1. Preamble

This is a contract of insurance between **You** and **Us** which is subject to the payment of the full premium in advance and the terms, conditions and exclusions to this **Policy**. This **Policy** has been issued on the basis of the **Disclosure to Information Norm**, including the information provided by **You** in respect of the **Insured Persons** in the Proposal and the **Information Summary Sheet**.

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

Note: The terms listed in Section 10 (Definitions & Interpretation) and used elsewhere in the Policy in Initial Capitals and Bold shall have the meaning set out against them in Section 10 wherever they appear in the Policy.

2. Benefits available under the Policy

a. The Benefits available under this **Policy** are described below.
b. The **Policy** covers **Reasonable and Customary Charges** incurred towards medical treatment taken by the **Insured Person** during the **Policy Period** for an **Illness**, **Injury** or conditions described in the sections below, if it is contracted or sustained by an **Insured Person** during the **Policy Period**. The Benefits listed in the sections below will be payable subject to the terms, conditions and exclusions of this **Policy** and the availability of the **Sum Insured** and subject always to any sub-limits in respect of that Benefit as specified in the **Product Benefits Table** and any limits specified in the **Product Benefits Table** as applicable under the Plan in force for the **Insured Person** as specified in the **Schedule of Insurance Certificate**.
c. All claims for any benefits under the **Policy** must be made in accordance with the process defined under Section 7 (Claim process & Requirements).
d. All claims paid under any benefit except for Section 2.10 (Health Checkup) and Section 3.1 (Hospital Cash) shall reduce the **Sum Insured** for that **Policy Year** and only the balance **Sum Insured** after payment of claim amounts admitted shall be available for all future claims arising in that **Policy Year**.

2.1 Inpatient Care

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

a. The **Hospitalization** is **Medically Necessary** and advised and follows **Evidence Based Clinical Practices** and Standard Treatment Guidelines.
b. The **Medical Expenses** incurred are **Reasonable and Customary Charges** for one or more of the following:
   i. **Room Rent**;
   ii. Nursing charges for **Hospitalization** as an **Inpatient** excluding private nursing charges;
   iii. **Medical Practitioners'** fees, excluding any charges or fees for **Standby Services**;
   iv. Physiotherapy, investigation and diagnostics procedures directly related to the current admission;
   v. Medicines, drugs as prescribed by the treating **Medical Practitioner**;
   vi. Intravenous fluids, blood transfusion, injection administration charges and /or consumables;
   vii. Operation theatre charges;
   viii. The cost of prosthetics and other devices or equipment, if implanted internally during **Surgery**;
   ix. **Intensive Care Unit** charges.
c. If the **Insured Person** is admitted in the **Hospital** in a room category higher than the eligibility as specified in the **Product Benefits Table**, then **We** shall be liable to pay only a pro-rated proportion of the total **Associated Medical Expenses** (including surcharge or taxes thereon) in the proportion of the difference between the **Room Rent** actually incurred and the entitled room category to the **Room Rent** actually incurred.
d. **We** shall not be liable to pay the visiting fees or consultation charges for any **Medical Practitioner** visiting the **Insured Person** unless such:
   i. **Medical Practitioner's** treatment or advice has been sought by the **Hospital**; and
   ii. Visiting fees or consultation charges are included in the **Hospital's** bill; and
   iii. Visiting fees or consultation charges are not more than the treating or referral **Medical Practitioner's** consultation charges.

2.2 **Pre-hospitalization Medical Expenses**

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

a. **We** have accepted a claim for **Inpatient Care** under Section 2.1 (**Inpatient Care**) above.
b. **We** will not be liable to pay **Pre-hospitalization Medical Expenses** for more than 30 days immediately preceding the **Insured Person's** admission to **Hospital** for **Inpatient Care** or such expenses incurred prior to inception of the **First Policy** with **Us**.
c. **Pre-hospitalization Medical Expenses** can be claimed under the **Policy** on a **Reimbursement** basis only.
d. **Pre-hospitalization Medical Expenses** incurred on Physiotherapy will also be payable provided that such Physiotherapy is **Medically Necessary** and advised by the treating **Medical Practitioner** and has been availed as **Complementary & Alternative Medicine** only.

2.3 **Post-hospitalization Medical Expenses**

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

a. **We** have accepted a claim for **Inpatient Care** under Section 2.1 (**Inpatient Care**) above.
b. **We** will not be liable to pay **Post-hospitalization Medical Expenses** for more than 60 days immediately following the **Insured Person's** discharge from **Hospital**.
c. **Post-hospitalization Medical Expenses** can be claimed under the **Policy** on a **Reimbursement** basis only.
d. **Post-hospitalization Medical Expenses** incurred on Physiotherapy will also be payable provided that such Physiotherapy is **Medically Necessary** and advised by the treating **Medical Practitioner** and has been availed as **Complementary & Alternative Medicine** only.

2.4 **Alternative Treatments**

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

Pre-hospitalization Medical Expenses incurred for upto 30 days prior to the **Alternative Treatments** being commenced and **Post-hospitalization Medical Expenses** incurred for up to 60 days following the **Alternative Treatment** being concluded will also be indemnified under this Benefit provided that these **Medical Expenses** relate only to **Alternative Treatments** only and not Allopathy.

Section 6.6 of the Permanent Exclusions shall not apply to the extent this Benefit is applicable.

2.5 **Day Care Treatment**

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

a. The **Day Care Treatment** is **Medically Necessary** and follows the written advice of a **Medical Practitioner**.
b. The **Medical Expenses** incurred are **Reasonable and Customary Charges** for any procedure where such procedure is undertaken by an **Insured Person** as **Day Care Treatment**.
c. The following procedures will be covered as **Day Care Treatment** under this benefit as they each require a period of specialized observation or care after completion of the procedure :
    i. Stereotactic radiotherapy, radiotherapy, chemotherapy and immunotherapy for cancer (approved immunosuppressant drugs will be payable only if administered as a part of these procedures)
    ii. Renal dialysis (Erythropoietin for chronic renal failure will be payable only if administered as a part of this procedure)
d. **We** will not cover any **OPD Treatment** and **Diagnostic Services** under this Benefit.

2.6 **Domiciliary Hospitalization**

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

a. The **Domiciliary Hospitalization** continues for at least 3 consecutive days in which case **We** will make payment under this Benefit in respect of **Medical Expenses** incurred from the first day of **Domiciliary Hospitalization**;
b. The treating **Medical Practitioner** confirms in writing that the **Insured Person's** condition was such that the **Insured Person** could not be transferred to a **Hospital** OR the **Insured Person** satisfies **Us** that a **Hospital** bed was unavailable.

