Bajaj General Insurance Limited
(Formerly known as Bajaj Allianz General Insurance Co. Ltd.)
Bajaj Insurance House, Airport Road, Yerawada, Pune - 411006. IRDAI Reg No.: 113.
CIN: U66010PN2000PLC015329 | UIN: BAJHLIP26074V022526
Email: careforyou@bajajgeneral.com | Website: www.bajajgeneralinsurance.com
Sales - 1800 209 0144 / Service - 1800 209 5858 (Toll Free No.)

CARINGLY YOURS

POLICY WORDING

MY HEALTH CARE PLAN EDGE+ (PLAN 9)

SECTION A) PREAMBLE

Whereas the Insured (hereinafter called the 'Insured' or "Policyholder" or "Insured Person") has made a Proposal to Bajaj General Insurance Limited (Formerly known as Bajaj Allianz General Insurance Co. Ltd.) (hereinafter called the "Company" or "insurance company" or "Insurer" or "Bajaj General") which is hereby agreed to be the basis of this Policy and in consideration of payment of Premium, as specified in the Schedule, by You and realized by Us, the Company agrees, subject to the following terms, conditions, exclusions, definitions, and limitations of the Policy, and to indemnify Insured Person(s)/make payment, in excess of the amount of the Deductible and subject to the Sum Insured and/or Limit of Indemnity, in the manner and to the extent as provided herein.

SECTION B) DEFINITIONS- STANDARD DEFINITIONS

1. Accident, Accidental
   An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

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

3. AYUSH Hospital
   An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a. Central or State Government AYUSH Hospital; or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i. Having at least 5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out
      iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

4. AYUSH Day Care Centre
   AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

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

7. Congenital Anomaly
Congenital Anomaly means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
   a. Internal Congenital Anomaly- Congenital anomaly which is not in the visible and accessible parts of the body
   b. External Congenital Anomaly- Congenital anomaly which is in the visible and accessible parts of the body.

8. Co-Payment
A co-payment means a cost-sharing requirement under a health insurance Policy that provides that the Policyholder/Insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

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

10. Day care centre
A day care centre means any institution established for day care treatment of Illness and / or injuries or a medical set-up with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner and must comply with all minimum criteria as under:
   i. has qualified nursing staff under its employment,
   ii. has qualified medical practitioner(s) in charge,
   iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
   iv. maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

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

12. Deductible
Deductible means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified amount (in INR) 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.
Deductible will be applicable either per year (Aggregate Deductible) or per claim, as specified in the Policy Schedule.

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

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

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

16. Emergency Care
Emergency care means management of an Illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long-term impairment of the Insured's health.

17. Grace Period
Grace period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

18. Hospital
A hospital means any institution established for in-patient care and day care treatment of Illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
    i. has qualified nursing staff under its employment round the clock;
    ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    iii. has qualified medical practitioner(s) in charge round the clock;
    iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v. Maintains daily records of patients and makes these accessible to the Insurance Company's authorized personnel.

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

20. Illness
Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a. Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
    b. Chronic condition – A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
        ii. it needs ongoing or long-term control for relief of symptoms
        iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
        iv. it continues indefinitely
        v. it recurs or is likely to recur.

21. Injury
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.

22. Inpatient Care
Inpatient care means treatment for which the Insured has to stay in a hospital for more than 24 hours for a covered event.

23. Intensive Care Unit (ICU)
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.

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

25. Maternity Expenses
Maternity expenses means;
a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
b) expenses towards lawful medical termination of pregnancy during the Policy Period.

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

27. Medical expenses
Medical Expenses means those expenses that an Insured 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 had not been insured and no more than other Hospitals or Medical Practitioners in the same locality would have charged for the same Medical Treatment

28. Medical Practitioner/Doctor/ Physician
Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license and acceptable to Us.

For the purposes of International Cover (Emergency Care Only) and Global Cover, Medical practitioner would mean a person who holds a valid registration from the Medical council of the respective country where the treatment is being taken by the insured

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

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

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

32. Network Provider
Network Provider means Hospitals or health care providers enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a Cashless facility.

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

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

35. Notification of Claim: Notification of claim means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

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

37. Pre-Existing Disease:
Pre-existing disease means any condition, ailment or injury or disease
    a. That is/are diagnosed by a Physician within 36 months prior to the effective date of the Policy issued by the Insurer or its reinstatement Or
    b. For which medical advice or treatment was recommended by, or received from, a physician/Medical Practitioner within 36 months prior to the effective date of the Policy issued by the Insurer or its reinstatement.

38. Pre-hospitalization Medical Expenses
Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the Hospitalization of the Insured Person, provided that:
    a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurer.

39. Post-hospitalization Medical Expenses
Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the Insured Person is discharged from the Hospital provided that:
    a. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and
    b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

41. Reasonable and Customary charges
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.

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

43. Room rent
Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

44. Specific waiting period
Specific waiting period means a period up to 24 months from the commencement of Policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break

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

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

SECTION B) DEFINITION- SPECIFIC DEFINITIONS

1. Act of Terrorism
Means an act or thing by any person or group(s) of persons, whether acting alone or on behalf of or in connection with or in connivance with or at the instance or instigation of any person or group(s) or organisation(s) or associations(s), who are committed or proclaimed to be committed for political, religious or ideological purposes, whether such person or group(s) of persons or organisation(s) or association(s) are or are not banned any law, in such a manner or with intent to threaten the unity, integrity, security or sovereignty of India or to strike terror in the people or any section of the people by using bombs, dynamite or other explosive substances or inflammable substances or firearms or other lethal weapons or poisons or noxious gases or other chemicals or by any other substances (whether biological or otherwise) of a hazardous nature or by any other means whatsoever, with intend to cause, or likely to cause, death or, or injuries to any person or persons or loss of, or damage to, or destruction of, property or disruption of any supplies or services essential to the life of the community or causes damage or destruction of any property or equipment used or intended to be used for the defence of India or in connection with any other purposes of the Government of India, any State Government or an of their agencies, or detains any person and threatens to kill or injure such person in order to compel the Government or any other person to do or abstain from doing any act. Provided further that for the above acts appropriate criminal prosecution has been initiated by police and charge sheet has been filed in competent court of criminal jurisdiction, either under special law or under general law.

2. Aggregate Deductible
Aggregate Deductible means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified amount (in INR) 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/claims are payable by the Insurer. A deductible does not reduce the Sum Insured. The deductible is applicable in aggregate towards Hospitalisation expenses incurred during the Policy Period.

3. AYUSH treatment
AYUSH treatment refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

4. Bajaj General Network Hospitals / Network Hospitals/Network Providers
Bajaj General Network Hospitals / Network Hospitals means the Hospitals which have been empanelled by the Insurer as per the latest version of the list of Hospitals maintained by the Insurer, which is available to You on request. For updated list please visit our website.

5. Bajaj General Diagnostic Centre
Bajaj General Diagnostic Centre means the diagnostic centres which have been empanelled by us as per the latest version of the schedule of diagnostic centres maintained by Us, which is available to You on request.

6. Dependent child
A child is considered a dependent for insurance purposes provided he is financially dependent, on the proposer/Insured.

7. Disappearance
Disappearance means the event of the disappearance of the Insured Person, following a forced landing, stranding, sinking or wrecking of a conveyance in which such Insured Person was known to have been travelling as an occupant, it shall be deemed after twelve (12) months, subject to all other terms and conditions of this Policy, that such Insured Person shall have died as the result of an Accident.

8. Endorsement
Means any writing on a Policy Schedule or Policy, in addition to its normal wording which supplements or modifies its terms. It may be added when Policy is prepared, or subsequently. Provided however any Service Level Agreement [SLA] or Agreement/MOU laying down various service levels shall not be treated as Endorsement.

9. Family or Family Members
For the purpose of Individual Sum Insured Policy- includes the Insured; his/her lawfully wedded spouse, dependent children, dependent parents, dependent Sister, dependent Brother, dependent Parents-in- law, dependent Aunt, dependent Uncle, dependent Grandchildren.
For the purpose of Family Floater policy- includes the Insured; his/her lawfully wedded spouse and dependent children.
For Parents/ Parents in law separate floater Policy can be taken.

10. General Ward
General ward is a common unit where patients who are admitted share the same room. Facilities are catered as per patient's diagnosis, age, comfort and other essential factors.

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

12. Hospital (for International Cover- Emergency Care Only/ Global Cover)
Hospital for international practice is any establishment which is licensed as a medical or surgical Hospital in the country where it operates and where the patient is permanently supervised by a Doctor. The following are not considered Hospitals: “rest and nursing homes, spas, cure-centers and health resorts.”

13. Limit of Indemnity
Limit of Indemnity represents our maximum liability to make payment for each and every claim per Insured person and collectively for all Insured persons mentioned in the Schedule during the Policy Period and in the aggregate for the Insured person(s) named in the schedule during the Policy Period, and means the amount stated in the Schedule against each Cover.

14. Medical Consumable
Medical consumables and equipment include syringes, needles, sutures, staples, packaging, tubing, catheters, medical gloves, gowns, masks, adhesives and sealants for wound dressing and a whole host of other devices and tools used with a hospital or surgical environment.

15. Named Insured/ Insured/Insured Person/Insured Beneficiary
Insured means the persons, or his Family Members, named in the Schedule with entry age criteria as below
• Adults 18 years to Lifelong.
• Dependent Children/Grandchildren: 3 months – 30 years.

16. Kidney Failure Requiring Regular Dialysis
End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a Specialist Medical Practitioner.

17. Nominee
Nominee means a person designated by You to receive the proceeds of this Policy upon Your/Insured persons death.

18. Obesity
Obesity means abnormal or excessive fat accumulation that may impair health. Obesity is measured in Body Mass Index. Body mass index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m2). The WHO definition is:
- BMI greater than or equal to 25 is overweight
- BMI greater than or equal to 30 is obesity

19. Proposal
Proposal means the proposal form (in physical form or digital form) and other information and documentation supplied to us in any other mode of communication in considering whether and on what terms to offer this insurance.

20. Policy or Contract
Policy or Contract means the Proposal, the Policy Schedule, along with these Policy Wordings /Terms and Conditions issued to the Insured and any annexures and/or Endorsements attaching to and / or forming part thereof either at the commencement of Policy Period or during the Policy Period.

21. Policy Period
Policy Period means period from risk inception date [RID] to risk end date [RED], as mentioned in the Policy Schedule.

22. Policy Schedule or Schedule
Policy Schedule or Schedule means the policy schedule attached to and forming part of this Policy specifying the details of the Insured Persons, the Sum Insured, the Policy Period etc. and the Sub-limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then latest in time.

23. Policy Year
Policy Year means the period of 12 months. In case of long-term Policy for more than one year, then each year viz. 1st year, 2nd year, 3rd year, 4th year, 5th year shall be treated as a separate Policy Year.

24. Service Provider/s
Service Provider means the service provider/s engaged / named by the Company for providing the services as covered in this Policy.

25. Single Private room
Single Private Room means a single occupancy air-conditioned room with an attached washroom/toilet and it excludes a suite.

26. Specialist
Specialist Consultant means a person who holds a medical post graduate or higher degree in the specific line of treatment under Allopathic medicine.

27. Sum Insured
Sum Insured means the amount specified in the Schedule which is Our maximum, total and cumulative liability under this Policy for any and all claims arising under this Policy in a Policy Year in respect of the Insured Person(s).

28. Twin Sharing Room
Twin Sharing Room means a Hospital room where at least two patients are accommodated at the same time. Such room shall be the most basic and the most economical of all accommodations available as twin sharing rooms in that Hospital.

29. You, Your, Yourself, Your Family
You, Your, Yourself, Your Family named in the Policy Schedule means the Insured or Insured's Family Members who are beneficiaries that We insure as set out in the Schedule.

30. We, Us, Our, Ours, Insurer, Company
We, Us, Our, Ours, Insurer, Company means the Bajaj General Insurance Limited.

GENERAL CONDITIONS APPLICABLE TO ALL THE BENEFITS AND OPTIONAL BENEFITS:

1. If a claim is paid under In-patient Hospitalisation Treatment, Pre-Hospitalisation Medical Expense, Post-Hospitalisation Medical Expense, Modern Treatment Methods and Advancement in Technologies, AYUSH Hospitalization Cover, Day Care Treatment, Organ donor expenses, Road Ambulance, Domiciliary Hospitalization, Family Visit, Air Ambulance, Major Illness and Accident Multiplier (Indemnity), Double Sum Insured Benefit, Cost of Prescribed External Medical Aid, Global Cover (Planned & Emergency treatment), Consumables Expenses, Consumables Plus, Age Shield then, the Cumulative Bonus/Super Cumulative Bonus will be reduced.
2. If Insured Person opts for Super Cumulative Bonus then the benefits under this cover will over-ride the benefits of Section C) 11. Cumulative Bonus.
3. If opted, Air Ambulance, Major Illness and Accident Multiplier (Indemnity), Double Sum Insured Benefit, Cost of Prescribed External Medical Aid, Super Cumulative Bonus, International Cover- Emergency Care only, Global Cover (Planned & Emergency treatment), Health Limitless, Consumable Expenses, Consumables Plus, Age Shield, Health Prime Rider shall be available on Individual Basis in an Individual Policy and Floater Basis in a Floater Policy.
4. If opted, Insta Shield, NRInsure, Fetal Flourish shall be available on Individual Basis in Individual and Floater Policy.
5. Claim under Health Prime Rider will not impact Cumulative Bonus/Super Cumulative Bonus, Age Shield, StepUp Benefit.
6. Either Voluntary Co-payment or Voluntary Aggregate Deductible can be opted. Both cannot be opted together in the same policy.
7. Where applicable, the total Sum Insured shall be utilized per following sequence in the event of a claim:
   - In-patient Hospitalisation Treatment (Base) Sum Insured.
   - Cumulative Bonus/ Super Cumulative Bonus (If opted).
   - Double Sum Insured (If opted).
   - Major Illness & Accident Multiplier (If opted).
   - Sum Insured Reinstatement.
   - Health Limitless (If opted).

SECTION C) COVERAGE

Scope of cover:
The Company hereby agrees to indemnify Insured Person in respect of Reasonable and Customary expenses in an admissible claim, for any or all of the following covers as opted, subject to the Sum Insured ("SI"), Limits, Deductibles, Co-payment, Terms, Conditions, Definitions and Exclusions contained or otherwise expressed in this Policy.

1. In-patient Hospitalisation Treatment
   If You are Hospitalized for In-Patient Care on the advice of a Medical Practitioner because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then We will indemnify you against Reasonable and Customary Medical Expenses incurred for:
   i. Room and Boarding expenses as Single Private A/c room or as specified on the Policy Schedule.
   ii. If admitted in ICU, the Company will pay up to ICU expenses at actuals.
   iii. Nursing Expenses as provided by the Hospital.
   iv. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees.
   v. Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical appliances.
   vi. Medicines & Drugs, Medical Consumables, Dialysis, Chemotherapy, Radiotherapy, Physiotherapy.
   vii. Cost of prosthetic devices and other devices or equipment if implanted internally like pacemaker during a surgical process.
   viii. Relevant laboratory diagnostic tests, X-ray and such similar expenses that are medically necessary prescribed by the treating Medical Practitioner.

   Note
   a) In case of admission to a room at rates/category exceeding the opted limits/category as mentioned under this cover, the reimbursement of all other expenses incurred at the Hospital, with the exception of cost of Pharmacy/medicines, Medical consumables, implants, medical devices & diagnostics, shall be payable in the same proportion as the admissible rate per day bears to the actual rate per day of room rent charges.
   b) Proportionate deductions shall not apply in respect of the Hospitals which do not follow differential billings or for those expenses in respect of which differential billing is not adopted based on the room category.
   c) The Insured Person has an option to modify the room category to Actuals or Twin Sharing.

2. Pre-Hospitalisation Medical Expense
   We will indemnify you against the Reasonable and Customary Medical Expenses incurred, up to 60 days as specified on the Policy Schedule up to Inpatient Hospitalization Treatment Sum Insured, for a specific period immediately before the Insured beneficiary was Hospitalised, provided that,

   i. Such Medical Expenses were incurred for the same Illness/Injury for which subsequent Hospitalisation was required.
   ii. The Company has accepted an Inpatient Care claim under "In-patient Hospitalisation treatment".

3. Post-Hospitalisation Medical Expense
   We will indemnify You against the Reasonable and Customary Medical Expenses incurred, up to 90 days as specified on the Policy Schedule, up to Inpatient Hospitalization Treatment Sum Insured, for a specific period immediately after the Insured beneficiary was discharged post Hospitalisation provided that,

   i. Such Medical Expenses were incurred for the same Illness/Injury for which earlier Hospitalisation was required.
   ii. The Company has accepted an Inpatient Care claim under "In-patient Hospitalisation treatment".

4. Modern Treatment Methods and Advancement in Technologies

We will indemnify You against all the eligible Reasonable and Customary Medical Expenses incurred if You undergo procedures as listed below, maximum up to "In-Patient Hospitalization Treatment" Sum Insured.

i. Uterine Artery Embolization and HIFU
ii. Balloon Sinuplasty
iii. Deep Brain stimulation
iv. Oral chemotherapy
v. Immunotherapy- Monoclonal Antibody to be given as injection
vi. Intra-vitreal injections
vii. Robotic surgeries
viii. Stereotactic radio surgeries
ix. Bronchial Thermoplasty
x. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
xi. IONM - (Intra Operative Neuro Monitoring)
xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

5. AYUSH Hospitalization Cover

If You are hospitalized in an AYUSH Hospital for a period not less than 24 hours on the advice of a Medical Practitioner because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then We will indemnify You against Reasonable and Customary Medical Expenses incurred for AYUSH treatment up to "In-patient Hospitalization Treatment" Sum Insured.

The following expenses are payable under this cover:

i. Room rent, boarding expenses as per the Room limit/category specified on the Policy Schedule for "In-patient Hospitalization Treatment";
ii. Nursing Expenses as provided by the Hospital;
iii. Consultation and Surgeon fees;
iv. Medicines, drugs and Medical consumables;
v. AYUSH treatment procedures.

Specific Exclusion

a) The Illness/Injury & the procedure performed on the Insured on Out-patient basis will not be payable.
b) Comfort treatment involving steam bath/sauna/oil massages are excluded. Such treatments being combined with any stay packages at resorts where the treatment forms a part of an overall leisure package shall not be payable.

6. Day Care Treatment

We will indemnify You against the Reasonable and Customary Medical Expenses up to" In-Patient Hospitalization Treatment" Sum Insured for Day Care Procedures / surgeries taken as an In-Patient in a Hospital or Day care center but not in the Outpatient department.
Indicative list of Day Care Treatments is given in Annexure I of this Policy document.

7. Organ Donor Expenses

We will indemnify You against the expenses incurred towards organ donor's treatment for harvesting of the donated organ up to In-Patient Hospitalization Treatment Sum Insured, provided that,

i. The organ donor is any person whose organ has been made available in accordance and in compliance with THE TRANSPLANTATION OF HUMAN ORGANS (AMENDMENT) BIL; and
ii. We have accepted an In-patient Hospitalization treatment claim for the Insured Person under "In-patient Hospitalization Treatment";
iii. We will pay if Insured Person is the receiver of the organ.

Specific Exclusion:

a) Pre and Post-Hospitalization expenses, and any other consequential medical expenses in respect of donor are not payable.

b) Major Illness and Accident Multiplier (Indemnity), Sum Insured Reinstatement, Double Sum Insured Benefit, Health Limitless will not be applicable for/under Organ donor expenses cover.

8. Road Ambulance

We will indemnify You against the Reasonable and Customary expenses, up to In-patient Hospitalization Sum Insured, incurred on a road ambulance offered by a healthcare or ambulance service provider for transferring You to the nearest Hospital with adequate emergency facilities for the provision of health services following an Emergency.

We will also reimburse the expenses incurred on a road ambulance offered by a healthcare or ambulance service provider for transferring You from the Hospital where You were admitted initially to another Hospital with higher medical facilities.

Claim under this section shall be payable by Us only when:

i. Such life-threatening emergency condition is certified by the Medical Practitioner, and
ii. We have accepted Your Claim under "In-patient Hospitalization Treatment" or "Day Care Procedures" section of the Policy.

9. Domiciliary Hospitalization

We will indemnify You against Reasonable and Customary Medical Expenses for Medical Treatment for and illness/disease/injury up to In-patient Hospitalization Treatment Sum Insured, which in the normal course, would require care and treatment at a Hospital but, on the advice of the attending Medical Practitioner, is taken whilst confined at home under any of the following circumstances.

1. The condition of the patient is such that he/she is not in a condition to be moved to a Hospital; or
2. The patient takes treatment at home on account of non-availability of room in a hospital;
3. Domiciliary Hospitalization should exceed 3 days.

However, this coverage/benefit shall not cover the following-

a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza,
b. Arthritis, Gout and Rheumatism,
c. Chronic Nephritis and Nephritic Syndrome,
d. Diarrhoea and all type of Dysenteries including Gastroenteritis,
e. Diabetes Mellitus and Insipidus,
f. Epilepsy,
g. Hypertension,
h. Psychiatric or Psychosomatic Disorders of all kinds,
i. Pyrexia of unknown origin
j. Vector-borne diseases

10. Family Visit

If Insured Beneficiary sustains Accidental Injury or contracts Illness during the Policy Period requiring Hospitalisation in an outstation location 200 kms away from Insured Beneficiary's place of residence, We will reimburse the actual to and fro economy class transportation expenses of most direct route via Common Carrier for one family member or relative or friend of the Insured Beneficiary as per the limit specified on the Policy Schedule, subject to the below conditions:

a. This claim would be admissible if claim is accepted by Us under "In-patient Hospitalisation Treatment".
b. This coverage shall be provided only if treating Physician has advised and certified for necessity attendance of a Family Member or relative or friend and upon our satisfaction on the reason provided.
c. Only domestic travel expenses will be paid.

11. Cumulative Bonus

Cumulative Bonus ("CB") will be increased by 25% of In-patient Hospitalisation Treatment (Base) Sum Insured per annum subject to maximum upto 100%, as specified in the Policy Schedule in respect of each claim free policy year (no claims are reported), provided the Policy is renewed with the company without a break. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the Policy Year.

Note

i. In case where the policy is on individual basis, the CB shall be added and available individually to the Insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured person.
ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.
iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
iv. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
v. If a claim is made in the expiring Policy Year and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

12. Sum Insured Reinstatement

The In-patient Hospitalisation Treatment Sum Insured would be "reinstated" unlimited times as specified in the Policy Schedule for the particular Policy Year subject to the below conditions,

i. The reinstated Sum Insured will be available for utilization for subsequent claim made by the Insured Beneficiary provided that the subsequent hospitalization is after a gap of at least 15 days from the date of discharge. This 15-day period is not applicable if the subsequent claim is for the other Insured Beneficiary.
ii. The reinstated Sum Insured can be used for claims made by the Insured in respect of the benefits stated in Inpatient Hospitalization Treatment
iii. For any claim under this benefit, the maximum liability per claim shall not exceed the In-patient Hospitalization Sum Insured.
iv. This benefit is applicable during each Policy year and will not be carried forward to the subsequent policy year/ renewals.
v. Sum Insured Reinstatement for floater policy will be at policy level.
vi. For individual Sum Insured policy, Sum Insured Reinstatement would be available on Insured Beneficiary level.

13. Renewal Premium Waiver Benefit

In event of death of the proposer (who is also an Insured Person during the Policy Period due to Accidental Injury or Illness, we will pay the Renewal premium of My Health Care Plan EDGE+ (Plan 9) for the dependent Insured Person covered under the Policy for same coverages. The Renewal premium as My Health Care Plan EDGE+ (Plan 9) premium table is payable only for one Policy Year for the dependent Insured Person for same sum insured. Benefit under this cover will be given only in case the claim for Renewal of the Policy under this cover is made within Policy Period or within Grace Period.

A. OPTIONAL COVERS

In consideration of payment of additional premium by the Insured Person to the Company and realization thereof by the Company, it is hereby agreed that We will indemnify/ pay You against the Reasonable and Customary expenses, as the case may be, in respect of an admissible claim under any or all of the following Optional covers as opted subject to the Sum Insured, Limits, Deductibles, Co-payment, Terms, Conditions, Definitions and Exclusions contained or otherwise expressed in this Policy.

1. Air Ambulance

   If this cover is opted by the Insured, it is hereby agreed and declared that My Health Care Plan EDGE+ (Plan 9) is extended to pay the expenses incurred for ambulance transportation in an airplane or helicopter for rapid ambulance transportation from the site of first occurrence of the Illness/ Accident to the nearest Hospital during Policy Period which directly and independently of all other causes results in emergency life threatening health conditions provided such hospitalization claim is admissible under the My Health Care Plan EDGE+ (Plan 9). The claim under this cover would be reimbursed up to the actual expenses subject to a maximum of 10 lakhs as specified under the Air Ambulance Cover in the Policy Schedule, subject otherwise to all other terms, conditions and Exclusions of the Policy.

   Claim under this section shall be payable only when:

   i. Such life-threatening emergency condition is certified by the Medical Practitioner; and
   ii. We have accepted Insured Person's Claim under "In-patient Hospitalisation Treatment" or "Day Care Treatment" section of the Policy;
   iii. Up to the maximum of Sum Insured Limit per Policy Year as per the option specified on the policy schedule for this cover;
   iv. This cover is applicable only for Air Ambulance facility availed within the Indian Geographical limits;
   v. Return transportation to the Insured's home by air ambulance is excluded;
   vi. Such air ambulance should have been duly licensed to operate as such by competent authorities of the Government/s.

2. Major Illness and Accident Multiplier (Indemnity)

   If this cover is opted and if You are Hospitalised for Inpatient Care on the advice of a Medical Practitioner for the below listed Critical Illnesses or due to Accidental Bodily Injuries during the Policy Period, then the sum insured for such Major Illnesses or Injury would be increased upto Two Times of "Inpatient Hospitalization Treatment" Sum Insured as specified in the Policy Schedule, subject otherwise to all other terms, conditions and exclusions of the policy.

   i. Cancer
   ii. Open Chest Coronary Artery Bypass Grafting (CABG)
   iii. Kidney Failure Requiring Regular Dialysis
   iv. Major Organ Transplantation
   v. Multiple Sclerosis with Persisting Symptoms
   vi. Permanent Paralysis of Limbs
   vii. Open Heart Replacement or Repair of Heart Valves
   viii. End Stage Liver Failure
   ix. End Stage Lung Failure
   x. Bone Marrow Transplant

3. Double Sum Insured Benefit

   If this cover is opted by You, the Sum Insured specified under In-patient Hospitalization Sum Insured would get doubled subject to the following conditions.

   i. This cover shall be applied only once during each Policy Year and any unutilized amount, in whole or in part will not be carried forward to the subsequent Policy Year.
   ii. The cover can be utilized for any number of claims admissible under the Policy during the Policy Year.
   iii. The cover will be applicable only after exhaustion of In-patient Hospitalisation Sum Insured.
   iv. In case of family floater policy, the cover will be available on floater basis for all Insured persons covered under the Policy and will operate in accordance with the above conditions.
   v. For Individual Sum Insured policy, Double Sum Insured benefit would be available on each Insured Person level.

4. Cost Of Prescribed External Medical Aid
If this cover is opted, We will indemnify you against the Reasonable and Customary Expenses incurred for purchase of External Medical Aids prescribed by a treating Medical Practitioner for the specific illness or injury against which We have accepted Insured's Claim under "In-patient Hospitalization Treatment" with a limit of 10% of Sum Insured, max up to 5 lakhs.

Note- If this Cover is part of your plan, then SECTION D) WAITING PERIOD AND EXCLUSIONS III. Specific Exclusion Point no 4 is deemed to be inoperative for this cover.

5. Super Cumulative Bonus
If this cover is opted, the Super Cumulative Bonus ("SCB") will be increased by specific amount as specified in the Policy Schedule in respect of each claim free Policy year (no claims are reported), provided the Policy is renewed with the Company.

Specific Condition for Super Cumulative Bonus:

i. If the In-Patient Hospitalization treatment claim paid amount (in a single or multiple claims) does not exceed INR 100,000 in a Policy Year then the Super Cumulative Bonus, if any, accrued under this Cover will not be reduced at renewal. The Super Cumulative Bonus would be maintained as per the expiring policy.
ii. In case where the Policy is on individual Sum Insured basis, the SCB shall be accrued and available individually to the Insured Person if no claim has been reported in respect of that Insured Person. In case of claim, SCB in respect of the Insured Person who has made the claim shall be reduced at the same rate at which it has accrued, subject to Point i. above.
iii. In case where the Policy is on floater Sum Insured basis, the SCB shall be accrued and available to the Family on floater basis, provided no claim has been reported from any member of the Family. In case of claim, SCB shall be reduced at the same rate at which it has accrued, subject to Point i. above.
iv. In case the accrued SCB reduces, the Sum Insured will be maintained and will not be reduced in the Renewal Policy Year.
v. SCB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
vi. If the Sum Insured has been reduced at the time of Renewal, the applicable SCB shall be reduced in the same proportion to the Sum Insured in current Policy. If the Sum Insured under the Policy has been increased at the time of Renewal the SCB shall be calculated on the Sum Insured of the last completed Policy Year.
vii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium then any awarded accrued SCB shall be withdrawn, subject to Point i. above.
viii. This clause does not alter the annual character of this insurance.

6. Consumable Expenses: (For SI 5 Lakhs, 7.5 Lakhs and 10 Lakhs)
If this cover is opted, We will indemnify You against the Non-Medical Expenses/ consumables (as specified in Annexure III) incurred during treatment of the Insured Person during the Policy Period up to Inpatient hospitalisation treatment Sum Insured, provided that the claim is admissible and payable under "In-patient Hospitalization Treatment" cover.

Note: All other Non-medical items apart from those listed in Annexure III will be excluded.

7. International Cover- Emergency Care Only:
If You are hospitalized on the advice of a Medical Practitioner because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then We will indemnify You against Reasonable and Customary Medical Expenses incurred outside India and anywhere across the World for Emergency Care only, for below listed expenses, up to the Sum Insured specified on the Policy Schedule.

i. Room and Boarding expenses as per the limit/category specified on the Policy Schedule.
ii. If admitted in ICU, the Company will pay up to ICU expenses at actuals.
iii. Nursing Expenses as provided by the Hospital.
iv. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees.
v. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical appliances.
vi. Medicines & Drugs, Medical Consumables prescribed to manage the emergency condition.
vii. Equipment if implanted internally like pacemaker during a surgical process.
viii. Relevant laboratory diagnostic tests, X-ray and such similar expenses that are medically necessary prescribed by the treating Medical Practitioner.

Specific Conditions for International Cover- Emergency Care only:

a. The Injury or Illness should occur while the Insured Person is outside India.
b. The treatment must commence immediately on diagnosis of the Illness or occurrence of the Injury.
c. A mandatory co-payment of 10% is applicable which will be in addition to any other co-payment/ deductible if any applicable in the policy.
d. The benefit is available for 45 continuous days from date of travel in a Single trip and 180 days on a cumulative basis as whole in a Policy year.
e. The Medical Expenses payable shall be limited to Inpatient hospitalization treatment only. Pre and Post hospitalization expenses, Day care treatment are not covered under the purview of this cover.
f. The payment of any claim under this cover will be based on the rate of exchange as on the date of loss published by the Reserve Bank of India and shall be used for conversion of foreign currency into Indian Rupees for payment of claims.
g. The Insured person has to inform us within 24 hours of occurrence of the emergency condition and take prior approval for Medical Treatment.
h. Reinstatement, Cumulative Bonus, Super Cumulative Bonus, Major Illness and Accident Multiplier (Indemnity), Health Limitless or Double Sum Insured Benefit accrued cannot be used for payment of claims under International Cover- Emergency Care only.
i. Kindly download Our Company's App, where you will be able to locate the step-by-step guide for availing the benefits under the International Cover- Emergency Care Only.

All other terms, conditions, definitions, exclusions will be as per those applicable to In-patient Hospitalization Treatment Cover.

B. RIDERS

In consideration of payment of additional premium by the Insured Person to the Company and realization thereof by the Company, it is hereby agreed that We will indemnify/ pay You against the Reasonable and Customary expenses, as the case may be, in respect of an admissible claim under any or all of the following Optional covers as opted subject to the Sum Insured, Limits, Deductibles, Co-payment, Terms, Conditions, Definitions and Exclusions contained or otherwise expressed in this Policy.

1. Global Cover: (For SI above 10 Lakhs) (UIN- BAJHLIA27077V012627)

If this Rider is opted, and if You are hospitalized on the advice of a Medical Practitioner because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then We will indemnify You against Reasonable and Customary Medical Expenses incurred outside India and anywhere across the World for Emergency Care as well as planned treatments, for below listed expenses, up to the Sum Insured specified on the Policy Schedule.

i. Room and Boarding expenses as per the limit/category specified on the Policy Schedule.
ii. If admitted in ICU, the Company will pay up to ICU expenses at actuals.
iii. Nursing Expenses as provided by the Hospital Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees.
iv. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, surgical appliances.
v. Medicines & Drugs, Medical Consumables prescribed to manage the emergency condition.
vi. Equipment if implanted internally like pacemaker during a surgical process.
vii. Relevant laboratory diagnostic tests, X-ray and such similar expenses that are medically necessary prescribed by the treating Medical Practitioner.

Specific Conditions for Global Cover

a. There is no separate Sum Insured for this optional rider and any claim triggered under this benefit shall reduce the In-patient Hospitalization Treatment Sum Insured opted in the Base Plan.
b. You will have to choose from a range of mandatory co-payment options- 10%, 20%, 30%, 40%, 50%.
c. The benefit is available for 45 continuous days from date of travel in a Single trip and 180 days on a cumulative basis as whole in a Policy year.
d. If claim is paid under this Rider, any accrued Cumulative Bonus will be impacted.
e. This Rider is not available to Non-Indian citizens & people who are not permanent residents of India.
f. We will cover up to Single private room only for planned treatments under this Rider.
g. The Medical Expenses payable shall be limited to In-patient hospitalization treatment including Day care treatment.

h. Pre and post hospitalization expenses, Organ donor expenses, Road Ambulance are not covered under the purview of this cover.
i. The payment of any claim under this cover will be based on the rate of exchange as on the date of loss published by the Reserve Bank of India and shall be used for conversion of foreign currency into Indian Rupees for payment of claims.
j. Treatment under this cover should be taken at a Hospital or clinic duly recognized and registered under the applicable law of the country where the treatment is taken.
k. Sum Insured Reinstatement, Cumulative Bonus/ Super Cumulative Bonus, Major Illness and Accident Multiplier (Indemnity), Health Limitless or Double Sum Insured Benefit accrued cannot be used for payment of claims under Global Cover.
l. In case of planned Hospitalization, prior intimation of at least 7 days of the travel shall be provided to Us / Service Provider / Network Provider and due approval from Us will be necessary.
m. This benefit is available under cashless and reimbursement.
n. Countries / Territories / Geographies placed in the Grey and Black List by the Financial Action Task Force shall be excluded from this cover. For updated list please visit: https://www.fatf-gafi.org/en/countries/black-and-grey-lists.html.
o. Kindly download Our Company's App, where you will be able to locate the step-by-step guide for availing the benefits under the Global Cover.

All other terms, conditions, definitions, exclusions will be as per those applicable to In-patient Hospitalization Treatment Cover under Base Policy.

2. Consumables Plus (For SI above 10 lakhs): (UIN- BAJHLIA27077V012627)
If this Rider is opted, We will indemnify You against the Non-Medical Expenses/ consumables (mentioned in List I, II, III, IV of Annexure II) incurred during treatment of the Insured Person during the Policy Period up to Inpatient hospitalisation treatment Sum Insured, provided that the claim is admissible and payable under "In-patient Hospitalization Treatment" cover" of Base Policy.
   i. This cover shall not be available outside the geographical boundaries of India, even where International Cover- Emergency Care Only and Global Cover has been opted.

All other terms, conditions, definitions, exclusions will be as per those applicable to In-patient Hospitalization Treatment Cover under Base Policy.

Note: If this Optional Cover is opted by You, then Exclusion D. III. 7 will be deemed to be inoperative for the purpose of this coverage only.

3. Smart Tenure (UIN- BAJHLIA27077V012627)
If the Insured Person has opted for this Rider, then in the case of multi-year Base Policy, the annual Sum Insured under Base Policy for Insured Person(s) will be combined for the entire Base Policy tenure. Such combined Sum Insured will be available as a single cumulative limit for all admissible claims during the Base Policy Period.

(For example: For a 5-year Policy with an annual Sum Insured of Rs 5 Lakhs, the combined Sum Insured available would be Rs 25 Lakhs (Rs 5 Lakhs x 5 Years).
Illustrations:
Scenario 1: 5-year Policy, available Sum Insured would be 25 lakhs

Policy Year	Claim Amount	Payable/ Non-Payable
1st Year	20 Lakhs	Payable
2nd Year	5 Lakhs	Payable
3rd Year	1 Lakhs	Payable under Sum Insured Reinstatement

Scenario 2: 5-year Policy, available Sum Insured would be 25 lakhs

Policy Year	Claim Amount	Payable/ Non-Payable
1st Year	25 Lakhs	Payable
2nd Year	5 Lakhs	Payable under Sum Insured Reinstatement

Scenario 3: 5-year Policy, available Sum Insured would be 25 lakhs

Policy Year	Claim Amount	Payable/ Non-Payable
1st Year	10 Lakhs	Payable
2nd Year	10 Lakhs	Payable
3rd Year	5 Lakhs	Payable
4th Year	10 Lakhs	5 Lakhs Payable under Sum Insured Reinstatement

This cover shall be subject to the following conditions:

i. The combined Sum Insured may only be utilized for expenses arising out of any of the following applicable covers under the Base Policy: In-patient Hospitalisation Treatment, Day Care Treatment, Modern Treatment Methods and Advancement in Technologies, Pre & Post Hospitalisation Medical Expense, AYUSH Hospitalization Cover, Organ donor expenses and Road Ambulance.
ii. Any balance Sum Insured will be carried forward to the remaining Policy Tenure as depicted in Scenario above.
iii. Only the In-patient Hospitalisation Treatment Sum Insured of the Base Policy shall be considered for calculating combined Sum Insured under Base Policy under this Rider.
iv. This cover is applicable only for hospitalization claims arising within India.
v. Any claim paid under the Base Policy that reduces the Sum Insured will correspondingly reduce the combined Sum Insured available under this cover.
vi. Applicable for Individual Sum Insured policy only.
vii. If this Rider is opted, then the Insured is not eligible for Major Illness and Accident Multiplier (Indemnity), Health Limitless, International Cover- Emergency Care Only, Global Cover or Double Sum Insured Benefit.
viii. Premium payment in instalment is not applicable if Smart Tenure is opted.

4. StepUp Benefit (UIN- BAJHLIA27077V012627)
If this Rider is opted, The Insured Person shall be entitled to a once-in-a-lifetime option to enhance the Sum Insured of Base Policy at Renewal to the next available slab, subject to the following conditions:

i. Continuity of waiting period shall apply to the enhanced Sum Insured slab.
ii. The Insured person shall be eligible for this benefit only if no claims have been made under the Base Policy.
iii. This option shall be available only once during the lifetime of the Insured person under the Base Policy.

5. Health Limitless (For SI 10 Lakh & above) (UIN- BAJHLIA27077V012627)
If this Rider is opted, We will indemnify the Medical Expenses incurred in respect of Hospitalization of the Insured Person under In-Patient Hospitalisation Treatment / Day Care Treatment/ AYUSH Hospitalization for any one claim during the lifetime of the Base Policy without any limits on the Annual Sum Insured subject to the following conditions:

i. The time period to opt for this optional cover shall be limited to 2 Base Policy Years (irrespective of the Base Policy Tenure). Such that:
    a. If the Base Policy Tenure is of single year and is continuously renewed as single year, the Insured Person has to opt for this Rider cover either at the time of Base Policy Inception or the

first Renewal. This Optional Cover shall not be applicable in case the Insured Person wishes to opt for this Rider at the time of second Renewal.

b. If the Policy Tenure is of 2 , 3, 4 or 5 years, the Rider has to be opted at the time of Base Policy inception itself to avail the benefit.

ii. This cover is applicable only for one claim in the lifetime of the Base Policy, irrespective of Policy Tenure or Policy Type (Individual or Floater), and should be admissible under Inpatient Hospitalisation Treatment/Day Care Treatment/ AYUSH Hospitalization. All the conditions applicable to the basic covers under Base Policy shall be applicable to this Rider.

iii. Once a claim has been made under this Optional Cover, the cover will cease to exist and cannot be opted again upon subsequent Renewals.

iv. Voluntary Co-payment or Voluntary Aggregate Deductible, if opted by the You, shall be applicable under this cover.

6. NRInsure: (UIN-BAJHLIA26076V012526)
If this rider is opted, Insured Person is entitled for a discount of 35% on the premium payable under the base policy for Insured Person(s), subject to compliance with the conditions listed below.

i. The insured shall submit a declaration confirming that they are Non-Resident Indians / Overseas citizens of India based abroad in entirety for the Policy Year.

ii. The Insured shall provide acceptable proof of overseas residence prior to or at the inception of Add-on and at each subsequent Renewal to continue availing the discount.

iii. The following documents must be submitted for verification at the time of inception and all subsequent renewals:
- A copy of valid Passport with applicable Visa Stamping.
- Applicable Tax Documentation, Work Visa, or Employment/Work Permit outside of India.
- A signed Residential Agreement (lease/rental or ownership) in the overseas address.
- Any other document as may be specified by the Company from time to time.

iv. The Insured Person shall have and maintain an Indian bank account for payment of premium and for facilitating claim payments, if any. The Company may seek proof of the same at inception or renewal.

v. All waiting periods, as per the Base Policy terms and conditions, shall continue to apply to the Insured Person covered under this rider. This rider does not reduce, modify, or waive any waiting periods.

vi. If the Insured Person ceases to reside outside India, then the discount under this rider shall cease immediately from next renewal. Premium shall thereafter be charged as per the applicable rate for residents in India. The Insured Person(s) shall promptly intimate the Company of any change in the residency status.

vii. International Cover – Emergency Care only and Global Cover benefit under the Base Policy shall not be available to Insured Person(s) availing this rider or to Non-Resident Indian/ Overseas citizens of India.

7. Insta Shield: (UIN-BAJHLIA26072V012526)
If this rider is opted, We shall indemnify the Medical Expenses incurred related to an admissible Hospitalization of the Insured Person under the Base Policy, including In-patient Hospitalization Treatment, Pre-Hospitalisation Medical Expense and Post-Hospitalisation Medical Expense due to the chronic condition(s) listed below and their complications from the 31st day of Policy inception date after serving initial waiting period of 30 days, provided that,

i. The chronic diseases/illnesses/conditions is declared by the Insured Person and accepted by Us at the inception of the Base Policy and mentioned in the Policy Schedule; or

ii. If the chronic diseases/illnesses/conditions is detected during Pre-policy medical examination, coverage shall apply only if accepted by the Company and reflected in the Policy Schedule.

iii. Once applied, the premium loading for Insta Shield Rider continues for all renewals.

iv. The above reduced waiting period of 30 days shall be applicable only for specified Insured Persons who have opted and paid additional premium for this rider.

v. The Optional Cover shall be applicable on Individual basis in case of an Individual Base Policy. In case of a Floater Base Policy, the Optional Cover shall be applicable on Individual basis who have declared the Pre-Existing Diseases (PED), applied for this cover and accepted by us.

vi. This cover will be available only during inception of the policy or upon addition of a new member in the Base Policy during Renewal.

vii. Increase in Base Sum Insured- A waiting period of 30 days shall be applicable on the incremented Sum Insured in case the Base Sum Insured is increased at the time of renewal. The acceptance of enhancement

of Sum Insured would be at the discretion of the Company, based on the health condition of the Insured Person(s) & claim history of the Policy.

Diseases/illnesses/conditions covered under this rider:

i. **Asthma-** Asthma is a chronic, non-communicable respiratory disease characterized by inflamed and narrowed airways in the lungs that make airflow difficult which causes recurrent, variable episodes of breathlessness and wheezing, often accompanied by chest tightness and cough.

ii. **Blood pressure (Hypertension)-** Blood pressure (Hypertension) a condition where the pressure in the blood vessels is persistently too high, with readings of 140/90 mmHg or higher on two separate occasions. This elevated pressure means the heart has to work harder to pump blood throughout the body and can lead to serious health problems like heart attack, stroke, and kidney disease.

iii. **Cholesterol (Hyperlipidemia)-** Hyperlipidemia is a condition where there are abnormally high levels of fats (lipids), such as cholesterol and triglycerides, in the blood. This condition is a major risk factor for heart disease and stroke.

iv. **Diabetes mellitus-** Diabetes mellitus is a chronic metabolic disease characterized by elevated blood glucose levels, resulting from defects in insulin secretion, insulin action, or both. This condition leads to long-term damage and dysfunction of vital organs such as the eyes, kidneys, nerves, heart, and blood vessels, causing severe health complications like vision loss, kidney failure, nerve damage, and increased risk of heart attack and stroke.

v. **Obesity-** Obesity means abnormal or excessive fat accumulation that may impair health. Obesity is measured in Body Mass Index. Body mass index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m2). The WHO definition is:
   a. BMI greater than or equal to 25 is overweight.
   b. BMI greater than or equal to 30 is obesity.

vi. **Hypothyroidism disorders-** Hypothyroidism is a condition where the thyroid gland doesn't produce enough thyroid hormones to meet the body's needs, causing many bodily functions to slow down. Diagnosed by high Thyroid-Stimulating Hormone (TSH) and low thyroxine (T4) levels, it affects metabolism and can lead to symptoms like fatigue, cold intolerance, and weight gain.

8. Fetal Flourish: (UIN- BAJHLIA26070V012526)
If this rider is opted, We will pay a lump sum payment towards invasive investigations and/or treatment for complications of Your Unborn baby, subject to following conditions.

i. The treatment must be undertaken as inpatient /Day-care hospitalization.
ii. The cover shall be subject to a waiting period of nine (9) months from the date of first inception of Fetal Flourish cover under Base Policy.
iii. Upon opting this Rider, the Standard Exclusion Investigation and Evaluation (Code-Excl04) stands waived up to the extent of this benefit limit as per Base Policy.

Cover Overview	
Sum Insured	INR 2,00,000* (Maximum per maternity event) Benefit based pay out
Benefit offered	Up to 2 maternity events (initial two events classified as G2)
Waiting Period	Nine (9) months from the date the cover under this Rider is first opted under Base Policy
Age Eligibility	Applicable for ages 18 to 45 years

List of procedures covered:

1. Amniocentesis
2. Chorionic Villus Sampling (CVS)
3. Percutaneous Umbilical Blood Sampling (PUBS) or Cordocentesis
4. Fetal Tissue Biopsy
5. Amnioinfusion
6. Amnio-reduction

7. Thoracoamniotic Shunt for Fetal Pleural Effusion
8. Fetoscopy
9. Fetoscopic Laser Surgery for Twin-to-Twin Transfusion Syndrome (TTTS)
10. Fetal Reduction
11. Surgeries for neural tube defects
12. Fetal Cystoscopic Surgery
13. Fetoscopic Endotracheal Occlusion (FETO) for Congenital Diaphragmatic Hernia (CDH)
14. Amniotic Band Syndrome (ABS) Surgery
15. Fetal Aortic Valvuloplasty for Severe Aortic Stenosis
16. Intra-uterine transfusion (IUT)

Note: Detailed description of listed procedures and *Sub-Limits applicable to individual listed covered procedures above are given in Annexure IV of this Policy Wordings.

9. Age Shield: (UIN- BAJHLIA27077V012627)
If this Rider is opted, the premium payable in respect of the Base Policy at each Renewal shall be calculated based on the age of the insured person at the time of inception of first Base Policy ("Entry Age"), and the applicable Sum Insured, provided that no claim has been paid against the Base Policy.

E.g. If You first purchase the Base Policy at the age of 25 years and opt for this Rider, then at each Renewal of Base Policy the premium will be charged at the then prevailing rate applicable to age 25 years for the relevant Sum Insured, provided no claim has been paid under the Base Policy.

Special Conditions for Age Shield:

i. Once a claim is paid, the premium for subsequent Renewals of Base Policy will be applicable as per Your age at the time of Renewal as per standard age band and Sum Insured as mentioned in the Premium Table (Rate Chart) then in force.
ii. No additional premium will be charged in the middle of the Policy tenure in case of claims. Upon Renewal after claim, the premium will be charged as per the current age of the Insured Person at the time of Renewal.
iii. In a Base Policy covering multiple Insured Persons with separate individual Sum Insured, the benefit under this Rider will cease only for those Insured Persons in respect of whom a claim is paid.
iv. In a floater Base Policy, if a claim is paid in respect of any one Insured Person covered therein, then the benefit under this Rider will cease for the entire floater Base Policy.
v. If you add a new member to the existing floater Base Policy mid-term, then the premium will be charged as per the Entry Age of the eldest Insured Person in Base Policy and the premium for Renewal will be locked as per the age of that eldest Insured Person, till a claim is paid.
vi. If you add a new Insured Person to an individual Base Policy and convert it into a Floater plan, then the premium will be charged as per the Entry Age of the eldest insured person and the premium for Renewal will be locked as per the age of that eldest Insured Person, till a claim is paid.
vii. If the eldest Insured Person is no longer part of the floater plan Base Policy, then the floater premium will be calculated as per the original Entry Age of the eldest covered Insured Person in the Base Policy amongst the remaining members and the premium for Renewal will be locked and charged as per the age of eldest covered Insured Person, till a claim is paid.
viii. If an existing floater Base Policy, splits into multiple individual policies, then the benefit under this cover will be carry forward, provided and determined in accordance with the Entry Age of the individual member at which the floater Base Policies were taken by individuals, provided no claim is paid under the floater Base Policy.

10. Walk to Win: (UIN- BAJHLIA27077V012627)
If this Rider is opted, at each Renewal of Base Policy with Us, You will be entitled for a wellness discount, subject to below mentioned criteria being fulfilled by You during the preceding Base Policy Year.

Steps can be tracked through Our mobile application.

Parameter Achieved	Discount
7,500 steps daily for 24 days of every month, for minimum 9 months in a policy year	5%
10,000 steps daily for 24 days of every month, for minimum 9 months in a policy year	10%

Eligibility Criteria:

1. This discount and criteria is applicable for member's age 21 years and above.
2. In case of long-term Base Policy-
   The criteria mentioned above has to be met by each Insured Person every year in a long-term Base Policy to be eligible for discount at Renewal.
3. In case of floater Base Policy-
   The criteria mentioned above has to be met by each eligible Insured Person every year to be avail the discount at Renewal.

11. No Claim Discount: (UIN- BAJHLIA27077V012627)
    If this cover is opted, it is agreed that, at time of Renewal, the Cumulative Bonus / Super Cumulative Bonus accrued shall not be applicable and You will be entitled for Renewal discount of 1.5%, provided that no claim is registered in the Base Policy.

    Please Note:

    - Cumulative Bonus/ Super Cumulative Bonus will apply afresh, if they are to be re-opted at Renewal.
    - In case You have claimed in the preceding Base Policy year, You will not be eligible for No claim discount at the time of Renewal.

12. Health Prime Rider: (UIN-BAJHLIA24087V022324)
    If this rider is opted, We will render services/ indemnify/ pay Customary and Reasonable Medical Expenses incurred for below listed coverages during the Policy Period up to the Sum Insured/ number of sessions/ vouchers as specified under respective cover and as specified in the Policy Schedule or up to the limit of indemnity as specified in the Rider/ Policy Schedule:
    a. Tele Consultation Cover (Insta Consultation)
    b. Doctor Consultation Cover (In-clinic)
    c. Doctor prescribed Investigations Cover– Pathology & Radiology Cover
    d. Annual Preventive Health Check-up Cover
    e. Dental wellness- Consultation, Investigation & Procedures Cover
    f. Diet & Nutrition Consultations Cover
    g. Emotional Wellness Cover
    h. Physical Fitness Cover

    Note:

    During every Policy Year under Rider Period, Insured/ Insured Member will be eligible for coverages as per the Rider plan/ option selected from the below table.
    For Long Term Policies if the Rider is opted, the benefits given in the table below will be applicable for each Policy Year.

Options available in this Rider:

Benefits	Individual Options							
	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
Tele Consultation Cover (Insta Consultation)	Unlimited (General Physicians)	Unlimited (All Specialties)	Unlimited (All Specialties)	Unlimited (All Specialties)	Unlimited (All Specialties)	Unlimited (All Specialties)	Unlimited (All Specialties)	Unlimited (All Specialties)
Doctor Consultation Cover (In-clinic)	-	-	1,000	2,000	3,000	15,000	7,500	30,000
Doctor prescribed Investigations Cover – Pathology & Radiology Cover	-	1,500	3,000	5,000	7,000		7,500	30,000
Annual Preventive Health Check-up Cover	1 Voucher (Silver)	1 Voucher (Silver)	1 Voucher (Silver)	1 Voucher (Silver)	1 Voucher (Silver)	1 Voucher (Silver)	1 Voucher (Gold)	1 Voucher (Platinum)
Dental wellness - Consultation, Investigation & Procedures Cover	-	-	-	-	-	-	5,000	30,000
Diet & Nutrition Consultations Cover	-	-	-	-	-	-	10 Sessions	30 Sessions
Emotional Wellness Cover	-	-	-	-	-	-	6 sessions	20 Sessions
Physical Fitness Cover	-	-	-	-	-	-	-	365 Sessions

Benefits	Floater Options					
	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Tele Consultation Cover (Insta consultation)	Unlimited (All Specialties)	Unlimited (All Specialties)	Unlimited (All Specialties)	Unlimited (All Specialties)	Unlimited (All Specialties)	Unlimited (All Specialties)
Doctor Consultation Cover (In-clinic)	10,000	20,000	25,000	10,000	12,500	30,000
Doctor prescribed Investigations Cover – Pathology & Radiology Cover				10,000	12,500	30,000
Annual Preventive Health Check-up Cover	2 Vouchers (Silver)	2 Vouchers (Silver)	2 Vouchers (Silver)	2 Vouchers (Gold)	4 Vouchers (Gold)	4 Vouchers (Platinum)
Dental wellness - Consultation, Investigation & Procedures Cover	-	-	-	10,000	12,500	30,000
Diet & Nutrition Consultations Cover	-	-	-	15 Sessions	25 Sessions	30 Sessions
Emotional Wellness Cover	-	-	-	8 Sessions	15 Sessions	20 Sessions
Physical Fitness Cover	-	-	-	-	-	365 Sessions

A. Tele Consultation Cover (Insta Consultation):

Coverage:

If the Insured/ Insured Member is suffering from any Illness or Injury, he / she can consult Medical Practitioner/ Physician/Doctor listed on the digital platform of Insurer or concerned Service Provider's application via video, audio, or chat channel, where the Insured/ Insured Member will be able to select the specialty of Doctor and will be able to consult the Doctor available at the time of call. This cover shall be in compliance with the Telemedicine Practice Guidelines dated 25th of March 2020 and as amended from time to time. This is a cashless service.

Exclusions for "Tele Consultation Cover (Insta Consultation)"

1. Tele consultation outside the digital platform of Insurer' or concerned Service Provider's application/website video/audio/chat consultation, in-clinic/physical consultation is not covered under this cover of Rider.
2. Teleconsultation benefit is not transferrable to any other person/member unless such person/member is covered under the Base Policy and has opted this Rider.
3. If the Tele Consultation is not availed in the Policy Year, the benefit cannot be carried forward to the subsequent Policy Year.
4. Reimbursement of expenses incurred for teleconsultation benefit is excluded.

5. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b) This exclusion shall not, however apply if the Insured Member has continuous coverage for more than twelve months.
   c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

B. Doctor Consultation Cover (In-clinic):

Coverage:

If the Insured/Insured Member/s is suffering from any Illness or injury he / she can consult Medical Practitioner/ Physician/Doctor in person from prescribed network centres of concerned Service Providers up to the limit as specified under this Rider read with Base Policy Schedule.

This is a cashless service; the cashless process is defined under the Service Delivery Process/claim process section.

If the desired Medical Practitioner/ Physician/Doctor is not available in the prescribed network, Insured/ Insured Member/s can take a prior approval of the Insurer for consulting the desired Medical Practitioner/ Physician/Doctor and claim the charges/consultation fees by way of reimbursement process as defined under claim process. The Doctor Consultation expenses would be payable up to the limit specified under this Rider.

Exclusions for "Doctor Consultation Cover (In-clinic)":

1. Other expenses of investigations, medicines, surgical or non-surgical procedures or any medical, non-medical items are not covered under this cover/section.
2. If the Doctor consultation cover is not availed in the Policy Year, the benefit cannot be carried forward to the subsequent Policy Year.
3. Claims related to Ante Natal consultations and investigations shall not be covered. However, consultations for pregnancy related complications would be covered.
4. Dietician/nutritionist consultations/sessions will not be covered under this cover/benefit.
5. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b) This exclusion shall not, however apply if the Insured Member has continuous coverage for more than twelve months.
   c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.
6. Pre-Existing Diseases Waiting Period (Code- Excl01)
   a. Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of specified number of months of continuous coverage after the date of inception of the first Rider plan and the Base Policy Schedule with Us.
   b. The PED waiting period would be as per the Base policy opted and as specified on the Policy Schedule.
   c. If the Insured/ Insured Member's continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations, then Waiting Period for the same would be reduced to the extent of prior coverage.
   d. Coverage under the Rider after the expiry of the waiting period as specified in Base Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

Please refer below table for inclusions & exclusions of doctor specialties.

Specialty	Doctor Specialization	Covered/Excluded
General Physician	General Physician	Covered
	Ayurveda	Covered
	Homeopath	Covered
	Physiotherapist	Covered

	Unani	Covered
Specialist	Paediatrician	Covered
	Dentist	Covered
	Dermatologist	Covered
	Orthopaedic	Covered
	Psychologist	Excluded
	Ophthalmologist	Covered
	Gynaecologist & Obstetrician	Covered
	ENT	Covered
	Psychiatrist	Covered
	General Surgeon	Covered
	Dietitian/Nutritionist	Excluded
	Audiologist	Excluded
	Anaesthesiologist	Covered
	Radiologist	Covered
	Pathologist	Covered
	Sexologist	Covered
	Cosmetologist*	Excluded
	Cosmetic & Plastic Surgeon*	Excluded
	Electropathy	Excluded
	Dermatologist	Covered
	ENT Surgeon	Covered
	Speech Therapist	Excluded
	Embryologist	Excluded
	Haematologist	Covered
	Preventive medicine specialist	Covered
Super specialist	Paediatric surgeon	Covered
	Dental Surgeon	Covered
	Cardiologist	Covered
	Pulmonologist	Covered
	Diabetologist	Covered
	Oncologist	Covered
	Neurologist	Covered
	Gastroenterologist	Covered
	Nephrologist	Covered
	Urologist	Covered
	Orthodontic	Covered
	Orthopaedics & Joint Replacement	Covered
	Rheumatologist	Covered
	Endocrinologist	Covered
	Laparoscopic Surgeon	Covered
	General Surgeon	Covered
	Vascular Surgeon	Covered
	Infectious disease specialist	Covered

* Expenses for consultations with Cosmetologist or Cosmetic & Plastic Surgeon are excluded, unless following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the Insured/ Insured Member. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

C. Doctor Prescribed Investigations Cover – Pathology & Radiology Expenses

Coverage:

If the Insured/Insured Member/s is suffering from any Illness or injury he / she can avail the cashless service for investigations prescribed by a registered Medical Practitioner for pathology or radiology from prescribed network centres of the Service Provider up to the limit as specified under this Rider read with Base Policy Schedule.

If the Investigation – Pathology or radiology lab is not available in the prescribed network of the Service Provider, Insured/ Insured Member/s can take a prior-approval of the Insurer for the prescribed investigations and claim the expenses by way of reimbursement process as defined under claim process/ Service Delivery Process. The investigation expenses would be payable up to the limit specified on the policy schedule.
Lab test must be done within 30 days of the doctor prescription.

Exclusions for "Doctor Prescribed Investigations Cover – Pathology & Radiology Expenses"

1. If the Investigation cover is not availed in the respective Policy Year, the benefit cannot be carried forward to the subsequent Policy Year.
2. Claims related to Ante Natal investigations shall not be covered.
   However, investigations for pregnancy related complications would be covered.
3. Any preventive health tests shall not be covered under this benefit.
4. Invasive tests shall not be covered. Please refer Annexure V for the list of Invasive tests.
5. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b) This exclusion shall not, however apply if the Insured Member has continuous coverage for more than twelve months.
   c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.
6. Pre-Existing Diseases Waiting Period (Code- Excl01)
   a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of specified number of months of continuous coverage after the date of inception of the first Rider Plan and the Base Policy with Us.
   b) The PED waiting period would be as per the Base Policy opted and as specified on the Policy Schedule.
   c) If the Insured/ Insured Member's continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations then Waiting Period for the same would be reduced to the extent of prior coverage.
   d) Coverage under the Rider after the expiry of the waiting period as specified in Base Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

D. Annual Preventive Health Check-up cover:

Coverage:

1. The Insured/Insured Member/s can avail the free Preventive health check-up once in every Policy Year as per the list given below in the network centres of the Service Provider.

Silver Package:

Test	Component
Hemogram	Monocytes - Absolute Count, Lymphocyte Percentage, Nucleated Red Blood Cells, Neutrophils, Basophils, MCHC, Eosinophils, Haemoglobin, Platelet Count, Mean Corpuscular Volume(Mcv), Immature Granulocytes(Ig), Eosinophils - Absolute Count, Lymphocytes - Absolute Count, Basophils - Absolute Count, Neutrophils - Absolute Count, Immature Granulocyte Percentage(Ig%), Nucleated Red Blood Cells %, Haematocrit(Pcv), Red Cell Distribution Width - Sd(Rdw-Sd), Red Cell Distribution Width (Rdw-Cv), Total Rbc, Total Leucocytes Count, Mean Corpuscular Haemoglobin(Mch), Monocytes, ESR
Liver Function Test	Albumin Serum, Bilirubin- Indirect serum, Globulin, SGOT/SGPT Ratio, GGTP (Gamma GT), Alkaline Phosphatase Serum, SGOT/AST, A/G Ratio, SGPT/ALT, Bilirubin Direct Serum, Proteins Serum, Bilirubin Total Serum
Urine Routine	Color, Urinary Leucocytes, Epithelial Cells, Crystals, Urine Ketone, Urobilinogen, Urinary Glucose, Urinary Protein, Urine Blood
Diabetic Profile	Fasting Blood Sugar, HbA1C
Lipid Profile	VLDL, HDL / LDL Cholesterol Ratio, HDL Cholesterol Direct, LDL Cholesterol -

	Calculated, Non-HDL Cholesterol Serum, LDL/HDL RATIO, CHOL/HDL RATIO, Cholesterol-Total Serum, Triglycerides Serum
Kidney Function Tests	Blood Urea Nitrogen (BUN), Creatinine- Serum
Thyroid	T3 - Total Tri Iodothyronine, TSH Ultra - sensitive, T4 - Total Thyroxine
Bone Health	Serum Calcium

Gold Package:

Test	Component
Hemogram	Monocytes- Absolute Count, Lymphocyte Percentage, Nucleated Red Blood Cells, Neutrophils, Basophils, MCHC, Eosinophils, Haemoglobin, Platelet Count, Mean Corpuscular Volume(Mcv), Immature Granulocytes(Ig), Eosinophils- Absolute Count, Lymphocytes- Absolute Count, Basophils- Absolute Count, Neutrophils- Absolute Count, Immature Granulocyte Percentage(Ig%), Nucleated Red Blood Cells %, Haematocrit(Pcv), Red Cell Distribution Width- Sd(Rdw-Sd), Red Cell Distribution Width (Rdw-Cv), Total Rbc, Total Leucocytes Count, Mean Corpuscular Hemoglobin(Mch), Monocytes, ESR
Liver Function Test	Albumin Serum, Bilirubin- Indirect serum, Globulin, SGOT/SGPT Ratio, GGTP (Gamma GT), Alkaline Phosphatase Serum, SGOT/AST, A/G Ratio, SGPT/ALT, Bilirubin Direct Serum, Proteins Serum, Bilirubin Total Serum
Urine Routine	Colour, Urinary Leucocytes, Epithelial Cells, Crystals, Urine Ketone, Urobilinogen, Urinary Glucose, Urinary Protein, Urine Blood
Diabetic Profile	Fasting Blood Sugar, HbA1C
Lipid Profile	VLDL, HDL / LDL Cholesterol Ratio, HDL Cholesterol Direct, LDL Cholesterol - Calculated, Non-HDL Cholesterol Serum, LDL/HDL RATIO, CHOL/HDL RATIO, Cholesterol-Total Serum, Triglycerides Serum
Complete Kidney Function Profile	Uric Acid, Sr. Creatinine, Blood urea Nitrogen, BUN/Creatinine ratio
Thyroid	T3 - Total Tri Iodothyronine, TSH Ultra - sensitive, T4 - Total Thyroxine
Bone Health	Calcium
Vitamins	Vitamin B12 (Cyanocobalamin), Vitamin D Total-25 Hydroxy

Platinum Package:

Test	Component
Hemogram	Monocytes- Absolute Count, Lymphocyte Percentage, Nucleated Red Blood Cells, Neutrophils, Basophils, MCHC, Eosinophils, Hemoglobin, Platelet Count, Mean Corpuscular Volume(Mcv), Immature Granulocytes(Ig), Eosinophils- Absolute Count, Lymphocytes- Absolute Count, Basophils- Absolute Count, Neutrophils- Absolute Count, Immature Granulocyte Percentage(Ig%), Nucleated Red Blood Cells %, Haematocrit(Pcv), Red Cell Distribution Width- Sd(Rdw-Sd), Red Cell Distribution Width (Rdw-Cv), Total Rbc, Total Leucocytes Count, Mean Corpuscular Hemoglobin(Mch), Monocytes, ESR
Liver Function Test	Albumin Serum, Bilirubin- Indirect serum, Globulin, SGOT/SGPT Ratio, GGTP (Gamma GT), Alkaline Phosphatase Serum, SGOT/AST, A/G Ratio, SGPT/ALT, Bilirubin Direct Serum, Proteins Serum, Bilirubin Total Serum
Urine routine	Color, Urinary Leucocytes, Epithelial Cells, Crystals, Urine Ketone, Urobilinogen, Urinary Glucose, Urinary Protein, Urine Blood
Diabetic Profile	Fasting Blood Sugar, HbA1C
Lipid profile	VLDL, HDL / LDL Cholesterol Ratio, HDL Cholesterol Direct, LDL Cholesterol-Calculated, Non- HDL Cholesterol Serum, LDL/HDL RATIO, CHOL/HDL RATIO, Cholesterol-Total Serum, Triglycerides Serum
Complete Kidney Function Profile	Uric Acid, Sr. Creatinine, Blood urea Nitrogen, BUN/Creatinine ratio
Thyroid	T3 - Total Tri Iodothyronine, TSH Ultra - sensitive, T4 - Total Thyroxine
Bone Health	Calcium
Vitamins	Vitamin B12 (Cyanocobalamin), Vitamin D Total-25 Hydroxy

Iron Deficiency Profile	Total Iron Binding Capacity (Tibc), % Transferrin Saturation, Iron
Cardiac Risk Markers	Apo lipoprotein – B (Apo-B), Apo lipoprotein – A1 (Apo-A1), Apo B / Apo A1 Ratio (Apo B/A1), High Sensitivity C-Reactive Protein (Hs-Crp), Lipoprotein (A) [Lp(A)]

2. The health checkup can be availed on a cashless basis in the prescribed list of hospitals or diagnostic centers.
3. List of prescribed hospitals or diagnostic centers can be accessed from the Insurer's website or digital application of the Insurer/Service Provider.
4. The health check-up benefit must be availed within the Policy Period only, cover cannot be extended after the expiry of the Policy Period read with Base Policy.
5. The list of tests listed above cannot be changed.

Exclusions for "Annual Preventive Health Check-up Cover"

1. Preventive health check-up cannot be availed outside the prescribed list of hospitals or diagnostic centers.
2. Home collection facility will be available only at selected locations. For locations where home sample collection is not available, the customer will have to physically go and take the tests.
3. The complete list of tests as given above has to be completed in a single appointment.
4. If the health check-up is not availed in the Policy Year during the Policy Period, the benefit cannot be carried forward to the subsequent Policy Year.
5. Reimbursement of preventive health check-up expenses is excluded from the scope of this Rider.
6. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
   c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

E. Dental Wellness- Consultation, Investigation & Procedures Cover:

Coverage:

If the Insured/ Insured Member/s is suffering from any dental ailment, he / she can consult a Medical Practitioner with minimum qualification of BDS degree from prescribed network centres of the Service Provider, up to the limit as specified under this Rider read with Base Policy Schedule. This benefit will have below coverages and can be availed by Insured/ Insured Members under the Rider.

This is a cashless service. The cashless process to avail this benefit through the prescribed network of Service Provider is defined under the Service Delivery Process/claim process.
If the desired doctor/dentist is not available in the prescribed network, Insured/ Insured Member/s can take a prior-approval for consulting the desired dentist and claim the charges of consultation/procedure fees by way of reimbursement process as defined under claim process. Such reimbursements will be capped for respective services as per the table below. However, this capping will apply only for reimbursement claims and where co-payment is not opted.

Procedure	Capping amount
Consultation charges	500
IOPA/X-ray	
IOPA	250
Digital X ray	400
Root canal treatment	
RCT with GIC /Miracle /SF POR	5000
RCT with composite POR	6000
Third molar RCT	9500
Repeat RCT	10000
Post and core	4000
Restoration /Filling	

GIC	1000
Silver filling	2000
Composite	3000
Diastema Closure	3500
Anterior Fracture Repair	3000
Extraction	
Mobile tooth	700
Firm tooth	1000
Badly carious/Surgical/Erupted wisdom	2500
Disimpassion	12000
Extraction – wisdom tooth – upper jaw	3000
Extraction – wisdom tooth – lower jaw	5000
Extraction – Impacted/Surgical removal	6000
Extraction – Root canal treated teeth -Nonsurgical	3000
Extraction – Root canal treated teeth -surgical	6000
Crown	
Ni-Cr Metal crown	3000
Co-Cr Metal crown	4500
RFM (Ceramic)	6000
CAD CAM PFM	6000
Zirconia	10000
Brux zir	12000
Lava / Porcera / E-max	12000
Paediatric dentistry	
Extraction of primary teeth	750

Exclusions for "Dental Wellness- Consultation, Investigation & Procedures Cover":

1. Other expenses of investigations, medicines, surgical or non-surgical procedures or any medical, non-medical items not mentioned under this coverage are excluded.
2. This dental benefit shall not be applicable/available on cosmetic level scaling/polishing, bleaching, cap of teeth, braces, aligner, and tooth replacement, any other cosmetic and aesthetic treatment.
3. This benefit cannot be availed outside the prescribed network of dentists and hospitals.
4. If the benefit under this cover is not availed in the Policy Year, the benefit cannot be carried forward to the subsequent Policy Year.
5. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
   c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.
6. Pre-Existing Diseases Waiting Period (Code- Excl01)
   a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of specified number of months of continuous coverage after the date of inception of the first Rider Plan and the Policy Schedule with Us.
   b) The PED waiting period would be as per the Base Policy opted and as specified on the Policy Schedule.
   c) If the Insured Person is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations, then Waiting Period for the same would be reduced to the extent of prior coverage.
   d) Coverage under the Policy after the expiry of the waiting period as specified in Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

F. Diet & Nutrition Consultation Cover

Coverage:

If the Insured/ Insured Member/s wants to maintain a balance between good nutrition and diet, he / she can consult a Dietician or Nutritionist listed on the Digital platform of Insurer/ Service Provider's application via video, audio, or chat channel. This benefit can be availed by Insured/ Insured Members covered under this Rider. This is a cashless service and can be availed through the prescribed network of Service Provider.

Exclusions for "Diet & Nutrition Consultation Cover":

1. Consultation with the dietician is strictly limited to in-app/website video/audio/chat consultation, no in-clinic/physical consultation is allowed.
2. Dietician & Nutritionist consultation benefit is not transferrable.
3. If the benefit is not availed in the policy year the benefit cannot be carried forward to the subsequent policy year.
4. Reimbursement of dietician & nutritionist consultation expenses is excluded from the scope of the Rider.
5. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
   c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

G. Emotional Wellness Cover:

If the Insured/ Insured Member/s wants to avail emotional wellbeing services, he / she can consult an emotional health coach/psychologist listed on the Digital platform of Insurer/ Service Provider's application via video, audio, or chat channel. This benefit can be availed by Insured/ Insured Members covered under the Rider. This is a cashless service and can be availed through the prescribed network of Service Provider.

Exclusions for "Emotional Wellness Cover":

1. Consultation with the emotional health coach/psychologist is strictly limited to in-app/website video/audio/chat consultation, no in-clinic/physical consultation is allowed.
2. Emotional wellbeing benefit is not transferrable.
3. If the benefit is not availed in the policy year the benefit cannot be carried forward to the subsequent policy year.
4. Reimbursement of emotional health coach/psychologist consultation expenses is excluded from the scope of the Rider.
5. 30-day Waiting Period (Code-Excl03)

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

H. Physical Fitness Cover

Coverage:

Physical fitness/ Gymnasium benefit covers the fitness facilities offered by the network Gymnasium/Physical fitness centres. The Insured/ Insured Members can avail the facilities in network Gymnasium for 365 days during the Policy Period.
For Floater Plans, 1 Insured Member would be eligible for 1 session per day per family under this benefit
For Individual Plans, the Insured Members who have opted for the plan with Physical Fitness Coverage can avail 1 session per day.

Exclusions for "Physical Fitness Cover":

1. This benefit cannot be availed outside the prescribed network of gyms and fitness centers and is not available to children below 18 years insured in the Rider read with the Base Policy.
   If the benefit is not availed/partially availed in the policy year the benefit cannot be carried forward to the subsequent policy year.

13. Discount on Services (UIN- BAJHLIA27077V012627)
    The Insured Person may have access to special rates on services such as OPD, Diagnostics, Pharmacy and other wellness services through Network as available on the Company's website/ app.

SECTION D) WAITING PERIOD AND EXCLUSIONS - STANDARD EXCLUSIONS

I. Exclusion Name: Waiting Period

1. Pre-Existing Diseases Waiting Period (Code-Excl01)
   a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first My Health Care Plan EDGE+ (Plan 9) and the Policy Schedule with Us. The PED waiting period as opted would be specified on the Policy Schedule.
   b) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increased.
   c) If the Insured is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
   d) Coverage under the Policy after the expiry of the waiting period of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

2. Specified disease/procedure Waiting Period (Code-Excl02)
   a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first My Health Care Plan EDGE+ (Plan 9) and the Policy Schedule with Us. This exclusion shall not be applicable for claims arising due to an Accident. The Specified Disease/Procedure Waiting Period as opted would be specified on the Policy Schedule In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
   b) If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing diseases, then the longer of the two waiting periods shall apply.
   c) The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
   d) If the Insured is continuously covered without any break as defined under the applicable norms on Portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
   e) List of specific diseases/ procedures/ surgeries/ treatments is as below:

List of specific diseases/ procedures/ surgeries/ treatments	
1. Any type gastrointestinal ulcers	2. Cataracts
3. Any type of fistula	4. Macular Degeneration
5. Benign prostatic hypertrophy	6. Hernia of all types
7. All types of sinuses	8. Fissure in ano
9. Haemorrhoids, piles	10. Hydrocele
11. Dysfunctional uterine bleeding	12. Fibromyoma
13. Endometriosis	14. Hysterectomy
15. Uterine Prolapse	16. Stones in the urinary and biliary systems
17. Surgery on ears/tonsils/ adenoids/ paranasal sinuses	18. Surgery on all internal or external tumours/ cysts/nodules/polyps of any kind including breast lumps except malignancy
19. Diseases of gall bladder including cholecystitis	20. Pancreatitis

21. All forms of Cirrhosis	22. Gout and rheumatism
23. Surgery for varicose veins and varicose ulcers	24. Chronic Kidney Disease
25. Alzheimer's Disease	26. Joint replacement surgery
27. Surgery for vertebral column disorders (unless necessitated due to an Accident)	28. Surgery to correct deviated nasal septum
29. Hypertrophied turbinate	30. Congenital internal diseases or anomalies
31. Treatment for correction of eye sight due to refractive error recommended by Ophthalmologist for medical reasons with refractive error greater or equal to 7.5	32. Bariatric Surgery

3. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
   c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

II. General Exclusions

1. Investigation & Evaluation (Code-Excl04)
   a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded even if the same requires confinement at a Hospital.
   b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

2. Rest Cure, rehabilitation and respite care (Code-Excl05)
   a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
      i. 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.
      ii. Any services for people who are terminally ill to address medical, physical, social, emotional and spiritual needs.

3. Obesity/Weight Control (Code-Excl06)

   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   1) Surgery to be conducted is upon the advice of the Doctor
   2) The surgery/Procedure conducted should be supported by clinical protocols
   3) The member has to be 18 years of age or older and
   4) Body Mass Index (BMI);
      a) greater than or equal to 40 or
      b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         i. Obesity-related cardiomyopathy
         ii. Coronary heart disease
         iii. Severe Sleep Apnea
         iv. Uncontrolled Type2 Diabetes

4. Change-of-gender treatments (Code-Excl07)
   Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

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

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

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

8. Excluded Providers (Code-Excl11)
   Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the Policy Holder/Insured Person are not admissible. However, in case of life-threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

9. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code- Excl12).

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

11. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalisation claim or day care procedure. (Code-Excl14)

12. Refractive Error (Code-Excl15)
    Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

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

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

15. Maternity: (Code Excl18)
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;
    ii. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the Cover Period.

iii. This exclusion stands deleted if Maternity Package Expenses is covered under the respective plan of My Health Care Plan EDGE+.

III. SPECIFIC EXCLUSIONS

1. Any dental treatment that comprises of cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring Hospitalization.
2. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority.

   Any Medical expenses incurred due to Act of Terrorism will be covered under the Policy.
3. The cost of spectacles, contact lenses, hearing aids, crutches, dentures, artificial teeth and similar expenses.
4. External medical equipment of any kind used at home as post Hospitalization care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition.
5. Congenital external diseases or defects or anomalies, growth hormone therapy, stem cell implantation or surgery except for Hematopoietic stem cells for bone marrow transplant for haematological conditions.
6. Vaccination or inoculation unless forming a part of post bite treatment or if medically necessary and forming a part of treatment recommended by the treating Medical Practitioner.
7. All non-medical Items as per Annexure II.
8. Any medical treatment received outside India is not covered under this Policy except in case of optional cover/rider- International Cover-emergency care only or Global Cover is opted.
9. Circumcision unless required for the treatment of Illness or Accidental bodily injury.
10. Treatment for any other system other than modern medicine (allopathy) and AYUSH therapies.
11. NRInsure Rider- The Company shall not be liable to pay any Pre-Hospitalization and Post Hospitalisation Medical expenses incurred outside India.
12. Insta Shield Rider- the exclusion of Pre-Existing Diseases (Code- Excl01) under the Base Policy shall not apply only to the extent of coverage expressly provided for those chronic conditions/diseases that have been declared by the insured person, have been accepted by the Company, and are specifically listed in the Policy Schedule.
13. Fetal Flourish Rider- We shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or attributable to any of the following.
    i. Voluntary/unlawful termination of pregnancy/investigations done for identification of fetal sex.
    ii. Expenses related to Delivery/termination of pregnancy.
    iii. Pre and Post hospitalization treatment expenses.
    iv. Treatment that are deemed to be unproven, experimental or investigational.
    v. Elective procedures deemed not medically necessary.
    vi. Procedures performed outside accredited fetal medicine centers.
    vii. Procedures/Treatment advised by any medical practitioner other than a registered Obstetrics and Gynecology specialist or Fetal medicine specialist.
14. Treatment for any other system other than modern medicine (allopathy) and AYUSH therapies.
15. Specific exclusions (Applicable for Health Prime Rider):

    Exclusions for "Tele Consultation Cover (Insta Consultation)"
    1. Tele consultation outside the Digital platform of service provider's application/ website video/audio/chat consultation, in-clinic/physical consultation is not covered under this benefit of the product.
    2. Teleconsultation benefit is not transferrable to any other member unless the member is covered under the Base Policy and has opted this coverage.
    3. If the Tele Consultation is not availed in the policy year during the Policy Period, the benefit cannot be carried forward to the subsequent policy year.
    4. Reimbursement of teleconsultation benefit is excluded from the scope of this Policy.
    5. 30-day Waiting Period (Code-Excl03)
       a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the

Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.

b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.

c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

Exclusions for Doctor Consultation Cover (In-clinic):

1. Other expenses of investigations, medicines, surgical or non-surgical procedures or any medical, non-medical items are not covered under this section.
2. If the Doctor Consultation cover is not availed in the policy year the benefit cannot be carried forward to the subsequent policy year.
3. Claims related to Ante Natal consultations and investigations shall not be covered. However, consultations for pregnancy related complications would be covered.
4. Dietician/nutritionist consultations/sessions will not be covered under this benefit
5. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
   c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.
6. Pre-Existing Diseases Waiting Period (Code- Excl01)
   a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of specified number of months of continuous coverage after the date of inception of the first Rider plan and the Policy Schedule with Us.
   b) The PED waiting period would be as per the Base policy opted and as specified on the Policy Schedule.
   c) If the Insured Person is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations, then Waiting Period for the same would be reduced to the extent of prior coverage.
   d) Coverage under the Policy after the expiry of the waiting period as specified in Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

Exclusions for "Doctor Prescribed Investigations Cover – Pathology & Radiology Expenses"

1. If the Investigation cover is not availed in the respective policy year the benefit cannot be carried forward to the subsequent policy year.
2. Claims related to Ante Natal investigations shall not be covered.
   However, investigations for pregnancy related complications would be covered.
3. Any preventive health tests shall not be covered under this benefit
4. Invasive tests shall not be covered.
5. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
   c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.
6. Pre-Existing Diseases Waiting Period (Code- Excl01)
   a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of specified number of months of continuous coverage after the date of inception of the first Rider Plan and the Policy Schedule with Us.
   b) The PED waiting period would be as per the Base policy opted and as specified on the Policy Schedule.
   c) If the Insured Person is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations then Waiting Period for the same would be reduced to the extent of prior coverage.
   d) Coverage under the Policy after the expiry of the waiting period as specified in Policy Schedule, for any

pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

Exclusions for "Annual Preventive Health Check -up cover"

1. Preventive health check-up cannot be availed outside the prescribed list of hospitals or diagnostic centres.
2. Home collection facility will available only at selected locations. For locations where home sample collection is not available, the customer will have to physically go and take the tests.
3. The complete list of tests as given above has to be completed in a single appointment.
4. If the health check-up is not availed in the policy year during the Policy Period the benefit cannot be carried forward to the subsequent policy year during the Policy Period.
5. Reimbursement of preventive health check-up expenses is excluded from the scope of the product.
6. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
   c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

Exclusions for "Dental wellness - Consultation, Investigation & Procedures Cover"

1. Other expenses of investigations, medicines, surgical or non-surgical procedures or any medical, non-medical items not mentioned under coverage are excluded
2. Dental benefit shall not be applicable on cosmetic level scaling/polishing, bleaching, cap of teeth, braces, aligner, tooth replacement, any other cosmetic and aesthetic treatment
3. This benefit cannot be availed outside the prescribed network of dentists and hospitals
4. If the benefit is not availed in the policy year the benefit cannot be carried forward to the subsequent policy year.
5. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
   c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.
6. Pre-Existing Diseases Waiting Period (Code- Excl01)
   a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of specified number of months of continuous coverage after the date of inception of the first Rider Plan and the Policy Schedule with Us.
   b) The PED waiting period would be as per the Base policy opted and as specified on the Policy Schedule.
   c) If the Insured Person is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations, then Waiting Period for the same would be reduced to the extent of prior coverage.
   d) Coverage under the Policy after the expiry of the waiting period as specified in Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

Exclusions for "Diet & Nutrition Coverage"

1. Consultation with the dietician is strictly limited to in-app/website video/audio/chat consultation, no in-clinic/physical consultation is allowed.
2. Dietician & Nutritionist consultation benefit is not transferrable.
3. If the benefit is not availed in the policy year the benefit cannot be carried forward to the subsequent policy year.
4. Reimbursement of dietician & nutritionist consultation expenses is excluded from the scope of the Policy.
5. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising

due to an Accident, provided the same are covered.

b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.

c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

Exclusions for "Emotional Wellness Coverage"

1. Consultation with the emotional health coach/psychologist is strictly limited to in-app/website video/audio/chat consultation, no in-clinic/physical consultation is allowed.
2. Emotional wellbeing benefit is not transferrable.
3. If the benefit is not availed in the policy year the benefit cannot be carried forward to the subsequent policy year.
4. Reimbursement of emotional health coach/psychologist consultation expenses is excluded from the scope of the Policy.
5. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
   c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

Exclusions for "Physical Fitness Coverage"

1. This benefit cannot be availed outside the prescribed network of gyms and fitness centers and is not available to children below 18 years insured in the policy.
2. If the benefit is not availed in the policy year the benefit cannot be carried forward to the subsequent policy year.
3. Reimbursement of Physical Fitness Coverage/ Gymnasium benefit is excluded from the scope of the product.

Exclusions applicable to all Sections of Health Prime Rider:

1. Cosmetic or plastic Surgery (Excl08):
   Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
2. Breach of law (Excl10):
   Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
3. Excluded Providers (Excl11):
   Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
4. Unproven Treatments (Excl16):
   Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
5. Experimental, investigational or Unproven Treatment devices and pharmacological regimens.
6. Treatment for alopecia, baldness, wigs, or toupees, and all treatment related to the same.
7. Congenital external diseases, defects or anomalies.
8. Venereal disease, all sexually transmitted disease or Illness including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
9. Sterility and Infertility (Excl17):
   Expenses related to sterility and infertility. This includes:
   a) Any type of contraception, sterilization
   b) Assisted Reproduction services including artificial insemination and advanced reproductive

technologies such as IVF, ZIFT, GIFT, ICSI
c) Gestational Surrogacy
d) Reversal of sterilization.

10. Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose.
11. Treatment taken from a person not falling within the scope of definition of Medical Practitioner.
12. Treatment charges or fees charged by any Medical Practitioner acting outside the scope of license or registration granted to him by any medical council.
13. Treatments rendered by a Medical Practitioner who is a member of the Customer's family or stays with him.
14. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.
15. Naturopathy treatment, acupressure, acupuncture, magnetic and such other therapies.
16. Treatment/Service taken outside India.

SECTION E) GENERAL TERMS AND CONDITIONS - STANDARD GENERAL TERMS AND CONDITIONS

1. Disclosure of Information
The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by Policyholder/ Insured.

2. Condition Precedent to Admission of Liability
The due observance and fulfilment of the terms and conditions of the Policy, by the Insured Person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the Policy.

3. Premium Payment in Installments
If the insured person has opted for Payment of Premium on an instalment basis i.e. Annual (for long term polices only), Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium.

ii. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.

iii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.

iv. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

v. No interest will be charged If the instalment premium is not paid on due date.

vi. In case of instalment premium due not received within the grace period, the policy will get cancelled.

vii. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

viii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

4. Multiple Policies

i. In case of multiple health policies taken by an Insured Person during a period from the same or one or more insurers to indemnify medical treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured Person having multiple policies shall also have the right to prefer claims under the Policy for the amounts disallowed under any other policy / policies even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of the Policy.

iii. If the amount to be claimed exceeds the Sum Insured under a single policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.

iv. Where an Insured Person has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the Hospitalisation costs in accordance with the terms and conditions of the chosen policy/Policy Schedule.

5. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest, to the Insured Person from the date of receipt of last necessary document to the date of payment of claim, at a rate 2% above the bank rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 15 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 15 days, the Company shall be liable to pay interest, to the Insured Person, at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

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

6. Renewal of Policy

i. Your Policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by You, provided this policy is not withdrawn and also subject to conditions stated at "Moratorium Period" of this Schedule.

ii. We shall not deny the Renewal of this policy on the ground that You have made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policy.

iii. We shall condone a delay in Renewal up to the Grace Period (30 days) from the due date of Renewal without considering such condonation as a Break in Policy.

iv. For this policy, the loadings on Renewal premium shall be at portfolio and not based upon any individual policy claim experience. However, discount in premium may be provided by Us to You for good claims experience.

v. We shall not resort to fresh underwriting by calling for medical examination, fresh proposal form etc. at Renewal stage where there is no change in Sum Insured offered. