We shall not be liable to make any payment under this optional benefit if the Insured Person does not survive the Survival Period.
f. If diagnosis of the Critical Illness takes place on or before the Policy expiry date specified in the Policy Schedule, but the Survival Period expires after the Policy expiry date, such claims would be admissible provided that the Insured Person survives the Survival Period.
g. In the event of death of the Insured Person post the Survival Period, the immediate family member/relative of the Insured Person claiming on Insured Person's behalf must inform Us in writing immediately and send a copy of all the required documents to prove the cause of death within 30 days of the death. We upon acceptance of the admission of claim under the Policy shall make payment to the Nominee/legal heirs of the Insured Person.
h. If We have admitted a claim under this optional benefit for an Insured Person in any Policy Year, this optional benefit shall not be renewed in respect of that Insured Person for any subsequent Policy Year, but the cover for this optional benefit will be renewable for other Insured Persons.

4.3 **e-Consultation**

What is covered:
If the Insured Person is diagnosed with an Illness or is planning to undergo a planned Surgery or a Surgical Procedure, the Insured Person can, at the Insured Person's sole discretion, obtain an e-Consultation during the Policy Period.

Conditions - The above coverage is subject to fulfilment of following conditions:
a. e-Consultation shall be requested through Our call centre or website chat.
b. e-Consultation will be arranged by Us (without any liabilities) and will be based solely on the information provided by the Insured Person.
c. e-Consultation must not be considered a substitute to medical opinion or advise nor shall be same pursued over a medical advice or opinion given by treating physician or doctor
d. By seeking e-Consultation under this benefit, the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.
e. The Insured Person is free to choose whether or not to obtain the e-Consultation, and if obtained then whether or not to act on it in whole or in part.
f. e-Consultation under this benefit shall not be valid for any medico-legal purposes.
g. We do not represent correctness of e-Consultation and shall not assume or deem to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

4.4 **Hospital Cash**

What is covered:

If We have accepted an Inpatient Care Hospitalization claim under Section 3.1 (Inpatient Care), We will pay the Hospital Cash amount specified in the Policy Schedule up to a maximum 30 days of Hospitalization during the Policy Year for the Insured Person for each continuous period of 24 hours of Hospitalization from the first day of Hospitalization subject to following conditions.

Conditions - The above coverage is subject to fulfilment of following conditions:
a. The Insured Person has been admitted in a Hospital for a minimum period of 48 hours continuously.

4.5 **Enhanced No Claim Bonus**

What is covered:
This optional benefit shall be subject to all guidelines and conditions mentioned under Section 3.10 (No Claim Bonus), except that the No Claim Bonus stated in Section 3.10 (a) shall automatically increase to 20% of Base Insured for every claim free Policy Year and the maximum No Claim Bonus shall not exceed 200% of the Base Sum Insured.

Conditions - The above coverage is subject to fulfilment of following conditions:
a. Once opted, this optional benefit cannot be opted out at the time of Renewal.

4.6 **Enhanced Re-fill Benefit**

What is covered:
This optional benefit shall be subject to all guidelines and conditions mentioned under Section 3.11 (Re-fill Benefit), except that the Re-fill benefit stated in Section 3.11 shall become 150% of Base Insured instead of 100% of Base Sum Insured.

Conditions - The above coverage is subject to fulfilment of following conditions:
a. Once opted, this optional benefit cannot be opted out at the time of Renewal.

5. Claim Cost Sharing:

Co-payment (if applicable) as specified in the Policy Schedule shall be applied on the amount payable by Us. A 20% Co-payment will apply under Classic plan available under the product for treatment in Delhi NCR, Mumbai (including Navi Mumbai and Thane), Kolkata & Gujarat State.

Co-payment will not apply to any claim under Section 3.8 (Emergency Ambulance), Section 3.9 (Pharmacy and Diagnostic Services), Section 3.12 (Health Check-up), Section 4.1 (Personal Accident Cover), Section 4.2 (Critical Illness Cover), Section 4.3 (e-Consultation) and Section 4.4 (Hospital Cash).

6. Waiting Periods

All the Waiting Periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly. On Renewal, if the Sum Insured is enhanced, the Waiting Periods would apply afresh to the extent of the increased Sum Insured only. The Waiting Periods set out below shall not apply to Section 3.9 (Pharmacy and Diagnostic Services), Section 4.1 (Personal Accident Cover), Section 4.2 (Critical Illness Cover) and Section 4.3 (e-Consultation). The Waiting Periods for Critical Illness Cover have already been specified under Section 4.2 respectively.

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

6.1 **Pre-existing Diseases (Code–Excl01):**
a. Expenses related to the treatment of a Pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first Policy with Us.
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the Policy after the expiry of 48 months for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by Us.

6.2 **Specified disease/procedure Waiting Period (Code–Excl02):**

a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1) or Cancer (covered after 30-day waiting period).
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedures:
    a. Pancreatitis and stones in biliary and urinary system
    b. Cataract, glaucoma and other disorders of lens, disorders of retina
    c. Hyperplasia of prostate, hydrocele and spermatocele
    d. Abnormal utero-vaginal bleeding, female genital prolapse, endometriosis/adenomyosis, fibroids, PCOD, or any condition requiring dilation and curettage or hysterectomy
    e. Hemorrhoids, fissure or fistula or abscess of anal and rectal region
    f. Hernia of all sites,
    g. Osteoarthritis, systemic connective tissue disorders, dorsopathies, spondylopathies, inflammatory polyarthropathies, arthrosis such as RA, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair
    h. Chronic kidney disease and failure
    i. Varicose veins of lower extremities
    j. All internal or external benign or in situ neoplasms/tumours, cyst, sinus, polyp, nodules, swelling, mass or lump
    k. Ulcer, erosion and varices of gastro intestinal tract
    l. Surgical treatment for diseases of middle ear and mastoid (including otitis media, cholesteatoma, perforation of tympanic membrane), Tonsils and adenoids, nasal septum and nasal sinuses
    m. Internal Congenital Anomaly
    n. Surgery of Genito-urinary system unless necessitated by malignancy
    o. Spinal disorders

6.3 **30-day waiting period (Code-Excl03):**

a. Expenses related to the treatment of any Illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months
c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

6.4 **Personal Waiting Periods:**

Conditions specified for an Insured Person under Personal Waiting Period in the Policy Schedule will be subject to a Waiting Period of 48 months from the inception of the First Policy with Us for that Insured Person and will be covered from the commencement of the fifth Policy Year for that Insured Person as long as the Insured Person has been insured continuously under the Policy without any break.

7. Permanent Exclusions

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy. Sections 7.1 to 7.28 are not applicable to Section 4.1 (Personal Accident Cover) and Section 4.2 (Critical Illness Cover).

The permanent exclusions applicable to Section 4.1 (Personal Accident Cover) and Section 4.2 (Critical Illness Cover) have been specified separately under Section 7.29 and Section 7.30 respectively.

7.1 **Investigation & Evaluation (Code-Excl04)**

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

7.2 **Rest Cure, rehabilitation and respite care (Code-Excl05)**

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

7.3 **Obesity/ Weight Control (Code-Excl06)**

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor.
b. The surgery/Procedure conducted should be supported by clinical protocols.
c. The member has to be 18 years of age or older and;
d. Body Mass Index (BMI);
    i. greater than or equal to 40 or
    ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
        1. Obesity-related cardiomyopathy
        2. Coronary heart disease
        3. Severe Sleep Apnea
        4. Uncontrolled Type2 Diabetes

7.4 **Change-of-Gender treatments (Code-Excl07)**

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

7.5 **Cosmetic or plastic Surgery (Code-Excl08)**

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

7.6 **Hazardous or Adventure sports (Code-Excl09)**

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7.7 **Breach of law (Code-Excl10)**

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

7.8 **Excluded Providers (Code-Excl11)**

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our website / notified to the Policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.
The complete list of excluded providers can be referred to on our website.

7.9 Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code-Excl12)**

7.10 Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code-Excl13)**

7.11 Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or Day Care procedure **(Code-Excl14)**

7.12 **Refractive Error (Code-Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

7.13 **Unproven Treatments (Code-Excl16)**
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

7.14 **Sterility and Infertility (Code-Excl17)**
Expenses related to sterility and infertility. This includes:
a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

7.15 **Maternity (Code-Excl18)**
a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;
b. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the Policy Period.

7.16 **Ancillary Hospital Charges**
Charges related to a Hospital stay not expressly mentioned as being covered. This will include RMO charges, surcharges and service charges levied by the Hospital.

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

7.18 **Conflict & Disaster:**
Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.

7.19 **External Congenital Anomaly:**
Screening, counseling or treatment related to external Congenital Anomaly.

7.20 **Dental/oral treatment:**
Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.

7.21 **Hormone Replacement Therapy:**
Treatment for any condition / illness which requires hormone replacement therapy.

7.22 Multifocal Lens and ambulatory devices such as walkers, crutches, splints, stockings of any kind and also any medical equipment which is subsequently used at home.

7.23 **Sexually transmitted Infections & diseases (other than HIV / AIDS):**
Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).

7.24 **Sleep disorders:**
Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.

7.25 Any treatment or medical services received outside the geographical limits of India.

7.26 **Unrecognized Physician or Hospital:**

a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central council of Homeopathy.
b. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.
c. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India.

7.27 Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state as demonstrated by:

a. Deep coma and unresponsiveness to all forms of stimulation; or
b. Absent pupillary light reaction; or
c. Absent oculovestibular and corneal reflexes; or
d. Complete apnea.

7.28 AYUSH Treatment
Any form of AYUSH Treatments, except as mentioned under Section 3.6

7.29 **Permanent Exclusions for Personal Accident Cover**
We shall not be liable to make any payment under any benefits under Section 4.1 (Personal Accident Cover) if the claim is attributable to, or based on, or arises out of, or is directly or indirectly connected to any of the following:

a. Suicide or self inflicted Injury, whether the Insured Person is medically sane or insane.
b. Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.
c. Service in the armed forces, or any police organization, of any country at war or at peace or service in any force of an international body or participation in any of the naval, military or air force operation during peace time.
d. Any change of profession after inception of the Policy or any Renewal which results in the enhancement of Our risk, if not accepted and endorsed by Us on the Policy Schedule.
e. Committing an assault, a criminal offence or any breach of law with criminal intent.
f. Taking or absorbing, accidentally or otherwise, any intoxicating liquor, drug, narcotic, medicine, sedative or poison, except as prescribed by a Medical Practitioner other than the Policyholder or an Insured Person.
g. Participation in aviation/marine activities (including crew) other than as a passenger in an aircraft/water craft that is authorized by the relevant regulations to carry such passengers between established airports or ports.
h. Engaging in or taking part in professional/adventure sports or any hazardous pursuits, speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving, polo, snow and ice sports, hunting.

i. Body or mental infirmity or any Illness except where such condition arises directly as a result of an Accident during the Policy Period. However this exclusion is not applicable to claims made under Section 4.1.3 (Permanent Partial Disability).

7.30 **Permanent Exclusions for Critical Illness Cover**

We shall not be liable to make any payment under Section 4.2 (Critical Illness Cover) directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy.

1. **AYUSH Treatment:**
   Any covered Critical Illnesses diagnosed and/or treated by a Medical Practitioner who practices AYUSH Treatment.

2. **Conflict & Disaster:**
   Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.

3. **External Congenital Anomaly:**
   Screening, counseling or treatment related to External Congenital Anomaly.

4. **Cosmetic or plastic Surgery (Code-Excl08)**
   Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

5. **Unproven Treatments (Code-Excl16)**
   Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

6. **Hazardous or Adventure sports (Code-Excl09)**
   Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
   .
   .

7. **Sterility and Infertility (Code-Excl17)**
   Expenses related to sterility and infertility. This includes:
   a. Any type of contraception, sterilization
   b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
   c. Gestational Surrogacy
   d. Reversal of sterilization

8. **Maternity(Code-Excl18)**
   a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;
   b. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the Policy Period.

9. **Sexually transmitted Infections & Diseases:**
   Screening, prevention and treatment for sexually related infection or disease.

10. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code-Excl12)**

11. **Breach of law (Code-Excl10)**
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

12. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code-Excl13)**

13. **Unrecognized Physician or Hospital:**
a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central council of Homeopathy.
b. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.
c. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India.

8. Claims Process & Requirements
The fulfillment of the terms and conditions of this Policy (including payment of full premium in advance by the due dates mentioned in the Policy Schedule) in so far as they relate to anything to be done or complied with by You or any Insured Person, including complying with the following in relation to claims, shall be Condition Precedent to admission of Our liability under this Policy.

8.1 **Claims Administration:**
On the occurrence or discovery of any Illness or Injury that may give rise to a claim under this Policy, the Claims Procedure set out below shall be followed:

a. We advise You to submit all claims related documents.
b. The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed.
c. We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
d. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.
e. It is hereby agreed and understood that no change in the Medical Record provided under the Medical Advice information, by the Hospital or the Insured Person to Us or Our Service Provider during the period of Hospitalization or after discharge by any means of request will be accepted by Us. Any decision on request for acceptance of such change will be considered on merits where the change has been proven to be for reasons beyond the claimant's control.

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

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

i. Process for Obtaining Pre-Authorization
A. For Planned Treatment:
We must be contacted to pre-authorize Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider.
B. In Emergencies:
If the Insured Person has been Hospitalized in an Emergency, We must be contacted to pre-authorize Cashless Facility within 48 hours of the Insured Person's Hospitalization or before discharge from the Hospital, whichever is earlier.

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

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

I. The health card We have issued to the Insured Person at the time of inception of the Policy (if available) supported with KYC document;
II. The Policy Number;
III. Name of the Policyholder;
IV. Name and address of Insured Person in respect of whom the request is being made;
V. Nature of the Illness/Injury and the treatment/Surgery required;
VI. Name and address of the attending Medical Practitioner;
VII. Hospital where treatment/Surgery is proposed to be taken;
VIII. Date of admission;
IX. First and any subsequent consultation paper / Medical Record since beginning of diagnosis of that treatment/Surgery;
X. Admission note;
XI. Treating Medical Practitioner certificate for Illness / Insured Event history with justification of Hospitalization.

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

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

In case of preauthorization request where chronicity of condition is not established as per clinical evidence based information, We may reject the request for preauthorization and ask the claimant to claim as Reimbursement. Claim document submission for Reimbursement shall not be deemed as an admission of Our liability.

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

We reserve the right to modify, add or restrict any Network Provider or Service Provider for Cashless Facility in Our sole discretion.

ii. Reauthorization
Cashless Facility will be provided subject to re-authorization if requested for either change in the line of treatment or in the diagnosis or for any procedure carried out on the incidental diagnosis/finding prior to the discharge from the Hospital.

b. For Reimbursement Claims:
For all claims for which Cashless Facility has not been pre-authorized or for which treatment has not been taken at a Network Provider or for which Cashless Facility is not available, 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:

i. The Policy Number;
ii. Name of the Policyholder;
iii. Name and address of the Insured Person in respect of whom the request is being made;
iv. Nature of Illness or Injury and the treatment/Surgery taken;
v. Name and address of the attending Medical Practitioner;
vi. Hospital where treatment/Surgery was taken;

vii. Date of admission and date of discharge;
viii. Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

8.3 **Claims Documentation:**

For medical claims – Reimbursement Facility:

We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense within 30 days of the Insured Event giving rise to a claim or within 30 days from the date of occurrence of an Insured Event or completion of Survival Period (in case of Critical Illness Cover).

For medical claims – Cashless Facility:

We will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital.

Necessary information and documentation for medical claims

a. Claim form duly completed and signed by the claimant.
b. Details of past medical history record, first and subsequent consultation.
c. Age / Identity proof document of Insured Person in case of claim approved under Cashless Facility (not required if submitted at the time of pre-authorization request) and Policyholder in case of Reimbursement claim.
   i. Self attested copy of valid age proof (passport / driving license / PAN card / class X certificate / birth certificate);
   ii. Self attested copy of identity proof (passport / driving license / PAN card / voter identity card);
   iii. Recent passport size photograph
d. Cancelled cheque/ bank statement / copy of passbook mentioning account holder's name, IFSC code and account number printed on it of Policyholder / nominee (in case of death of Policyholder).
e. Original discharge summary.
f. Bar code sticker and invoice for implants and prosthesis (if used and only in case of Surgery/Surgical Procedure).
g. Original final bill from Hospital with detailed break-up and paid receipt.
h. Room tariff of the entitled room category (in case of a Non-Network provider and if room tariff is not a part of Hospital bill): duly signed and stamped by the Hospital in which treatment is taken.
   (In case You are unable to submit such document, then We shall consider the Reasonable and Customary Charges of the Insured Person's eligible room category of Our Network Provider within the same geographical area for identical or similar services.)
i. Original bills of pharmacy/medicines purchased, or of any other investigation done outside Hospital with reports and requisite prescriptions.
j. For Medico-legal cases (MLC) or in case of Accident
   i. MLC/ Panchnama / First Information Report (FIR) copy attested by the concerned Hospital / police station (if applicable);
   ii. Original self-narration of incident in absence of MLC / FIR.
k. Original laboratory investigation, diagnostic, radiological & pathological reports with supporting prescriptions.

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

For Personal Accident claims

Additional claim documentation for Personal Accident Cover under Section 4.1:

1. Accident Death
   i. Copy of death certificate (issued by the office of Registrar of Births and Deaths or any other authorized legal institution)
   ii. Copy of post mortem report wherever applicable

2. *Accident Permanent Total Disability or Accident Permanent Partial Disability*
   i. Certificate of disability issued by a Medical Board duly constituted by the Central and/or the State Government.

For Critical Illness claims

Additional claim documentation for Critical Illness Cover under Section 4.2:

1. Treating Medical Practitioner's certification for insured person's survival post survival period.

8.4 **Claims Assessment & Repudiation:**

a. At Our discretion, We may investigate claims to determine the validity of a claim. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals/entities that are authorized by Us in writing.
b. 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.
c. If a claim is made which extends in to two Policy Periods, then such claim shall be paid taking into consideration the available Sum Insured in these Policy Periods. Such eligible claim amount will be paid to the Policyholder/Insured Person after deducting the extent of premium to be received for the Renewal/due date of premium of the Policy, if not received earlier.
d. All admissible claims under this Policy shall be assessed by Us in the following progressive order:-
    i. If a room has been opted in a Hospital for which the room category is higher than the eligible limit as applicable for that Insured Person as specified in the Policy Schedule, then the Associated Medical Expenses payable shall be pro-rated as per the applicable limits in accordance with Section 3.1.
    ii. Co-payment (if applicable) as specified in the Policy Schedule shall be applicable on the amount payable by Us.
e. The claim amount assessed in Section 8.4 e above would be deducted from the amount mentioned against each benefit and Sum Insured as specified in the Policy Schedule.

8.5 **Delay in Claim Intimation or Claim Documentation:**

If the claim is not notified to Us or claim documents are not submitted within the stipulated time as mentioned in the above sections, then We shall be provided the reasons for the delay, in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

8.6 **Claims process and documentation for Section 3.12 (Health Check-up) and Section 4.3 (e-Consultation):**

After validation of Insured Person and Policy details, We will evaluate the information of the Insured Person from the perspective to check eligibility of cover only and if the request is approved, We will facilitate arrangement as per the conditions specified under respective benefits admissible to the Insured Person.

9. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability

For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

10. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

11. General Terms and Conditions

11.1 **Free Look Period**

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days (thirty days for policies with a term of 3 years, if sold through distance marketing) from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

a. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person 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 insured person, a deduction towards the proportionate risk premium for period of cover or

Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

11.2 **Cancellation**

I. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

1 year		*2 years*		*3 years*	
Policy in-force up to	*Refund Premium (%)*	Policy in-force up to	*Refund Premium (%)*	Policy in-force up to	*Refund Premium (%)*
Up to 30 days	*75%*	Up to 30 days	*87.5%*	Up to 30 days	*90%*
31 to 90 days	*50%*	31 to 90 days	*75%*	31 to 90 days	*87.5%*
91 to 180 days	*25%*	91 to 180 days	*62.5%*	91 to 180 days	*75%*
exceeding 180 days	*0%*	181 to 365 days	*50%*	181 to 365 days	*60%*
		366 to 455 days	*25%*	366 to 455 days	*50%*
		456 to 545 days	*12%*	456 to 545 days	*25%*
		Exceeding 545 days	*0%*	545 to 720 days	*12%*
				Exceeding 720 days	*0%*

II. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

Automatic Cancellation:

i. Individual Policy:
The Policy shall automatically terminate in the event of death of the Insured Person.
ii. For Family Floater Policies:
The Policy shall automatically terminate in the event of the death of all the Insured Persons. .
iii. Refund:
A refund in accordance with the table in Section 11.2shall be payable if there is an automatic cancellation of the Policy provided that no claim has been made and Health Check-up or e-Consultation (if opted) have not been availed under the Policy by or on behalf of any Insured

Person. We will pay the refund of premium to the Nominee named in the Policy Schedule or Your legal heirs or legal representatives holding a valid succession certificate.

11.3 **Loading on Premium**

a. Based upon the disclosure of the health status of the persons proposed for insurance and declarations made in the Proposal or Insurance Summary Sheet, We may apply a risk loading on the premium payable (excluding statutory levies and taxes) under the Policy. The maximum risk loading applicable shall not exceed 50%.
b. These loadings will be applied from inception date of the First Policy including subsequent Renewal(s) with Us.
c. If a loading applies to the premium for the main Policy, such loading will also apply to the premium for the optional benefits selected except under Section 4.1 (Personal Accident Cover) and Section 4.3 (e-Consultation).

11.4 **Renewal of Policy**

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

I. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
II. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
III. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
IV. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
V. No loading shall apply on renewals based on individual claims experience.

11.5 **Other Renewal Conditions:**

a. Continuity of benefits on Timely Renewal:

i. The Renewal premium is payable on or before the due date and in any circumstances before the expiry of Grace Period
ii. Renewal premium rates for this Policy may be further altered by Us including in the following circumstances:
   A. You proposed to add an Insured Person to the Policy
   B. You change any coverage provision
iii. Renewal premium will alter based on individual Age. The reference of Age for calculating the premium for Family Floater Policies shall be the Age of the eldest Insured Person.

i. .

b. Reinstatement:

i. The Policy shall lapse after the expiration of the Grace Period. If the Policy is not Renewed within the Grace Period then We may agree to issue a fresh Policy subject to Our underwriting criteria, as per Our Board approved underwriting policy and no continuing benefits shall be available from the expired Policy.
ii. We will not pay for any Medical Expenses which are incurred between the date the Policy expires and the date immediately before the reinstatement date of Your Policy.
iii. If there is any change in the Insured Person's medical or physical condition, We may add exclusions or charge an extra premium from the reinstatement date.

c. Disclosures on Renewal:

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

d. Renewal for Insured Persons who have achieved Age 26:

If any Insured Person who is a child and has completed Age 26 years at the time of Renewal, then such Insured Person will have to take a separate policy based on Our underwriting guidelines, as per Our Board approved underwriting policy as he/she will no longer be eligible to be covered under a

Family Floater Policy. In such cases, the credit of the Waiting Periods served under the Policy will be passed on to the separate policy taken by such Insured Person.

e. Addition of Insured Persons on Renewal:
Where an individual is added to this Policy, either by way of endorsement or at the time of Renewal, the Pre-existing Disease clause, exclusions, loading (if any) and Waiting Periods will be applicable considering such Policy Year as the first year of the Policy with Us.

f. Changes to Sum Insured on Renewal:
You may opt for enhancement of Sum Insured at the time of Renewal, subject to underwriting. All Waiting Periods as defined in the Policy under Section 6 shall apply afresh for this enhanced limit from the effective date of such enhancement.

11.6 **Change of Policyholder**

a. The Policyholder may be changed only at the time of Renewal. The new Policyholder must be a member of the Insured Person's immediate family. Such change would be solely subject to Our discretion and payment of premium by You. The Renewed Policy shall be treated as having been Renewed without break. The Policyholder may be changed upon request in case of Your death, Your emigration from India or in case of Your divorce during the Policy Period.
b. Any alteration in the Policy due to unavoidable circumstances as in case of the Policyholder's death, emigration or divorce during the Policy Period should be reported to Us immediately.
c. Renewal of such Policies will be according to terms and conditions of existing Policy.

11.7 **Nomination**

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

11.8 **Obligations in case of a minor**

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

11.9 **Authorization to obtain all pertinent records or information:**

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

11.10 **Fraud**

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce

the insurer to issue an insurance policy: a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true; b) the active concealment of a fact by the insured person having knowledge or belief of the fact; c) any other act fitted to deceive; and d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

11.11 **Policy Disputes**

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

11.12 **Territorial Jurisdiction**

All benefits are available in India only and all claims shall be payable in India in Indian Rupees only.

11.13 **Notices**

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

a. You/the Insured Person at the address specified in the Policy Schedule or at the changed address of which We must receive written notice.
b. Us at the following address:

   Max Bupa Health Insurance Company Limited
   B-1/I-2, Mohan Cooperative Industrial Estate
   Mathura Road, New Delhi-110044

   Fax No.: 011-3090-2010
c. No insurance agents, brokers or other person/entity is authorized to receive any notice on Our behalf.
d. In addition, We may send You/the Insured Person other information through electronic and telecommunications means with respect to Your Policy from time to time.

11.14 **Alteration to the Policy**

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

11.15 **Possibility of Revision of Terms of the Policy Including the Premium Rates**

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

11.16 **Withdrawal of Policy**

In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

11.17 **Redressal of Grievances**:

a. In case of any grievance the insured person may contact the company through

Website:	www.maxbupa.com
Toll free:	1860-500-8888
E-mail:	customercare@maxbupa.com (Senior citizens may write to us at: seniorcitizensupport@maxbupa.com)
Fax :	011-3090-2010
Courier:	Customer Services Department Max Bupa Health Insurance Company Limited B-1/I-2, Mohan Cooperative Industrial Estate Mathura Road, New Delhi-110044

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at Head – Customer Services

Max Bupa Health Insurance Company Limited
B-1/I-2, Mohan Cooperative Industrial Estate
Mathura Road, New Delhi-110044
Contact No: 1860-500-8888
Fax No.: 011-3090-2010
Email ID: customercare@maxbupa.com

For updated details of grievance officer, kindly refer the link https://www.maxbupa.com/customer-care/health-services/grievance-redressal.aspx

If the Insured person is not satisfied with the above, they can escalate to GRO@maxbupa.com.

b. If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017 (at the addresses given in Annexure 1).
c. Grievance may also be lodged at IRDAI Integrated Grievance Management System - https:/igms. irda.qov. in/

11.18 **Assignment**

The Policy can be assigned subject to applicable laws.

11.19 **Claim settlement (Provision for Penal interest)**

I. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
II. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
III. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

IV. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

11.20 **Moratorium Period**

After completion of eight continuous years under the Policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first Policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the Policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract.

11.21 **Multiple Policies**

I. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person 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.

II. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

III. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

IV. Where an 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 treatment costs in accordance with the terms and conditions of the chosen policy

11.22 **Disclosure of Information**

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 by the policyholder

(Explanation: “Material facts” for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

11.23 **Condition Precedent to Admission of Liability**

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

11.24 **Complete Discharge**

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

12. Defined Terms

The terms listed below in Section 11 and used elsewhere in the Policy in Initial Capitals shall have the meaning set out against them in Section 11.

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

12.2 **Age** means age last birthday.

12.3 **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

12.4 **AYUSH Hospital:**

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

a. Central or State Government AYUSH Hospital; or

b. Teaching Hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council of Homeopathy; or

c. AYUSH Hospital, standalone or co-located with In-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH *Medical Practitioner* and must comply with all the following criterion*:*

i. Having at least 5 in-patient beds

ii. Having qualified AYUSH *Medical Practitioner* in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

12.5 **Associated Medical Expenses** shall include Room Rent, nursing charges, Medical Practitioners' fees and operation theatre charges

12.6 **Base Sum Insured** means the amount stated in the Policy Schedule.

12.7 **Bone Marrow Transplant** is the actual undergoing of a transplant of human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner. The following will be excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

12.8 **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

12.9 **Cancer** means 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.

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 Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

ix. All tumors in the presence of HIV infection.

12.10 **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.

12.11 **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.

12.12 **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 claim amount. A Co-payment does not reduce the Sum Insured.

12.13 **Critical Illness**, an Illness, medical event or Surgical Procedure specifically defined in Section 4.2.

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

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

a. has Qualified Nursing staff under its employment;
b. has qualified Medical Practitioner(s) in charge;
c. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

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

a. undertaken under General or Local Anaesthesia in a Hospital/Day Care Center in less than 24 hrs because of technological advancement, and
b. which would have otherwise required a Hospitalization of more than 24 hours.

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

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

12.18 **Diagnostic Services** means those diagnostic tests and exploratory or therapeutic procedures required for the detection, identification and treatment of a medical condition.

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

a. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
b. the patient takes treatment at home on account of non availability of room in a Hospital.

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

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

12.22 **e-Consultation** means opinion from a Medical Practitioner who holds a valid registration from the medical council of any state or medical council of India or council for Indian medicine or for homeopathy set up by the Government of India or a state government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

12.23 **Family Floater Policy** means a Policy described as such in the Policy Schedule where the family members (two or more) named in the Policy Schedule are Insured Persons under this Policy. Only the following family members can be covered under a Family Floater Policy:

a. Primary Insured Person; and/or
b. Primary Insured Person's legally married spouse (for as long as she/he continues to be married to the Primary Insured Person); and/or
c. Primary Insured Person's children who are less than 25 years of Age on the commencement of the Policy Period (a maximum 4 children can be covered under the Policy as Insured Persons).

12.24 **First Policy** means for the purposes of this Policy the Policy Schedule issued to the Policyholder at the time of inception of the first Policy mentioned in the Policy Schedule with Us.

12.25 **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to Renew or continue a policy in force without loss of continuity benefits such as Waiting Periods and coverage of Pre-existing Diseases. Coverage is not available for the period for which no premium is received.

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

a. has Qualified Nursing staff under its employment round the clock;
b. has at least 10 Inpatient beds in towns having a population of less than 10,00,000 and at least 15 Inpatient beds in all other places;
c. has qualified Medical Practitioner(s) in charge round the clock;

d. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

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

12.28 **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

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

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

(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
ii. it needs ongoing or long-term control or relief of symptoms
iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
iv. it continues indefinitely
v. it recurs or is likely to recur

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

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

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

12.33 **Individual Policy** means a Policy described as such in the Policy Schedule where the individual named in the Policy Schedule is the Insured Person under this Policy.

12.34 **Inpatient** means admission for treatment in a Hospital for more than 24 hours for an Insured Event.

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

12.36 **Insured Event** means any event specifically mentioned as covered under this Policy.

12.37 **Insured Person** means person(s) named as insured persons in the Policy Schedule.

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

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

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

12.41 **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 his licence.

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

12.43 **Medically Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

a. is required for the medical management of the Illness or Injury suffered by the insured;
b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

c. must have been prescribed by a Medical Practitioner;
d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

12.44 **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence.

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

12.46 **Network Provider** means Hospital enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a Cashless Facility.

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

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

12.49 **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.

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

12.51 **Policy Period** is the period between the inception 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.

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

12.53 **Pre-existing Disease** means any condition, ailment, injury or disease

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

12.54 **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

12.55 **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:

a. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and
b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

12.56 **Policy Schedule** means a certificate issued by Us, and, if more than one, then the latest in time. The Policy Schedule contains details of the Policyholder, Insured Persons, the Sum Insured and other relevant details related to the coverage.

12.57 **Portability** means the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

12.58 **Primary Insured Person** means the Policyholder if he/she is covered under the Policy as an Insured Person. In case Policyholder is not an Insured Person, then Primary Insured Person will be the eldest Insured Person covered under the Policy.

12.59 **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.

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

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

12.62 **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.

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

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

12.65 **Single Private Room** means an air conditioned room in a Hospital where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a single occupancy room in that Hospital.

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

12.67 **Sum Insured** means the total of the Base Sum Insured and No Claim Bonus as per Section 3.10 and Section 4.5 (if applicable), which is Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of all Insured Person9s0 which is specified in the Policy Schedule.

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

12.69 **Survival Period** means the period, if any, specified under the Policy after the occurrence of an Insured Event that the Insured Person has to survive before a claim becomes admissible under the Policy.

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

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

12.72 **You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us.

Annexure I - List of Insurance Ombudsmen

Office Details	Jurisdiction of Office Union Territory,District)
AHMEDABAD - **Shri Kuldip Singh** Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - **Smt. Neerja Shah** 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@ecoi.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava 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@ecoi.co.in	Madhya Pradesh Chhattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh.

Office Details	Jurisdiction of Office Union Territory,District)
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu,UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu 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 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, UT of Yanam and part of UT of Pondicherry.
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.

Office Details	Jurisdiction of Office Union Territory,District)
ERNAKULAM - Ms. Poonam Bodra 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@ecoi.co.in	Kerala, UT of (a)Lakshadweep,(b) Mahe-a part of UT of Pondicherry.
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, UT of Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly,

Office Details	Jurisdiction of Office Union Territory,District)
4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	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 N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

EXECUTIVE COUNCIL OF INSURERS,
3rd Floor, Jeevan Seva Annexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.

Tel.: 022 - 26106889 / 671 / 980
Fax: 022 - 26106949
Email:inscoun@ecoi.co.in
Shri. M.M.L. Verma, Secretary General
Smt. Moushumi Mukherji, Secretary

Annexure II - The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment

List I – Expenses not covered

Sl. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES

49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II – Items that are to be subsumed into Room Charges

Sl. No.	**Item**
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES

31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

Sl. No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into costs of treatment

Sl. No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION⁄STERILLIUM
17	GLUCOMETER & STRIPS

18	URINE BAG

ANNEXURE III – Product Benefit Table (all limits in INR unless defined as percentage)

	Classic Plan		Enhanced Plan	
Base Sum Insured (SI) per Policy Year (in Lacs)	3L/4L	5L/7.5L/10L/ 15L/20L/25L	3L/4L	5L/7.5L/10L/ 15L/20L/25L
Base Cover Benefits				
In-Patient Treatment				
Nursing Charges for Hospitalization as an inpatient excluding Private Nursing charges	Covered up to Sum Insured		Covered up to Sum Insured	
Medical Practitioner's fees, excluding any charges or fees for Standby Services				
Physiotherapy, investigation and diagnostic procedures directly related to the current admission				
Medicines, drugs and consumables as prescribed by the treating medical practitioner				
Intravenous fluids, blood transfusion, injection administration charges and/or consumables				
Operation Theatre charges				
Cost of prosthetics and other devices or equipment if implanted internally during surgery				
Room Rent (per day)	Up to 1% of Base Sum Insured per day or Single Private Room, whichever is lower	Single Private Room	Up to 1% of Base Sum Insured per day or Single Private Room, whichever is lower	Single Private Room
Intensive Care Unit charges	Up to 2% of Sum Insured per day	Covered up to Sum Insured	Up to 2% of Sum Insured per day	Covered up to Sum Insured
Pre-Hospitalization Medical Expenses (30 days)	Covered up to Sum Insured		Covered up to Sum Insured	
Post-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured		Covered up to Sum Insured	
Day Care Treatment	Covered up to Sum Insured		Covered up to Sum Insured	
Domiciliary Treatment	Covered up to Sum Insured		Covered up to Sum Insured	
Alternative Treatment	Covered up to Sum Insured		Covered up to Sum Insured	
Living Organ Donor Transplant	Covered up to Sum Insured		Covered up to Sum Insured	
Emergency Ambulance	Up to Rs.1,500 per hospitalization	Up to Rs.2,000 per hospitalization	Up to Rs.1,500 per hospitalization	Up to Rs.2,000 per hospitalization
Pharmacy and diagnostic services	Available		Available	

Notes:
(1) Re-Fill benefit - Reinstate up to 100% of Base Sum Insured. Applicable for different illness

No Claim Bonus	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured; no increase in sub-limits; no reduction in No Claim Bonus in case of claim	Increase of 10% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured; no increase in sub-limits; no reduction in No Claim Bonus in case of claim
Re-fill Benefit (1)	Up to 100% of Base Sum Insured	Up to 100% of Base Sum Insured
Health Check up	Annual, from 2nd policy year onwards	Annual, from 2nd policy year onwards
Mental Disorders Treatment	Covered up to Sum Insured (sub-limit applicable on few conditions)	Covered up to Sum Insured (sub-limit applicable on few conditions)
HIV / AIDS	Covered up to 10% of Base Sum Insured, subject to maximum of Rs. 50,000	Covered up to 10% of Base Sum Insured, subject to maximum of Rs. 50,000
Modern Treatments	Covered up to Sum Insured with sub-limit of Rs. 1Lac on few robotic surgeries	Covered up to Sum Insured with sub-limit of Rs. 1Lac on few robotic surgeries
Co-Payment	20% co-payment applicable for treatment in Delhi NCR, Mumbai (including Navi Mumbai and Thane), Kolkata and Gujarat.	No co-payment

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

(3) Enhanced Re-Fill benefit - Reinstate up to 150% of Base Sum Insured. Applicable for different illness

Optional Benefits (which may be added at customer level at an additional premium)	
Personal Accident cover -Accident Death -Accident Permanent Total Disability (125 % of PA cover SI) -Accident Permanent Partial Disability	Personal Accident cover will be equal to 5 times of Base Sum Insured; maximum up to Rs. 50 Lac
Critical Illness Cover	Critical illness cover will be equal to Base Sum Insured; maximum up to Rs. 10 Lac
e-Consultation	Unlimited tele / online consultations
Hospital Cash (2)	For Base Sum Insured of 5 Lac and below: Rs. 1,000 per day; For Base Sum Insured greater than 5 Lac: Rs. 2,000 per day
Enhanced No Claim Bonus	Increase of 20% of expiring Base Sum Insured in a Policy Year; maximum up to 200% of Base Sum Insured; no increase in sub-limits; no reduction in No Claim Bonus in case of claim
Enhanced Re-fill Benefits(3)	Re-fill up to 150% of Base Sum Insured

Annexure IV - Day Care Treatments

Sr. No	Header	Procedure Name
I	**Cardiology Related:**	
	1	CORONARY ANGIOGRAPHY
II	**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
III	**Dental Related:**	
	7	SPLINTING OF AVULSED TEETH
	8	SUTURING LACERATED LIP
	9	SUTURING ORAL MUCOSA
	10	ORAL BIOPSY IN CASE OF ABNORMAL TISSUE PRESENTATION
	11	FNAC
	12	SMEAR FROM ORAL CAVITY
IV	**ENT Related:**	
	13	MYRINGOTOMY WITH GROMMET INSERTION
	14	TYMPANOPLASTY (CLOSURE OF AN EARDRUM PERFORATION/RECONSTRUCTION OF THE AUDITORY OSSICLES)
	15	REMOVAL OF A TYMPANIC DRAIN
	16	KERATOSIS REMOVAL UNDER GA
	17	OPERATIONS ON THE TURBINATES (NASAL CONCHA)
	18	TYMPANOPLASTY (CLOSURE OF AN EARDRUM PERFORATION/RECONSTRUCTION OF THE AUDITORY OSSICLES)
	19	REMOVAL OF KERATOSIS OBTURANS
	20	STAPEDOTOMY TO TREAT VARIOUS LESIONS IN MIDDLE EAR
	21	REVISION OF A STAPEDECTOMY
	22	OTHER OPERATIONS ON THE AUDITORY OSSICLES
	23	MYRINGOPLASTY (POSTAURA/ENDAURAL APPROACH AS WELL AS SIMPLE TYPE -I TYMPANOPLASTY)
	24	FENESTRATION OF THE INNER EAR
	25	REVISION OF A FENESTRATION OF THE INNER EAR
	26	PALATOPLASTY
	27	TRANSORAL INCISION AND DRAINAGE OF A PHARYNGEAL ABSCESS
	28	TONSILLECTOMY WITHOUT ADENOIDECTOMY
	29	TONSILLECTOMY WITH ADENOIDECTOMY
	30	EXCISION AND DESTRUCTION OF A LINGUAL TONSIL
	31	REVISION OF A TYMPANOPLASTY
	32	OTHER MICROSURGICAL OPERATIONS ON THE MIDDLE EAR
	33	INCISION OF THE MASTOID PROCESS AND MIDDLE EAR
	34	MASTOIDECTOMY
	35	RECONSTRUCTION OF THE MIDDLE EAR
	36	OTHER EXCISIONS OF THE MIDDLE AND INNER EAR
	37	INCISION (OPENING) AND DESTRUCTION (ELIMINATION) OF THE INNER EAR

	38	OTHER OPERATIONS ON THE MIDDLE AND INNER EAR
	39	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE NOSE
	40	OTHER OPERATIONS ON THE NOSE
	41	NASAL SINUS ASPIRATION
	42	FOREIGN BODY REMOVAL FROM NOSE
	43	OTHER OPERATIONS ON THE TONSILS AND ADENOIDS
	44	ADENOIDECTOMY
	45	LABYRINTHECTOMY FOR SEVERE VERTIGO
	46	STAPEDECTOMY UNDER GA
	47	STAPEDECTOMY UNDER LA
	48	TYMPANOPLASTY (TYPE IV)
	49	ENDOLYMPHATIC SAC SURGERY FOR MENIERE'S DISEASE
	50	TURBINECTOMY
	51	ENDOSCOPIC STAPEDECTOMY
	52	INCISION AND DRAINAGE OF PERICHONDRITIS
	53	SEPTOPLASTY
	54	VESTIBULAR NERVE SECTION
	55	THYROPLASTY TYPE I
	56	PSEUDOCYST OF THE PINNA - EXCISION
	57	INCISION AND DRAINAGE - HAEMATOMA AURICLE
	58	TYMPANOPLASTY (TYPE II)
	59	REDUCTION OF FRACTURE OF NASAL BONE
	60	THYROPLASTY TYPE II
	61	TRACHEOSTOMY
	62	EXCISION OF ANGIOMA SEPTUM
	63	TURBINOPLASTY
	64	INCISION & DRAINAGE OF RETRO PHARYNGEAL ABSCESS
	65	UVULO PALATO PHARYNGO PLASTY
	66	ADENOIDECTOMY WITH GROMMET INSERTION
	67	ADENOIDECTOMY WITHOUT GROMMET INSERTION
	68	VOCAL CORD LATERALISATION PROCEDURE
	69	INCISION & DRAINAGE OF PARA PHARYNGEAL ABSCESS
	70	TRACHEOPLASTY
V	**Gastroenterology Related:**	
	71	CHOLECYSTECTOMY AND CHOLEDOCHO-JEJUNOSTOMY/ DUODENOSTOMY/GASTROSTOMY/EXPL ORATION COMMON BILE DUCT
	72	ESOPHAGOSCOPY, GASTROSCOPY, DUODENOSCOPY WITH POLYPECTOMY/ REMOVAL OF FOREIGN BODY/DIATHERMY OF BLEEDING LESIONS
	73	PANCREATIC PSEUDOCYST EUS & DRAINAGE
	74	RF ABLATION FOR BARRETT'S OESOPHAGUS
	75	ERCP AND PAPILLOTOMY
	76	ESOPHAGOSCOPE AND SCLEROSANT INJECTION
	77	EUS + SUBMUCOSAL RESECTION
	78	CONSTRUCTION OF GASTROSTOMY TUBE
	79	EUS + ASPIRATION PANCREATIC CYST
	80	SMALL BOWEL ENDOSCOPY (THERAPEUTIC)

	81	COLONOSCOPY ,LESION REMOVAL
	82	ERCP
	83	COLONSCOPY STENTING OF STRICTURE
	84	PERCUTANEOUS ENDOSCOPIC GASTROSTOMY
	85	EUS AND PANCREATIC PSEUDO CYST DRAINAGE
	86	ERCP AND CHOLEDOCHOSCOPY
	87	PROCTOSIGMOIDOSCOPY VOLVULUS DETORSION
	88	ERCP AND SPHINCTEROTOMY
	89	ESOPHAGEAL STENT PLACEMENT
	90	ERCP + PLACEMENT OF BILIARY STENTS
	91	SIGMOIDOSCOPY W / STENT
	92	EUS + COELIAC NODE BIOPSY
	93	UGI SCOPY AND INJECTION OF ADRENALINE, SCLEROSANTS BLEEDING ULCERS
VI	**General Surgery Related:**	
	94	INCISION OF A PILONIDAL SINUS / ABSCESS
	95	FISSURE IN ANO SPHINCTEROTOMY
	96	SURGICAL TREATMENT OF A VARICOCELE AND A HYDROCELE OF THE SPERMATIC CORD
	97	ORCHIDOPEXY
	98	ABDOMINAL EXPLORATION IN CRYPTORCHIDISM
	99	SURGICAL TREATMENT OF ANAL FISTULAS
	100	DIVISION OF THE ANAL SPHINCTER (SPHINCTEROTOMY)
	101	EPIDIDYMECTOMY
	102	INCISION OF THE BREAST ABSCESS
	103	OPERATIONS ON THE NIPPLE
	104	EXCISION OF SINGLE BREAST LUMP
	105	INCISION AND EXCISION OF TISSUE IN THE PERIANAL REGION
	106	SURGICAL TREATMENT OF HEMORRHOIDS
	107	OTHER OPERATIONS ON THE ANUS
	108	ULTRASOUND GUIDED ASPIRATIONS
	109	SCLEROTHERAPY,
	110	THERAPEUTIC LAPAROSCOPY WITH LASER
	111	INFECTED KELOID EXCISION
	112	AXILLARY LYMPHADENECTOMY
	113	WOUND DEBRIDEMENT AND COVER
	114	ABSCESS-DECOMPRESSION
	115	CERVICAL LYMPHADENECTOMY
	116	INFECTED SEBACEOUS CYST
	117	INGUINAL LYMPHADENECTOMY
	118	INCISION AND DRAINAGE OF ABSCESS
	119	SUTURING OF LACERATIONS
	120	SCALP SUTURING
	121	INFECTED LIPOMA EXCISION
	122	MAXIMAL ANAL DILATATION
	123	PILES

	124	A)INJECTION SCLEROTHERAPY
	125	B)PILES BANDING
	126	LIVER ABSCESS- CATHETER DRAINAGE
	127	FISSURE IN ANO- FISSURECTOMY
	128	FIBROADENOMA BREAST EXCISION
	129	OESOPHAGEAL VARICES SCLEROTHERAPY
	130	ERCP - PANCREATIC DUCT STONE REMOVAL
	131	PERIANAL ABSCESS I&D
	132	PERIANAL HEMATOMA EVACUATION
	133	UGI SCOPY AND POLYPECTOMY OESOPHAGUS
	134	BREAST ABSCESS I& D
	135	FEEDING GASTROSTOMY
	136	OESOPHAGOSCOPY AND BIOPSY OF GROWTH OESOPHAGUS
	137	ERCP - BILE DUCT STONE REMOVAL
	138	ILEOSTOMY CLOSURE
	139	COLONOSCOPY
	140	POLYPECTOMY COLON
	141	SPLENIC ABSCESSES LAPAROSCOPIC DRAINAGE
	142	UGI SCOPY AND POLYPECTOMY STOMACH
	143	RIGID OESOPHAGOSCOPY FOR FB REMOVAL
	144	FEEDING JEJUNOSTOMY
	145	COLOSTOMY
	146	ILEOSTOMY
	147	COLOSTOMY CLOSURE
	148	SUBMANDIBULAR SALIVARY DUCT STONE REMOVAL
	149	PNEUMATIC REDUCTION OF INTUSSUSCEPTION
	150	VARICOSE VEINS LEGS - INJECTION SCLEROTHERAPY
	151	RIGID OESOPHAGOSCOPY FOR PLUMMER VINSON SYNDROME
	152	PANCREATIC PSEUDOCYSTS ENDOSCOPIC DRAINAGE
	153	ZADEK'S NAIL BED EXCISION
	154	SUBCUTANEOUS MASTECTOMY
	155	EXCISION OF RANULA UNDER GA
	156	RIGID OESOPHAGOSCOPY FOR DILATION OF BENIGN STRICTURES
	157	EVERSION OF SAC UNILATERAL/BILATERAL
	158	LORD'S PLICATION
	159	JABOULAY'S PROCEDURE
	160	SCROTOPLASTY
	161	CIRCUMCISION FOR TRAUMA
	162	MEATOPLASTY
	163	INTERSPHINCTERIC ABSCESS INCISION AND DRAINAGE
	164	PSOAS ABSCESS INCISION AND DRAINAGE
	165	THYROID ABSCESS INCISION AND DRAINAGE
	166	TIPS PROCEDURE FOR PORTAL HYPERTENSION
	167	ESOPHAGEAL GROWTH STENT
	168	PAIR PROCEDURE OF HYDATID CYST LIVER

	169	TRU CUT LIVER BIOPSY
	170	PHOTODYNAMIC THERAPY OR ESOPHAGEAL TUMOUR AND LUNG TUMOUR
	171	EXCISION OF CERVICAL RIB
	172	LAPAROSCOPIC REDUCTION OF INTUSSUSCEPTION
	173	MICRODOCHECTOMY BREAST
	174	SURGERY FOR FRACTURE PENIS
	175	SENTINEL NODE BIOPSY
	176	PARASTOMAL HERNIA
	177	REVISION COLOSTOMY
	178	PROLAPSED COLOSTOMY- CORRECTION
	179	TESTICULAR BIOPSY
	180	LAPAROSCOPIC CARDIOMYOTOMY(HELLERS)
	181	SENTINEL NODE BIOPSY MALIGNANT MELANOMA
	182	LAPAROSCOPIC PYLOROMYOTOMY(RAMSTEDT)
	183	EXCISION OF FISTULA-IN-ANO
	184	EXCISION JUVENILE POLYPS RECTUM
	185	VAGINOPLASTY
	186	DILATATION OF ACCIDENTAL CAUSTIC STRICTURE OESOPHAGEAL
	187	PRESACRAL TERATOMAS EXCISION
	188	REMOVAL OF VESICAL STONE
	189	EXCISION SIGMOID POLYP
	190	STERNOMASTOID TENOTOMY
	191	INFANTILE HYPERTROPHIC PYLORIC STENOSIS PYLOROMYOTOMY
	192	EXCISION OF SOFT TISSUE RHABDOMYOSARCOMA
	193	MEDIASTINAL LYMPH NODE BIOPSY
	194	HIGH ORCHIDECTOMY FOR TESTIS TUMOURS
	195	EXCISION OF CERVICAL TERATOMA
	196	RECTAL-MYOMECTOMY
	197	RECTAL PROLAPSE (DELORME'S PROCEDURE)
	198	DETORSION OF TORSION TESTIS
	199	EUA + BIOPSY MULTIPLE FISTULA IN ANO
	200	CYSTIC HYGROMA - INJECTION TREATMENT
VII	**Gynecology Related:**	
	201	OPERATIONS ON BARTHOLIN'S GLANDS (CYST)
	202	INCISION OF THE OVARY
	203	INSUFFLATIONS OF THE FALLOPIAN TUBES
	204	OTHER OPERATIONS ON THE FALLOPIAN TUBE
	205	DILATATION OF THE CERVICAL CANAL
	206	CONISATION OF THE UTERINE CERVIX
	207	THERAPEUTIC CURETTAGE WITH COLPOSCOPY/BIOPSY/DIATHERMY/CRY OSURGERY/
	208	LASER THERAPY OF CERVIX FOR VARIOUS LESIONS OF UTERUS
	209	OTHER OPERATIONS ON THE UTERINE CERVIX
	210	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE VAGINA AND THE POUCH OF DOUGLAS
	211	INCISION OF VAGINA

	212	INCISION OF VULVA
	213	CULDOTOMY
	214	SALPINGO-OOPHORECTOMY VIA LAPAROTOMY
	215	ENDOSCOPIC POLYPECTOMY
	216	HYSTEROSCOPIC REMOVAL OF MYOMA
	217	D&C
	218	HYSTEROSCOPIC RESECTION OF SEPTUM
	219	THERMAL CAUTERISATION OF CERVIX
	220	MIRENA INSERTION
	221	HYSTEROSCOPIC ADHESIOLYSIS
	222	LEEP (LOOP ELECTROSURGICAL EXCISION PROCEDURE)
	223	CRYOCAUTERISATION OF CERVIX
	224	POLYPECTOMY ENDOMETRIUM
	225	HYSTEROSCOPIC RESECTION OF FIBROID
	226	LLETZ (LARGE LOOP EXCISION OF TRANSFORMATION ZONE)
	227	CONIZATION
	228	POLYPECTOMY CERVIX
	229	HYSTEROSCOPIC RESECTION OF ENDOMETRIAL POLYP
	230	VULVAL WART EXCISION
	231	LAPAROSCOPIC PARAOVARIAN CYST EXCISION
	232	UTERINE ARTERY EMBOLIZATION
	233	LAPAROSCOPIC CYSTECTOMY
	234	HYMENECTOMY(IMPERFORATE HYMEN)
	235	ENDOMETRIAL ABLATION
	236	VAGINAL WALL CYST EXCISION
	237	VULVAL CYST EXCISION
	238	LAPAROSCOPIC PARATUBAL CYST EXCISION
	239	REPAIR OF VAGINA (VAGINAL ATRESIA)
	240	HYSTEROSCOPY, REMOVAL OF MYOMA
	241	TURBT
	242	URETEROCOELE REPAIR - CONGENITAL INTERNAL
	243	VAGINAL MESH FOR POP
	244	LAPAROSCOPIC MYOMECTOMY
	245	SURGERY FOR SUI
	246	REPAIR RECTO- VAGINA FISTULA
	247	PELVIC FLOOR REPAIR(EXCLUDING FISTULA REPAIR)
	248	URS + LL
	249	LAPAROSCOPIC OOPHORECTOMY
	250	NORMAL VAGINAL DELIVERY AND VARIANTS
VIII	**Neurology Related:**	
	251	FACIAL NERVE PHYSIOTHERAPY
	252	NERVE BIOPSY
	253	MUSCLE BIOPSY
	254	EPIDURAL STEROID INJECTION
	255	GLYCEROL RHIZOTOMY

	256	SPINAL CORD STIMULATION
	257	MOTOR CORTEX STIMULATION
	258	STEREOTACTIC RADIOSURGERY
	259	PERCUTANEOUS CORDOTOMY
	260	INTRATHECAL BACLOFEN THERAPY
	261	ENTRAPMENT NEUROPATHY RELEASE
	262	DIAGNOSTIC CEREBRAL ANGIOGRAPHY
	263	VP SHUNT
	264	VENTRICULOATRIAL SHUNT
IX	**Oncology Related:**	
	265	RADIOTHERAPY FOR CANCER
	266	CANCER CHEMOTHERAPY
	267	IV PUSH CHEMOTHERAPY
	268	HBI-HEMIBODY RADIOTHERAPY
	269	INFUSIONAL TARGETED THERAPY
	270	SRT-STEREOTACTIC ARC THERAPY
	271	SC ADMINISTRATION OF GROWTH FACTORS
	272	CONTINUOUS INFUSIONAL CHEMOTHERAPY
	273	INFUSIONAL CHEMOTHERAPY
	274	CCRT-CONCURRENT CHEMO + RT
	275	2D RADIOTHERAPY
	276	3D CONFORMAL RADIOTHERAPY
	277	IGRT- IMAGE GUIDED RADIOTHERAPY
	278	IMRT- STEP & SHOOT
	279	INFUSIONAL BISPHOSPHONATES
	280	IMRT- DMLC
	281	ROTATIONAL ARC THERAPY
	282	TELE GAMMA THERAPY
	283	FSRT-FRACTIONATED SRT
	284	VMAT-VOLUMETRIC MODULATED ARC THERAPY
	285	SBRT-STEREOTACTIC BODY RADIOTHERAPY
	286	HELICAL TOMOTHERAPY
	287	SRS-STEREOTACTIC RADIOSURGERY
	288	X-KNIFE SRS
	289	GAMMAKNIFE SRS
	290	TBI- TOTAL BODY RADIOTHERAPY
	291	INTRALUMINAL BRACHYTHERAPY
	292	ELECTRON THERAPY
	293	TSET-TOTAL ELECTRON SKIN THERAPY
	294	EXTRACORPOREAL IRRADIATION OF BLOOD PRODUCTS
	295	TELECOBALT THERAPY
	296	TELECESIUM THERAPY
	297	EXTERNAL MOULD BRACHYTHERAPY
	298	INTERSTITIAL BRACHYTHERAPY
	299	INTRACAVITY BRACHYTHERAPY

	300	3D BRACHYTHERAPY
	301	IMPLANT BRACHYTHERAPY
	302	INTRAVESICAL BRACHYTHERAPY
	303	ADJUVANT RADIOTHERAPY
	304	AFTERLOADING CATHETER BRACHYTHERAPY
	305	CONDITIONING RADIOTHEARPY FOR BMT
	306	EXTRACORPOREAL IRRADIATION TO THE HOMOLOGOUS BONE GRAFTS
	307	RADICAL CHEMOTHERAPY
	308	NEOADJUVANT RADIOTHERAPY
	309	LDR BRACHYTHERAPY
	310	PALLIATIVE RADIOTHERAPY
	311	RADICAL RADIOTHERAPY
	312	PALLIATIVE CHEMOTHERAPY
	313	TEMPLATE BRACHYTHERAPY
	314	NEOADJUVANT CHEMOTHERAPY
	315	ADJUVANT CHEMOTHERAPY
	316	INDUCTION CHEMOTHERAPY
	317	CONSOLIDATION CHEMOTHERAPY
	318	MAINTENANCE CHEMOTHERAPY
	319	HDR BRACHYTHERAPY
X	**Operations on the salivary glands & salivary ducts:**	
	320	INCISION AND LANCING OF A SALIVARY GLAND AND A SALIVARY DUCT
	321	EXCISION OF DISEASED TISSUE OF A SALIVARY GLAND AND A SALIVARY DUCT
	322	RESECTION OF A SALIVARY GLAND
	323	RECONSTRUCTION OF A SALIVARY GLAND AND A SALIVARY DUCT
	324	OTHER OPERATIONS ON THE SALIVARY GLANDS AND SALIVARY DUCTS
XI	**Operations on the skin & subcutaneous tissues:**	
	325	OTHER INCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
	326	SURGICAL WOUND TOILET (WOUND DEBRIDEMENT) AND REMOVAL OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
	327	LOCAL EXCISION OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
	328	OTHER EXCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
	329	SIMPLE RESTORATION OF SURFACE CONTINUITY OF THE SKIN AND SUBCUTANEOUS TISSUES
	330	FREE SKIN TRANSPLANTATION, DONOR SITE
	331	FREE SKIN TRANSPLANTATION, RECIPIENT SITE
	332	REVISION OF SKIN PLASTY
	333	OTHER RESTORATION AND RECONSTRUCTION OF THE SKIN AND SUBCUTANEOUS TISS
	334	CHEMOSURGERY TO THE S
	335	DESTRUCTION OF DISEASED TISSUE IN THE SKIN AND SUBCUTANEOUS TISSUES
	336	RECONSTRUCTION OF DEFORMITY/DEFECT IN NAIL BED
	337	EXCISION OF BURSIRTIS
	338	TENNIS ELBOW RELEASE
XII	**Operations on the Tongue:**	
	339	INCISION, EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TONGUE

	340	PARTIAL GLOSSECTOMY
	341	GLOSSECTOMY
	342	RECONSTRUCTION OF THE TONGUE
	343	SMALL RECONSTRUCTION OF THE TONGUE
XIII	**Ophthalmology Related:**	
	344	SURGERY FOR CATARACT
	345	INCISION OF TEAR GLANDS
	346	OTHER OPERATIONS ON THE TEAR DUCTS
	347	INCISION OF DISEASED EYELIDS
	348	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE EYELID
	349	OPERATIONS ON THE CANTHUS AND EPICANTHUS
	350	CORRECTIVE SURGERY FOR ENTROPION AND ECTROPION
	351	CORRECTIVE SURGERY FOR BLEPHAROPTOSIS
	352	REMOVAL OF A FOREIGN BODY FROM THE CONJUNCTIVA
	353	REMOVAL OF A FOREIGN BODY FROM THE CORNEA
	354	INCISION OF THE CORNEA
	355	OPERATIONS FOR PTERYGIUM
	356	OTHER OPERATIONS ON THE CORNEA
	357	REMOVAL OF A FOREIGN BODY FROM THE LENS OF THE EYE
	358	REMOVAL OF A FOREIGN BODY FROM THE POSTERIOR CHAMBER OF THE EYE
	359	REMOVAL OF A FOREIGN BODY FROM THE ORBIT AND EYEBALL
	360	CORRECTION OF EYELID PTOSIS BY LEVATOR PALPEBRAE SUPERIORIS RESECTION (BILATERAL)
	361	CORRECTION OF EYELID PTOSIS BY FASCIA LATA GRAFT (BILATERAL)
	362	DIATHERMY/CRYOTHERAPY TO TREAT RETINAL TEAR
	363	ANTERIOR CHAMBER PARACENTESIS/ CYCLODIATHERMY/CYCLOCRYOTHERAP Y/ GONIOTOMY/TRABECULOTOMY AND FILTERING AND ALLIED OPERATIONS TO TREAT GLAUCOMA
	364	ENUCLEATION OF EYE WITHOUT IMPLANT
	365	DACRYOCYSTORHINOSTOMY FOR VARIOUS LESIONS OF LACRIMAL GLAND
	366	LASER PHOTOCOAGULATION TO TREAT RATINAL TEAR
	367	BIOPSY OF TEAR GLAND
	368	TREATMENT OF RETINAL LESION
XIV	**Orthopedics Related:**	
	369	SURGERY FOR MENISCUS TEAR
	370	INCISION ON BONE, SEPTIC AND ASEPTIC
	371	CLOSED REDUCTION ON FRACTURE, LUXATION OR EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
	372	SUTURE AND OTHER OPERATIONS ON TENDONS AND TENDON SHEATH
	373	REDUCTION OF DISLOCATION UNDER GA
	374	ARTHROSCOPIC KNEE ASPIRATION
	375	SURGERY FOR LIGAMENT TEAR
	376	SURGERY FOR HEMOARTHROSIS/PYOARTHROSIS
	377	REMOVAL OF FRACTURE PINS/NAILS
	378	REMOVAL OF METAL WIRE
	379	CLOSED REDUCTION ON FRACTURE, LUXATION
	380	REDUCTION OF DISLOCATION UNDER GA

	381	EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
	382	EXCISION OF VARIOUS LESIONS IN COCCYX
	383	ARTHROSCOPIC REPAIR OF ACL TEAR KNEE
	384	CLOSED REDUCTION OF MINOR FRACTURES
	385	ARTHROSCOPIC REPAIR OF PCL TEAR KNEE
	386	TENDON SHORTENING
	387	ARTHROSCOPIC MENISCECTOMY - KNEE
	388	TREATMENT OF CLAVICLE DISLOCATION
	389	HAEMARTHROSIS KNEE- LAVAGE
	390	ABSCESS KNEE JOINT DRAINAGE
	391	CARPAL TUNNEL RELEASE
	392	CLOSED REDUCTION OF MINOR DISLOCATION
	393	REPAIR OF KNEE CAP TENDON
	394	ORIF WITH K WIRE FIXATION- SMALL BONES
	395	RELEASE OF MIDFOOT JOINT
	396	ORIF WITH PLATING- SMALL LONG BONES
	397	IMPLANT REMOVAL MINOR
	398	K WIRE REMOVAL
	399	POP APPLICATION
	400	CLOSED REDUCTION AND EXTERNAL FIXATION
	401	ARTHROTOMY HIP JOINT
	402	SYME'S AMPUTATION
	403	ARTHROPLASTY
	404	PARTIAL REMOVAL OF RIB
	405	TREATMENT OF SESAMOID BONE FRACTURE
	406	SHOULDER ARTHROSCOPY / SURGERY
	407	ELBOW ARTHROSCOPY
	408	AMPUTATION OF METACARPAL BONE
	409	RELEASE OF THUMB CONTRACTURE
	410	INCISION OF FOOT FASCIA
	411	CALCANEUM SPUR HYDROCORT INJECTION
	412	GANGLION WRIST HYALASE INJECTION
	413	PARTIAL REMOVAL OF METATARSAL
	414	REPAIR / GRAFT OF FOOT TENDON
	415	REVISION/REMOVAL OF KNEE CAP
	416	AMPUTATION FOLLOW-UP SURGERY
	417	EXPLORATION OF ANKLE JOINT
	418	REMOVE/GRAFT LEG BONE LESION
	419	REPAIR/GRAFT ACHILLES TENDON
	420	REMOVE OF TISSUE EXPANDER
	421	BIOPSY ELBOW JOINT LINING
	422	REMOVAL OF WRIST PROSTHESIS
	423	BIOPSY FINGER JOINT LINING
	424	TENDON LENGTHENING
	425	TREATMENT OF SHOULDER DISLOCATION

	426	LENGTHENING OF HAND TENDON
	427	REMOVAL OF ELBOW BURSA
	428	FIXATION OF KNEE JOINT
	429	TREATMENT OF FOOT DISLOCATION
	430	SURGERY OF BUNION
	431	INTRA ARTICULAR STEROID INJECTION
	432	TENDON TRANSFER PROCEDURE
	433	REMOVAL OF KNEE CAP BURSA
	434	TREATMENT OF FRACTURE OF ULNA
	435	TREATMENT OF SCAPULA FRACTURE
	436	REMOVAL OF TUMOR OF ARM/ ELBOW UNDER RA/GA
	437	REPAIR OF RUPTURED TENDON
	438	DECOMPRESS FOREARM SPACE
	439	REVISION OF NECK MUSCLE (TORTICOLLIS RELEASE)
	440	LENGTHENING OF THIGH TENDONS
	441	TREATMENT FRACTURE OF RADIUS & ULNA
	442	REPAIR OF KNEE JOINT
XV	**Other operations on the mouth & face:**	
	443	EXTERNAL INCISION AND DRAINAGE IN THE REGION OF THE MOUTH, JAW AND FACE
	444	INCISION OF THE HARD AND SOFT PALATE
	445	EXCISION AND DESTRUCTION OF DISEASED HARD AND SOFT PALATE
	446	INCISION, EXCISION AND DESTRUCTION IN THE MOUTH
	447	OTHER OPERATIONS IN THE MOUTH
XVI	**Plastic Surgery Related:**	
	448	CONSTRUCTION SKIN PEDICLE FLAP
	449	GLUTEAL PRESSURE ULCER-EXCISION
	450	MUSCLE-SKIN GRAFT, LEG
	451	REMOVAL OF BONE FOR GRAFT
	452	MUSCLE-SKIN GRAFT DUCT FISTULA
	453	REMOVAL CARTILAGE GRAFT
	454	MYOCUTANEOUS FLAP
	455	FIBRO MYOCUTANEOUS FLAP
	456	BREAST RECONSTRUCTION SURGERY AFTER MASTECTOMY
	457	SLING OPERATION FOR FACIAL PALSY
	458	SPLIT SKIN GRAFTING UNDER RA
	459	WOLFE SKIN GRAFT
	460	PLASTIC SURGERY TO THE FLOOR OF THE MOUTH UNDER GA
XVII	**Thoracic surgery Related:**	
	461	THORACOSCOPY AND LUNG BIOPSY
	462	EXCISION OF CERVICAL SYMPATHETIC CHAIN THORACOSCOPIC
	463	LASER ABLATION OF BARRETT'S OESOPHAGUS
	464	PLEURODESIS
	465	THORACOSCOPY AND PLEURAL BIOPSY
	466	EBUS + BIOPSY
	467	THORACOSCOPY LIGATION THORACIC DUCT

	468	THORACOSCOPY ASSISTED EMPYAEMA DRAINAGE
XVIII	**Urology Related:**	
	469	HAEMODIALYSIS
	470	LITHOTRIPSY/NEPHROLITHOTOMY FOR RENAL CALCULUS
	471	EXCISION OF RENAL CYST
	472	DRAINAGE OF PYONEPHROSIS/PERINEPHRIC ABSCESS
	473	INCISION OF THE PROSTATE
	474	TRANSURETHRAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
	475	TRANSURETHRAL AND PERCUTANEOUS DESTRUCTION OF PROSTATE TISSUE
	476	OPEN SURGICAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
	477	RADICAL PROSTATOVESICULECTOMY
	478	OTHER EXCISION AND DESTRUCTION OF PROSTATE TISSUE
	479	OPERATIONS ON THE SEMINAL VESICLES
	480	INCISION AND EXCISION OF PERIPROSTATIC TISSUE
	481	OTHER OPERATIONS ON THE PROSTATE
	482	INCISION OF THE SCROTUM AND TUNICA VAGINALIS TESTIS
	483	OPERATION ON A TESTICULAR HYDROCELE
	484	EXCISION AND DESTRUCTION OF DISEASED SCROTAL TISSUE
	485	OTHER OPERATIONS ON THE SCROTUM AND TUNICA VAGINALIS TESTIS
	486	INCISION OF THE TESTES
	487	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TESTES
	488	UNILATERAL ORCHIDECTOMY
	489	BILATERAL ORCHIDECTOMY
	490	SURGICAL REPOSITIONING OF AN ABDOMINAL TESTIS
	491	RECONSTRUCTION OF THE TESTIS
	492	IMPLANTATION, EXCHANGE AND REMOVAL OF A TESTICULAR PROSTHESIS
	493	OTHER OPERATIONS ON THE TESTIS
	494	EXCISION IN THE AREA OF THE EPIDIDYMIS
	495	OPERATIONS ON THE FORESKIN
	496	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE PENIS
	497	AMPUTATION OF THE PENIS
	498	OTHER OPERATIONS ON THE PENIS
	499	CYSTOSCOPICAL REMOVAL OF STONES
	500	CATHETERISATION OF BLADDER
	501	LITHOTRIPSY
	502	BIOPSY OFTEMPORAL ARTERY FOR VARIOUS LESIONS
	503	EXTERNAL ARTERIO-VENOUS SHUNT
	504	AV FISTULA - WRIST
	505	URSL WITH STENTING
	506	URSL WITH LITHOTRIPSY
	507	CYSTOSCOPIC LITHOLAPAXY
	508	ESWL
	509	BLADDER NECK INCISION
	510	CYSTOSCOPY & BIOPSY
	511	CYSTOSCOPY AND REMOVAL OF POLYP

	512	SUPRAPUBIC CYSTOSTOMY
	513	PERCUTANEOUS NEPHROSTOMY
	514	CYSTOSCOPY AND "SLING" PROCED
	515	TUNA- PROSTATE
	516	EXCISION OF URETHRAL DIVERTICULUM
	517	REMOVAL OF URETHRAL STONE
	518	EXCISION OF URETHRAL PROLAPSE
	519	MEGA-URETER RECONSTRUCTION
	520	KIDNEY RENOSCOPY AND BIOPSY
	521	URETER ENDOSCOPY AND TREATMENT
	522	VESICO URETERIC REFLUX CORRECTION
	523	SURGERY FOR PELVI URETERIC JUNCTION OBSTRUCTION
	524	ANDERSON HYNES OPERATION (OPEN PYELOPALSTY)
	525	KIDNEY ENDOSCOPY AND BIOPSY
	526	PARAPHIMOSIS SURGERY
	527	INJURY PREPUCE- CIRCUMCISION
	528	FRENULAR TEAR REPAIR
	529	MEATOTOMY FOR MEATAL STENOSIS
	530	SURGERY FOR FOURNIER'S GANGRENE SCROTUM
	531	SURGERY FILARIAL SCROTUM
	532	SURGERY FOR WATERING CAN PERINEUM
	533	REPAIR OF PENILE TORSION
	534	DRAINAGE OF PROSTATE ABSCESS
	535	ORCHIECTOMY
	536	CYSTOSCOPY AND REMOVAL OF FB

ANNEXURE V - ICD CODES FOR THE SPECIFIED DISORDERS / CONDITIONS

Disorder / Condition	ICD Codes
Severe Depression	F33.0, F33.1, F33.2, F33.4, F33.5, F33.6, F33.7, F33.8, F33.9, O90.6, F34.1, F32.81, F32.0, F32.1, F32.2, F32.4, F32.5, F32.6, F32.7, F32.8, F32.9, F33.9, F30.0, F30.1, F30.2, F30.4, F30.5, F30.6, F30.7, F30.8, F30.9, F32.3, F33.3, F43.21, F32.8, F33.40, F32.9
Schizophrenia	F20.0, F20.1, F20.2, F20.3, F20.5, F21, F22, F23, F24, F20.8, F25.0, F25.1, F25.8, F25.9
Bipolar Disorder	F31.0, F31.1, F31.2, F31.4, F31.5, F31.6, F31.7, F31.8, F31.9
Post traumatic stress disorder	F43.0, F43.1, F43.2, F43.8, F43.9
Eating disorder	F50.0, F50.2, F50.8, F98.3, F98.21, F50.8
Generalized anxiety disorder	F40.1, F41.0, F40.2, F40.8, F40.9, F41.1, F41.3, F41.8
Obsessive compulsive disorders	F42
Panic disorders	F41.1, F40.1, F60.7, F93.0, F94.0
Personality disorders	F60.0, F60.1, F60.2, F60.3, F60.4, F60.8, F60.6, F60.7, F60.5
Conversion disorders	F44.4, F44.5, F44.6, F44.7
Dissociative disorders	F44.5, F44.8, F48.1, F44.1, F44.2