2.7 **Living Organ Donor Transplant**

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

a. The donation conforms to The Transplantation of Human Organs Act 1994 and amendments thereafter and the organ is for the use of the **Insured Person**.
b. The recipient **Insured Person** has been **Medically Advised** to undergo an organ transplant.
c. **We** have accepted the recipient **Insured Person's** claim under Section 2.1 (**Inpatient Care**).
d. **Medical Expenses** incurred are **Reasonable and Customary Charges**.

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

a. The living organ donor's stay in a **Hospital** that is needed for them to donate their organ.
b. Stem cell donation except for **Bone Marrow Transplant**.
c. **Pre-hospitalization Medical Expenses** or **Post-hospitalization Medical Expenses** of the organ donor.
d. Screening or any other **Medical Expenses** of the organ donor.
e. Costs directly or indirectly associated with the acquisition of the donor's organ.
f. Transplant of any organ/tissue where the transplant is experimental or investigational.
g. Expenses related to organ transportation or preservation.
h. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

2.8 **Emergency Ambulance**

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

a. The medical condition of the **Insured Person** requires immediate ambulance services from the place where the **Insured Person** is injured or is ill to the nearest **Hospital** where appropriate medical treatment can be obtained or from the existing **Hospital** to another nearest **Hospital** with advanced facilities as advised by the treating **Medical Practitioner** for management of the current **Hospitalization**.
b. This benefit is available for one transfer per **Hospitalization**.
c. The ambulance service is offered by a healthcare or ambulance **Service Provider**.
d. **We** have accepted a claim under Section 2.1 (**Inpatient Care**) above.
e. **We** will cover expenses up to the amount specified in the **Product Benefits Table**.
f. **We** will not make any payment under this Benefit if the **Insured Person** is transferred to any **Hospital** or diagnostic centre for evaluation purposes only.

2.9 **Vaccination for Animal Bite**

We will indemnify the **Medical Expenses** incurred on **OPD Treatment** for vaccinations or immunizations required by the **Insured Person** for an animal bite that occurs during the **Policy Period** provided that:

a. The **Medical Expenses** incurred are **Medically Necessary** and are **Reasonable and Customary Charges**.
b. Claims under this Benefit can be availed on a **Reimbursement** basis only.

2.10 **Health Checkup**

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

a. Health check-up will be arranged only at **Our** empanelled **Service Providers**.
b. The **Insured Person** is above **Age** 18 on the commencement of that **Policy Year**.
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 test or amount cannot be carry forwarded to the next **Policy Year**.
e. The list of tests covered under this benefit is Complete Blood Count, Urine Routine, ESR, HBA1C, S Cholesterol, Sr. HDL, Sr LDL, Urea and Kidney Function Test.

2.11 **No Claim Bonus**

a. For an **Individual Policy** or **Family Floater Policy**, if the **Policy** is **Renewed** with **Us** without a break or if the **Policy** continues to be in force for the 2nd **Policy Year** in the 2 year **Policy Period** (if applicable) and no claim has been made in the immediately preceding **Policy Year**, each **Policy Year We** will increase the **Sum Insured** applicable under the **Policy** by 20% of the **Base Sum Insured** of the immediately preceding **Policy Year**; subject up to maximum of 100% of the expiring **Base Sum Insured**. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the **Sum Insured**.

b. For a **Family First Policy**, if the **Policy** is **Renewed** with **Us** without a break or if the **Policy** continues to be in force for the 2nd **Policy Year** in the 2 year **Policy Period** (if applicable) and no claim has been made in the immediately preceding **Policy Year**, each **Policy Year We** will increase the **Sum Insured** applicable under the **Policy** by 20% of the **Base Sum Insured** of each individual **Insured Person** only and the increase shall not apply to the Floater Sum Insured stated in the **Schedule of Insurance Certificate** as applicable under the **Policy**; subject up to maximum of 100% of the expiring **Base Sum Insured** of each individual **Insured Person**. The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the **Sum Insured**.

c. If the **Insured Person** in the expiring **Policy** is covered under an **Individual Policy** and has an accumulated **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** shall not provide any credit for the accumulated **No Claim Bonus** to the **Family Floater Policy**.

d. 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 First Policy**, then the accumulated **No Claim Bonus** to be carried forward for credit in the **Renewing Policy** would be the accumulated **No Claim Bonus** for that **Insured Person** only.

e. If the **Insured Persons** in the expiring **Policy** are covered under a **Family First Policy** and have an accumulated **No Claim Bonus** for each **Insured Person** in the expiring **Policy** under this benefit, and such expiring **Policy** is **Renewed** with **Us** on a **Family Floater Policy** with same or higher **Base Sum Insured**, then the accumulated **No Claim Bonus** to be carried forward for credit in the **Renewing Policy** would be the least of the accumulated **No Claim Bonus** amongst all the **Insured Persons**.

f. If the **Insured Persons** in the expiring **Policy** are covered under **Family First Policy** and have an accumulated **No Claim Bonus** for each **Insured Person** in the expiring **Policy** under this benefit, and such expiring **Policy** is **Renewed** with **Us** on an **Individual Policy** with same or higher **Base Sum Insured**, then the accumulated **No Claim Bonus** to be carried forward for credit in the **Renewing Policy** would be the accumulated **No Claim Bonus** for that **Insured Person**.

g. If the **Insured Persons** in the expiring **Policy** are covered on a **Family Floater Policy** and such **Insured Persons Renew** their expiring **Policy** with **Us** by splitting the Floater Sum Insured stated in the **Schedule of Insurance Certificate** in to two or more floater / individual / **Family First Policy**, then We shall not provide any credit of the accumulated **No Claim Bonus** to the split **Policy**.

h. 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**.

i. In case the **Base Sum Insured** under the **Policy** is increased at the time of **Renewal**, the applicable accumulated **No Claim Bonus** shall be carried forward.

j. 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.

2.12 **Re-fill Benefit (applicable for Individual Policy and Family Floater Policies only)**

If the **Base Sum Insured** and **No Claim Bonus** (if any) has been partially or completely exhausted due to claims made and paid or claims made and accepted as payable for a particular **Illness** during the **Policy Year** under Section 2, then **We** will provide a re-fill amount of up to 100% of the **Base Sum Insured** which may be utilized for claims arising in that **Policy Year**, provided that:

a. The re-fill amount may be used for only subsequent claims in respect of the **Insured Person** and not against any **Illness** (including its complications or follow up) for which a claim has been paid or accepted as payable in the current **Policy Year**;

b. We will provide a re-fill amount only once in a **Policy Year**;

c. For **Family Floater Policies**, the re-fill amount will be available on a floater basis to all **Insured Persons** in that **Policy Year**;

d. 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**.

3. Optional Benefits

The following optional benefit shall apply under the **Policy** as per the plan in the **Product Benefits Table** and as specified in the **Schedule of Insurance Certificate** and shall apply to all **Insured Persons** only if the optional benefit is selected by **You**. This optional benefit can be selected only at the time of issuance of the **First Policy** or at **Renewal** by **You**, on payment of the corresponding additional premium. If a loading applies to the premium for the main **Policy**, such loading will also apply to the premium for this optional benefit selected.

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

All claims for any benefits under the **Policy** must be made in accordance with the process defined under Section 7 (Claim process & Requirements).

3.1 Hospital Cash

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

a. The **Insured Person** has been admitted in a **Hospital** for a minimum period of 48 hours continuously.
b. **We** will not make any payment under this option for Section 2.6 (**Domiciliary Hospitalization**).

4. Claim Cost Sharing Options

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

4.1 Treatment only in Tiered Network (Available only to renewal customers (for life) who opted this cost sharing option in the expiring Policy)

By selecting this cost sharing option, **Insured Person** can avail **Cashless Facility** in **Our Network Providers** in locations except Delhi (NCR), Mumbai including Suburbs, Chennai, Bengaluru, Hyderabad, Kolkata, Pune, Ahmedabad and Surat. **Insured Person** can also avail treatment (on **Reimbursement** basis) in Delhi (NCR), Mumbai including Suburbs, Chennai, Bengaluru, Hyderabad, Kolkata, Pune, Ahmedabad, Surat **Hospitals** with 20% **Co-payment**.

Co-payment will not apply to any claim under Section 2.10 (Health Checkup) and Section 3.1 (Hospital Cash).

4.2 Annual Aggregate Deductible

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

It is further agreed that:

a. The provisions in Section 4.1 on **Co-payment** (if applicable) will apply to any amounts payable by **Us** in respect of a claim made by the **Insured Person** after the **Deductible** has been exhausted.
b. **Deductible** will not apply to any claim under Section 2.10 (Health Checkup) and Section 3.1 (Hospital Cash).

5. Waiting Periods

All the **Waiting Periods** shall be applicable individually for each **Insured Person** and claims shall be assessed accordingly. On **Renewal**, if an enhanced **Sum Insured** is applied, the **Waiting Periods** would apply afresh to the extent of the increase in **Sum Insured** only.
We shall not be liable to make any payment under this **Policy** directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

5.1 Pre-existing Diseases:

All **Pre-existing Diseases** shall not be covered until 48 months of continuous coverage have elapsed since the inception of the **First Policy** with **Us** for **Insured Persons** to whom Variant 1 Plan is applicable as specified in the **Product Benefits Table** and until 36 months of continuous coverage have elapsed since the inception of the **First Policy** with **Us** for **Insured Persons** to whom Variant 2, Variant 3 Plans and **Family First Policy** are applicable as specified in the **Product Benefits Table**.

5.2 Initial Waiting Period (30 days):

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

5.3 Specific Waiting Periods:

The medical conditions and/or surgical treatment listed below will be subject to a **Waiting Period** of 24 months unless the condition is directly caused by **Cancer** or an **Accident** and will be covered in the third **Policy Year** as long as the **Insured Person** has been insured continuously under the **Policy** without any break:

a. Pancreatitis and Stones in Biliary and Urinary System,
b. Cataract, Glaucoma and other disorders of lens, disorders of Retina,
c. Hyperplasia of Prostate, Hydrocele and spermatocele,
d. Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, PCOD, or any condition requiring dilation and curettage or Hysterectomy,
e. Hemorrhoids, Fissure or Fistula or Abscess of anal and rectal region,
f. Hernia of all sites,
g. Osteoarthritis, Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, inflammatory Polyarthropathies, Arthrosis such as RA, Gout, Intervertebral Disc disorders,
h. Chronic kidney disease and failure,
i. Diabetes and its related complications,
j. Varicose veins of lower extremities,
k. Disease of middle ear and mastoid including Otitis Media, Cholesteatoma, Perforation of Tympanic Membrane,
l. All internal or external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump,
m. Ulcer, Erosion and Varices of Upper Gastro Intestinal Tract,
n. Tonsils and Adenoids, Nasal Septum and Nasal Sinuses,
o. Internal Congenital Anomaly.

If the **Insured Person** is suffering from the above **Illness**/condition as a **Pre-existing Diseases** or a condition under Personal **Waiting Periods** at the time of inception of the **First Policy** with **Us**, any claim in respect of that **Illness**/condition shall not be covered until 48 months of continuous coverage have elapsed since the inception of the **First Policy** with **Us** for **Insured Persons** to whom Variant 1 Plan is applicable as specified in the **Product Benefits Table** and until 36 months of continuous coverage have elapsed since the inception of the **First Policy** with **Us** for **Insured Persons** to whom Variant 2, Variant 3 Plans and **Family First Policy** are applicable as specified in the **Product Benefits Table**.

*Note: For all **Renewing Insured Persons**, the terms of the Specific **Waiting Period** as set out in the **First Policy** document taken before <<Date of launch of this version>> (including the list of relevant medical conditions and surgical conditions as set out below) shall continue to apply until any **Waiting Period** has expired. The medical conditions and/or surgical treatments applicable to **First Policies** issued earlier are as follows:*

1. Stones in biliary and urinary systems
2. Lumps / cysts / nodules / polyps / internal tumours
3. Gastric and Duodenal Ulcers
4. Surgery on tonsils / adenoids
5. Osteoarthrosis / Arthritis / Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse
6. Cataract
7. Fissure / Fistula / Haemorrhoids
8. Hernia / Hydrocele
9. Chronic Renal Failure or end stage Renal Failure
10. Sinusitis / Deviated Nasal Septum / Tympanoplasty / Chronic Suppurative Otitis Media
11. Benign Prostatic Hypertrophy
12. Knee/Hip Joint replacement
13. Dilatation and Curettage
14. Varicose veins
15. Dysfunctional Uterine Bleeding / Fibroids / Prolapse Uterus / Endometriosis
16. Diabetes and related complications
17. Hysterectomy for any benign disorder

5.4 **Personal Waiting Periods:**

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

6. 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**.

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

6.2 **Hazardous Activities**
Any claim relating to **Hazardous Activities** unless declared beforehand and agreed by **Us**.

6.3 **Artificial life maintenance:**
Artificial life maintenance, including life support machine used to sustain a person, who has been declared brain dead, as demonstrated by:
a. Deep coma and unresponsiveness to all forms of stimulation; or
b. Absent pupillary light reaction; or
c. Absent oculovestibular and corneal reflexes; or
d. Complete apnea.

6.4 **Behavioral, Neurodevelopmental and Neurodegenerative Disorders:**
a. Disorders of adult personality including gender related problems, gender change;
b. Disorders of speech and language including stammering, dyslexia;
c. All Neurodegenerative disorders including Dementia, Alzheimer's disease and Parkinson's disease;
d. Other medical services for behavioral, neurodevelopmental delays and disorders.

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

6.6 **Complementary & Alternative Medicine:**
Any form of **Complementary & Alternative Medicine**.

6.7 **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.

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

6.9 **Convalescence & Rehabilitation:**
Hospital accommodation when it is used solely or primarily for any of the following purposes:
a. Any services related to **Complementary & Alternative Medicine** provided for the purpose of **Convalescence, Rehabilitation and Respite Care** other than for receiving eligible treatment of a type that normally requires a stay in **Hospital**.
b. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
c. Hospice care - Any services for people who are terminally ill to address medical, physical, social, emotional and spiritual need.

6.10 **Cosmetic and Reconstructive Surgery:**
a. Any treatment undergone purely for cosmetic or psychological reasons to improve appearance, unless such treatment is **Medically Necessary** as a part of reconstructive procedure related to cancer or treatment for **Injury** resulting from **Accidents** or burns, and is required to restore functionality.
b. Gynaecomastia, Abdominoplasty, blepharoplasty, mammoplasty, Chemical Peel, Rhinoplasty, Otoplasty, Liposuction and Lipectomy will not be payable even in case of **Accident** or burn or cancer.

6.11 **Dental/oral treatment:**

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

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

6.13 **Experimental or Unproven Treatment:**
a. Services including device, treatment, procedure or pharmacological regimens which are considered as experimental or unproven.
b. **Medical Devices**, Vascular or Coronary Stents: Biodegradable (bioresorbable, bioabsorbable) polymer drug eluting stents will be considered as experimental for all purpose.
c. Stem Cell Transplant: Any stem cell transplant other than for **Bone Marrow Transplant**.

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

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

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

6.17 **Mental and Psychiatric Conditions:**
Treatment related to symptoms, complications and consequences of mental **Illness**, mood disorders, psychotic and non-psychotic disorders such as:
a. Intentional self inflicted **Injury** or attempted suicide by any means.
b. Depression, anxiety, dissociative or stress-related disorders.

6.18 **Non-Medical Expenses:**
a. Items of personal comfort and convenience.
   i. Personal attendant or beauty services, cosmetics, toiletry items, guest services and similar incidental expenses or services.
   ii. Issue of medical certificate and examinations as to suitability for employment or travel or any other such purpose.
   Any charges incurred to procure any treatment/**Illness** related documents pertaining to any period of **Hospitalization/Illness**.
   iii. Intra Ocular Lens: Any of the following classes of intraocular lens implants for any indication, including aphakia such as Multifocal IOL, Presbyopia or Astigmatism Correcting IOL, Phakic IOL, Pseudoaccommodating IOL.
b. External or Ambulatory Devices
   i. External and or durable medical/non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD or infusion pump.
   ii. Ambulatory devices such as walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, diabetic foot wear, glucometer /thermometer and similar items and also any medical equipment which is subsequently used at home.
c. Visiting Charges:
   Any travelling charge for visiting consultant.

6.19 **OPD Treatment:**
OPD Treatment is not covered except for animal bite vaccinations to the extent stated in Section 2.9.

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

6.21 **Off- label drug or treatment:**
Use of pharmaceutical drugs for an unapproved indication or in an unapproved age group, dosage, or route of administration as regulated and approved by Central Drugs Standard Control Organization (CDSCO).

6.22 **Puberty and Menopause related Disorders:**
Treatment for any symptoms, **Illness**, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing.

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

a. Birth Control
Any type of contraception, sterilization, abortions, voluntary termination of pregnancy or family planning;
b. Assisted Reproduction
Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI, Gestational Surrogacy;
c. Sexual disorder and Erectile Dysfunction.
Treatment of any sexual disorder including impotence (irrespective of the cause) and sex changes or gender reassignments or erectile dysfunction;
d. Any costs or expenses related to pregnancy, complications arising from pregnancy or medical termination of pregnancy.

However, the above exclusions do not apply to treatment for ectopic pregnancy or accidental miscarriage.

6.24 **Robotic Assisted Surgery, Light Amplification by Stimulated Emission of Radiation (LASER) & Light based Treatment:**
Any invasive or non invasive procedures in which a robotic surgical system or light based measure is used either in conjugation with base procedure or alone and liability will be based on the agreed tariff rate or Reasonable and Customary Charges for the base procedure including but not limited to Cyberknife, Da Vinci, Laser Ablation, Femto second laser.

6.25 **Sexually transmitted Infections & diseases:**
Screening, prevention and treatment for sexually related infection or disease including but not limited to Genital Warts, Syphilis, Gonorrhea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.

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

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

6.28 **Unlawful Activity:**
Any condition occurring as a result of breach of law with criminal intent.

6.29 **Treatment received outside India:**
Any treatment or medical services received outside India.

6.30 **Unrecognized Physician or Hospital:**

a. Treatment or **Medical Advice** provided by a **Medical Practitioner** not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central council of Homeopathy.
b. Treatment or **Medical Advice** related to one system of medicine provided by a **Medical Practitioner** of another system of medicine.
c. Treatment provided by anyone with the same residence as an **Insured Person** or who is a member of the **Insured Person's** immediate family or relatives.
d. Treatment provided by **Hospital** or health facility that is not recognized by the relevant authorities in India.
e. Treatment or services received in health hydros, nature cure clinics or any establishment that is not a recognized **Hospital** or healthcare facility.

6.31 **Generally Excluded Expenses**

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

7. 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 **Schedule of Insurance Certificate**) in so far as they relate to anything to be done or complied with by **You** or any **Insured Person**, including complying with the following in relation to claims, shall be **Condition Precedent** to admission of **Our** liability under this **Policy**.

7.1 **Claims Administration:**

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

a. The directions, advice and guidance of the treating **Medical Practitioner** shall be strictly followed. **We** shall not be obliged to make any payment that arises out of wilful failure to comply with such directions, advice or guidance.
b. **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.
c. **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.
d. It is hereby agreed and understood that no change in the **Medical Record** provided under the **Medical Advice** information, by the **Hospital** or the **Insured Person** to **Us** or **Our Service Provider** during the period of **Hospitalization** or after discharge by any means of request will be accepted by **Us**. Any decision on request for acceptance of change will be at **Our** discretion.

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

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

i. Process for Obtaining Pre-Authorization

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

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

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

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

I. The health card **We** have issued to the **Insured Person** at the time of inception of the **Policy** (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**.

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

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

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

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

ii. Reauthorization

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

b. For Reimbursement Claims:

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

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

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

a. Claim form duly completed and signed by the claimant.
   Please provide mandatorily following information if applicable
   i. Current diagnosis and date of diagnosis;
   ii. Past history and first consultation details;
   iii. Previous admission/**Surgery** if any.
b. Age/Identity proof document: Of **Insured Person** in case of cashless claim (not required if submitted at the time of pre-authorization request) and Proposer in case of **Reimbursement** claim.
   i. Self attested copy of 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);
c. Cancelled cheque/ bank statement / copy of passbook mentioning account holder's name, IFSC code and account number printed on it of **Policyholder** / nominee (in case of death of **Policyholder**).
d. Original discharge summary.
e. Additional documents required in case of **Surgery**/**Surgical Procedure**.
   i. Bar code sticker and invoice for implants and prosthesis (if used);
f. Original final bill from **Hospital** with detailed break-up and paid receipt.
g. Room tariff of the entitled room category (in case of a **Non-Network** provider 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.)

h. Original bills of pharmacy/medicines purchased, or of any other investigation done outside **Hospital** with reports and requisite prescriptions.
i. Copy of death certificate (in case of demise of the **Insured Person**).
j. For Medico-legal cases (MLC) or in case of **Accident**
   i. MLC/First Information Report (FIR) copy attested by the concerned **Hospital** / police station (if applicable);
   ii. Original self-narration of incident in absence of MLC / FIR.
k. Original laboratory investigation, diagnostic & pathological reports with supporting prescriptions.
l. Original X-Ray/ MRI / ultrasound films and other radiological investigations.

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

7.4 **Claims Assessment & Repudiation:**

a. At **Our** discretion, **We** may investigate claims to determine the validity of a claim. All costs of investigation will be borne by **Us** and all investigations will be carried out by those individuals/entities that are authorized by **Us** in writing.
b. **We** shall settle or repudiate a claim within 30 days of the receipt of the last necessary information and documentation set out above. In case of any suspected fraud, the last "necessary" document shall include the receipt of the investigation report from **Our** investigator/representatives. In case of delay in payment, **We** shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by **Us**.
c. Payment for **Reimbursement** claims will be made to **You**. In the unfortunate event of **Your** death, **We** will pay the Nominee named in the **Schedule of Insurance Certificate** or **Your** legal heirs or legal representatives holding a valid succession certificate.
d. If a claim is made which extends in to two **Policy Periods**, then such claim shall be paid taking into consideration the available **Sum Insured** in these **Policy Periods** including the **Deductible** for each **Policy Period**. Such eligible claim amount will be paid to the **Policyholder**/**Insured Person** after deducting the extent of premium to be received for the **Renewal**/due date of premium of the **Policy**, if not received earlier.
e. All admissible claims under this **Policy** shall be assessed by **Us** in the following progressive order:-
   i. If a room has been opted in a **Hospital** for which the room category is higher than the eligible limit as applicable for that **Insured Person** as specified in the **Schedule of Insurance Certificate**, then the **Associated Medical Expenses** payable shall be pro-rated as per the applicable limits in accordance with Section 2.1c.
   ii. The **Deductible** (if applicable) shall be applied to the aggregate of all claims that are either paid or payable under this **Policy**. **Our** liability to make payment shall commence only once the aggregate amount of all eligible claims as per policy terms and conditions exceeds the **Deductible** limit within the same **Policy Year**.
   iii. **Co-payment** (if applicable) as specified in the **Schedule of Insurance Certificate** shall be applicable on the amount payable by **Us**.
f. The claim amount assessed in Section 7.4 e above would be deducted from the amount mentioned against each benefit and **Sum Insured** as specified in the **Schedule of Insurance Certificate**. The re-fill amount will be applied only once the **Base Sum Insured** and **No Claim Bonus** is exhausted in the **Policy Year**.

7.5 **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.

7.6 **Claims process for Section 2.10 (Health Checkup)**
a. The **Insured Person** shall seek appointment by contacting **Our Service Provider**.
b. **Our Service Provider** will facilitate **Your** appointment.
c. Reports of the medical tests can be collected directly from the **Service Provider**.

8. Portability Option

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

a. The ported **Insured Person** was insured continuously and without a break under another Indian retail health insurance policy with any other Indian general insurance company or stand-alone health insurance company or any group/retail indemnity health insurance policy from **Us**.
b. The **Waiting Period** with respect to change in **Sum Insured** or plan shall be taken into account as follows:
   i. If the ported **Sum Insured** is higher than the **Sum Insured** under the expiring policy, **Waiting Periods** would be applied on the amount of proposed increase in **Sum Insured** only, in accordance with the existing guidelines of the **IRDAI**.
   ii. If the proposed Plan is to be changed and not the **Sum Insured** then the applicable **Waiting Periods** would be applied as per the proposed plan.
c. In case of different policies and plan in previous years, the **Portability** Option would be provided for the expiring policy or Plan which is to be ported to **Us**.
d. The **Portability** Option has been accepted by **Us** within 15 days of receiving **Your** Proposal and **Portability** Form subject to the following:
   i. **You** shall have paid **Us** the applicable premium in full;
   ii. **We** might have, subject to **Our** medical underwriting as per **Our** Board approved underwriting policy, restricted the terms upon which **We** have offered cover, the decision as to which shall be in **Our** sole and absolute discretion;
   iii. There was no obligation on **Us** to insure all **Insured Persons** or to insure all **Insured Persons** on the proposed terms, even if **You** have given **Us** all documentation;
   iv. **We** have received necessary details of medical history and claim history from the previous insurance company for the **Insured Person's** previous health insurance policy through the **IRDAI's** web portal.
   v. No additional loading or charges have been applied by **Us** exclusively for porting the **Policy**.
e. In case **You** have opted to switch to any other insurer under **Portability** provisions(Porting Out) and the outcome of acceptance of the **Portability** request is awaited from the new insurer on the date of **Renewal**,
   i. **We** may upon **Your** request extend this **Policy** for a period of not less than one month at an additional premium to be paid on a pro rata basis.
   ii. If during this extension period a claim has been reported, **You** shall be required to first pay the balance of the full annual **Policy** premium. **Our** liability for the payment of such claim shall commence only once such premium is received. Alternately **We** may deduct the premium for the balance period and pay the balance claim amount if any and issue the **Policy** for the remaining period.
   iii. **We** reserve the right to modify or amend the terms and the applicability of the **Portability** option in accordance with the provisions of the regulations and guidance issued by the **IRDAI** as amended from time to time.

9. General Terms and Conditions

9.1 **Free Look Provision**

a. The free look period shall be applicable at the inception of the **Policy** and is not applicable and available at the time of **Renewal** of the **Policy** or in cases of **Portability**.
b. **You** have a period of 15 days from the date of receipt of the **Policy** document to review the terms and conditions of this **Policy**.
c. If **You** have any objections to any of the terms and conditions, **You** may cancel the **Policy** stating the reasons for cancellation and provided that no claims have been made under the **Policy**.
d. **We** will refund the premium paid by **You** after deducting the amounts spent on pre-insurance medical check-up (if any), stamp duty charges and proportionate risk premium for the period of cover.
e. **Your** rights under this **Policy** will immediately stand extinguished on the free look cancellation of the **Policy**

9.2 **Cancellation/Termination (other than Free Look cancellation)**

a. **Cancellation by You: You** may terminate this **Policy** by giving 30 days prior written notice to **Us**. **We** shall cancel the **Policy** for the balance of the **Policy Period** and refund the premium (exclusive of service tax) for the unexpired term as mentioned herein below, provided that no claim has been made under the **Policy** by or on behalf of any **Insured Person**:

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

b. Automatic Cancellation:

i. **Individual Policy**:
The **Policy** shall automatically terminate in the event of death of the **Insured Person**.

ii. For **Family Floater Policies** and **Family First Policies**:
The **Policy** shall automatically terminate in the event of the death of all the **Insured Persons**. .

iii. Refund:
A refund in accordance with the table in Section 9.2 (a) shall be payable if there is an automatic cancellation of the **Policy** provided that no claim has been made under the **Policy** by or on behalf of any **Insured Person**. **We** will pay the refund of premium to the **Nominee** named in the **Schedule of Insurance Certificate** or **Your** legal heirs or legal representatives holding a valid succession certificate.

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

i. **You** or any **Insured Person** or any person acting on behalf of either has acted in a dishonest or fraudulent manner under or in relation to this **Policy**; and/or
ii. **You** or any **Insured Person** has not disclosed the material facts or misrepresented in relation to the **Policy**; and/or
iii. **You** or any **Insured Person** has not co-operated with **Us**. In such cases, premium will be refunded on pro-rata basis provided that no claim has been filed under the **Policy** by or on behalf of any **Insured Person**.

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

9.3 **Loading on Premium**

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

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

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

9.4 **Renewal of Policy**

This **Policy** is **Renewable** for life however this **Policy** will automatically terminate at the end of the **Policy Period** or **Grace Period** and **We** are under no obligation to give intimation in this regard. The details pertaining to **Sum Insured** and **Waiting Period** will be shared by **Us** on **Policy Year** wise.

a. Continuity of Benefits on Timely Renewal:

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

ii. The **Renewal** premium is payable on or before the due date and in any circumstances before the expiry of **Grace Period**, at such rate as may be reviewed and notified by **Us** before completion of the **Policy Period**.

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

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

B. **You** change any coverage provision

C. **You** change **Your** residence to different zip code

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

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

b. Grace Period:

i. If **You** do not **Renew** the **Policy** by the due dates specified in the **Schedule of Insurance Certificate**, **You** or any other eligible adult **Insured Person** may apply to **Renew** the **Policy** within the **Grace Period** of 30 days after the end of the **Policy Period** subject to receipt of application and payment of premium. Such **Policy** shall be treated as having been **Renewed** without a break in cover.

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

c. Reinstatement:

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

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

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

d. Disclosures on Renewal:

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

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

f. Addition of Insured Persons on Renewal:
Where an individual is added to this **Policy**, 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**.

g. Changes to Sum Insured on Renewal:
i. Wherever the **Sum Insured** is reduced on any **Policy Renewals**, the **Waiting Periods** as defined under Section 4 shall be waived only up to the lowest **Sum Insured** of the last 48/36 consecutive months as applicable to the relevant **Waiting Periods** of the Plan opted.
ii. Any enhanced **Sum Insured** applied on **Renewal** will not be available for an **Illness** or **Injury** already contracted under the preceding **Policy Periods**. All **Waiting Periods** as defined in the **Policy** under Section 4 shall apply afresh for this enhanced limit from the effective date of such enhancement.

h. Renewal Promise:
Renewal of the **Policy** will not ordinarily be denied other than on grounds of moral hazard, misrepresentation or fraud or non-cooperation by **You**. **Sum Insured** of Rs. 2 Lacs will be available for life to renewal customers who opted this **Sum Insured** in the expiring **Policy**.

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

9.6 **Nomination & Assignment**
a. **You** are mandatorily required at the inception of the **Policy**, to make a nomination for the purpose of payment of claims under the **Policy** in the event of **Your** death.
b. Any change of nomination shall be communicated to **Us** in writing and such change shall be effective only when an endorsement on the **Policy** is made by **Us**.
c. In case of any **Insured Person** other than **You** under the **Policy**, for the purpose of payment of claims in the event of death, the default nominee would be **You**.
d. The **Policy** and the benefits there under cannot be assigned in whole or in part.

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

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

9.9 **Fraudulent claims**
If a claim is in any way found to be fraudulent, or if any false statement, or declaration is made or used in support of such a claim, or if any fraudulent means or devices are used by the **Insured Person** or anyone acting on behalf of the **Insured Person** or any false or incorrect **Disclosure to Information Norms** to obtain any benefit under this **Policy**, then **We** may reserve the right to re-underwrite or cancel the **Policy** and all

claims being processed shall be forfeited for all **Insured Persons** and all sums paid under this **Policy** shall be repaid to **Us** by **You** who shall be jointly liable for such repayment.

9.10 **Policy Disputes**

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

9.11 **Territorial Jurisdiction**

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

9.12 **Notices**

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

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

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

Fax No.: 1800-3070-3333

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

9.13 **Alteration to the Policy**

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

9.14 **Zonal pricing**

For the purpose of calculating premium, the country has been divided into the following 3 zones:

- Zone 1: Delhi (NCR), Surat, Kolkata, Mumbai, Thane
- Zone 2: Pune, Ludhiana, Jaipur
- Zone 3: Rest of India

9.15 **Revision or Modification**

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

9.16 **Withdrawal of Product**

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

9.17 **Customer Service and Grievances Redressal**:

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

Customer Services Department

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

Contact No: 1800-3010-3333

Fax No.: 1800-3070-3333

Email ID: customercare@maxbupa.com

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

Head – Customer Services

Max Bupa Health Insurance Company Limited

B-1/I-2, Mohan Cooperative Industrial Estate

Mathura Road, New Delhi-110044

Contact No: 1800-3010-3333

Fax No.: 1800-3070-3333

Email ID: customercare@maxbupa.com

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

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

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

i. Has been rejected by the Grievance Redressal Machinery of the Insurer;
ii. Within a period of one year from the date of rejection by the insurer;
iii. If it is not simultaneously under any litigation.

10. Definitions & Interpretation

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

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

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

10.2 **Age** means age last birthday.

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

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

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

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

10.7 **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.

10.8 **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.
Specific Exclusion: All tumors in the presence of HIV infection are excluded.

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

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

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

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

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

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

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

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

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

10.16 **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.

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

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

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

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

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

10.22 **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**.

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

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

10.25 **Family Floater Policy** means a **Policy** described as such in the **Schedule of Insurance Certificate** where the family members (two or more) named in the **Schedule of Insurance Certificate** are insured under this **Policy**. Only the following family members can be covered under a **Family Floater Policy**:
a. **Insured Person**; and/or
b. **Insured Person's** legally married spouse (for as long as they continue to be married); and/or
c. **Insured Person's** children who are less than 21 years of **Age** on the commencement of the **Policy Period** (maximum 4 children can be covered).

10.26 **Family First Policy** means a **Policy** described as such in the **Schedule of Insurance Certificate** where **You** and **Your** family members named in the **Schedule of Insurance Certificate** are insured under this **Policy**. Only the following family members can be covered under a **Family First Policy**:
a. **Your** legally married spouse for as long as **Your** spouse continues to be married to **You**;
b. Son;
c. Daughter-in-law as long as **Your** son continues to be married to **Your** Daughter-in-law;
d. Daughter;
e. Son-in-law as long as **Your** daughter continues to be married to **Your** Son-in-law;
f. Father;
g. Mother;
h. Father-in-law as long as **Your** spouse continues to be married to **You**;
i. Mother-in-law as long as **Your** spouse continues to be married to **You**;
j. Grandfather;
k. Grandmother;
l. Grandson;
m. Granddaughter;
n. Brother;
o. Sister;
p. Sister-in-law;
q. Brother-in-law;
r. Nephew;
s. Niece.

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

10.28 **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.

10.29 **Hazardous activities** means engaging in speed contest or racing of any kind (other than on foot), professional or competitive sport, bungee jumping, parasailing, ballooning, parachuting, base jumping, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, snow and ice sports or involving a naval military or air force operation.

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

a. has at least 10 **Inpatient** beds in towns having a population of less than 10,00,000 and at least 15 **Inpatient** beds in all other places;
b. has **Qualified Nursing** staff under its employment round the clock;
c. has qualified **Medical Practitioner (s)** in charge round the clock;
d. has a fully equipped operation theatre of its own where **Surgical Procedures** are carried out;
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

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

10.32 **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**.

10.33 **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**.

10.34 **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.

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

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

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

1. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
2. It needs ongoing or long-term control or relief of symptoms
3. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. It continues indefinitely
5. It recurs or is likely to recur

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

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

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

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

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

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

10.42 **Medical Advice** means any consultation or advice from a **Medical Practitioner including the issu**e of any prescription or repeat prescript**ion.**

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

10.44 **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.

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

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

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

a. is required for the medical management of the **Illness** or **Injury** suffered by the insured;
b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c. must have been prescribed by a **Medical Practitioner**;
d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

10.49 **No Claim Bonus** means an increase to the **Base Sum Insured** in accordance with the provisions of Section 2.11 in respect of claim free **Policy Years**.

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

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

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

10.53 **OPD Treatment** is one in which the **Insured Person** visits a clinic/ **Hospital**, or associated facility like a consultation room, for diagnosis and treatment based on the advice of a **Medical Practitioner**. The **Insured Person** is not admitted as a day care patient or **Inpatient**.

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

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

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

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

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

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

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

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

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

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

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

10.63 **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.

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

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

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

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

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

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

10.70 **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.

10.71 **Suite Room** means

a. a space available for boarding in a **Hospital** which contains two or more rooms; Or
b. a space available for boarding in a **Hospital** which contains an extended living/dining/kitchen area

10.72 **Sum Insured**: In case of **Individual Policy**, **Sum Insured** means the total of the **Base Sum Insured,** re-fill amount as per Section 2.12 and **No Claim Bonus** as per Section 2.11 which is **Our** maximum, total and cumulative liability for any and all claims during the **Policy Year** in respect of the **Insured Person**. However in case of a single claim, **Our** maximum liability for that claim during the **Policy Year** in respect of the **Insured Person** shall be the total of the **Base Sum Insured** and No Claims Bonus as per Section 2.11.

In case of **Family Floater Policy**, **Sum Insured** means the total of the **Base Sum Insured,** re-fill amount as per Section 2.12 and **No Claim Bonus** as per Section 2.11 which is **Our** maximum, total and cumulative liability for any and all claims during the **Policy Year** in respect of all **Insured Persons**.

In case of **Family First Policy**, **Sum Insured** means the total of the **Base Sum Insured** for each **Insured Person, No Claim Bonus** as per Section 2.11 for each **Insured Person** and the Floater Sum Insured specified in the **Schedule of Insurance Certificate** which is **Our** maximum, total and cumulative liability for all claims during a **Policy Year** in respect of each **Insured Person**. For these purposes:

a. The **Base Sum Insured** stated in the **Schedule of Insurance Certificate** for each **Insured Person** is available for claims in respect of that **Insured Person** only, during the **Policy Year**.
b. If the **Base Sum Insured** for an **Insured Person** is exhausted due to payment of claims, then that **Insured Person** may utilise the Floater Sum Insured stated in the **Schedule of Insurance Certificate** for any claims arising in that **Policy Year**. In the event of a claim being admitted from the Floater Sum Insured**,** the Floater Sum Insured shall stand correspondingly reduced by the amount of claim paid (including 'taxes') or admitted and only the remaining amount of the Floater Sum Insured shall be available for claims arising in that **Policy Year** in respect of the **Insured Persons** who have exhausted their **Base Sum Insured** during that **Policy Year**.
c. The total of the **Base Sum Insured** for all **Insured Persons, No Claim Bonus** as per Section 2.11 for all **Insured Persons,** and the Floater Sum Insured specified in the **Schedule of Insurance Certificate** is **Our** maximum, total and cumulative liability for all claims during a **Policy Year** in respect of all **Insured Persons**.

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

10.73 **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an **Illness** or **Injury**, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a **Hospital** or **Day Care Center** by a **Medical Practitioner**.

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

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

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

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

Annexure I - List of Insurance Ombudsmen

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD		Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Shri. M. Parshad	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@gbic.co.in	Karnataka
BHOPAL	Shri Raj Kumar Srivastava	Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, M alviya Nagar, Opp. Airtel, Near New Market, BHOPAL-462 023. Tel.:- 0755-2769201/2769202 Fax : 0755-2769203 Email: bimalokpal.bhopal@gbic.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Shri. B. N. Mishra	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest park Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in	Orissa
CHANDIGARH		Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir , Chandigarh
CHENNAI	Shri Virender Kumar	Insurance Ombudsman, Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Areas of Jurisdiction
DELHI	Smt. Sandhya Baliga	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in	Delhi
GUWAHATI		Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Shri G.Rajeswara Rao	Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in	Andhra Pradesh, Telangana and Yanam – a part of territory of Pondicherry
JAIPUR	Shri. Ashok K. Jain	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.co.in	Rajasthan
ERNAKULAM	Shri. P. K. Vijayakumar	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@gbic.co.in	Kerala , Lakshadweep , Mahe – a part of Pondicherry
KOLKATA	Shri. K. B. Saha	Insurance Ombudsman, Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@gbic.co.in	West Bengal , Andaman & Nicobar Islands , Sikkim

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Areas of Jurisdiction
LUCKNOW	Shri. N. P. Bhagat	Insurance Ombudsman, Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in	Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Shri A.K.Dasgupta	Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in	Goa, Mumbai metropolitan region excluding Navi Mumbai & Thane
NOIDA	Shri Ajesh Kumar	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15 Distt: Gautam Budh Nagar, UP – 201301 Tel: 0120-2514250/2514251/2514253 Email: bimalokpal.noida@gbic.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA	Shri Sadasiv Mishra	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800006 Tel: 0612-2680952 Email: bimalokpal.patna@gbic.co.in	Bihar, Jharkhand.
PUNE	Shri. A. K. Sahoo	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

GOVERNING BODY OF INSURANCE COUNCIL,
3rd Floor, Jeevan Seva Annexe,
S. V. Road, Santacruz (W),
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Tel.: 022 - 26106889 / 671 / 980
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Smt. Ramma Bhasin, Secretary General
Shri. Y.R. Raigar, Secretary

ANNEXURE II- LIST OF GENERALLY EXCLUDED ITEMS IN HOSPITALIZATION POLICY

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

52	Dvd, cd charges	Not payable (However If CD is specifically sought by Insurer/TPA then payable)
53	Eyelet collar	Not payable
54	Face mask	Not payable
55	Flexi mask	Not payable
56	Gause soft	Not payable
57	Gauze	Not payable
58	Hand holder	Not payable
59	Hansaplast/ adhesive bandages	Not payable
60	Lactogen/ infant food	Not payable
61	Slings	Reasonable costs for one sling in case of upper arm fractures may be considered

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

S. No.	Items	Recommendations
C	**Items which form part of Hospital services where separate consumables are not payable but the service is**	**Payable/non payable**
1	Ward and theatre booking charges	Payable under OT charges, not payable separately
2	Arthroscopy & endoscopy instruments	Rental charged by the hospital payable. Purchase of instruments not payable.
3	Microscope cover	Payable under OT charges, not payable separately
4	Surgical blades,harmonic scalpel,shaver	Payable under OT charges, not payable separately
5	Surgical drill	Payable under OT charges, not payable separately
6	Eye kit	Payable under OT charges, not payable separately
7	Eye drape	Payable under OT charges, not payable separately
8	X-ray film	Payable under radiology charges, not as consumable
9	Sputum cup	Payable under investigation charges, not as consumable
10	Boyles apparatus charges	Part of OT charges, not separately
11	Blood grouping and cross matching of donors samples	Part of cost of blood, not payable
12	Antiseptic or disinfectant lotions	Not payable-part of dressing charges
13	Band aids, bandages, sterile injections, needles, syringes	Not payable - part of dressing charges
14	Cotton	Not payable-part of dressing charges
15	Cotton bandage	Not payable-part of dressing charges

16	Micropore/ surgical tape	Not payable-payable by the patient when prescribed, otherwise included as dressing charges
17	Blade	Not payable
18	Apron	Not payable -part of hospital services/disposable linen to be part of OT/ ICU charges
19	Torniquet	Not payable (service is charged by hospitals, consumables cannot be separately charged)
20	Orthobundle, gynaec bundle	Part of dressing charges
21	Urine container	Not payable

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

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

S. No.	Items	Recommendations
F	**External Durable Devices**	**Payable/Non Payable**
1	Walking aids charges	Not payable
2	Bipap machine	Not payable
3	Commode not payable	Not payable
4	CPAP/ CPAD equipments device	Not payable
5	Infusion pump - cost device	Not payable
6	Oxygen cylinder (for usage outside the hospital)	Not payable (in case of post-hospitalization expenses, cost of oxygen prescribed payable, but not the cost of the cylinder)
7	Pulse oxymeter charges device	Not payable
8	Spacer	Not payable
9	Spirometre device	Not payable
10	Spo2 probe	Not payable
11	Nebulizer kit	Not payable
12	Steam inhaler	Not payable
13	Arm sling pouch	Not payable
14	Thermometer	Not payable (paid by patient)
15	Cervical collar	Not payable
16	Splint	Not payable
17	Diabetic foot wear	Not payable
18	Knee braces (long/ short/ hinged)	Not payable
19	Knee immobilizer/shoulder immobilizer	Not payable
20	Lumbo sacral belt	Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine
21	Nimbus bed or water or air bed charges	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/ quadriplegia for any reason and at reasonable cost of approximately Rs 200/day
22	Ambulance collar	Not payable
23	Ambulance equipment	Not payable
24	Microsheild	Not payable
25	Abdominal binder	Essential and should be paid at least in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.

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S. No.	Items	Recommendations
G	**Items Payable If Supported By A Prescription**	**Payable/Non Payable**
1	Betadine \ hydrogen peroxide\spirit\detol \savlon\ disinfectants etc	May be payable when prescribed for patient, not payable for hospital use in ot or ward or for dressings ward or for dressings
2	Private nurses charges- special nursing charges	Not payable if policy excludes; post hospitalization nursing charges not payable
3	Nutrition planning charges - dietician charges- diet charges	If policy excludes diet charges - not payable; patient diet provided by hospital is payable
4	Sugar free tablets	Payable -sugar free variants of admissible medicines are not excluded
5	Cream powder lotion (toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
6	Digestive gel/ antacid gel	Payable when prescribed
7	Ecg electrodes	Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable
8	Gloves sterilized gloves	Payable / unsterilized gloves not payable
9	Hiv kit	Payable - pre-operative screening
10	Listerine/ antiseptic mouthwash	Payable when prescribed
11	Lozenges	Payable when prescribed
12	Mouth paint	Payable when prescribed

13	Nebulisation kit	If used during hospitalization is payable reasonably
14	Neosprin	Payable when prescribed
15	Novarapid	Payable when prescribed
16	Volini gel/ analgesic gel	Payable when prescribed
17	Zytee gel	Payable when prescribed
18	Vaccination charges	Routine vaccination not payable / post bite vaccination payable

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

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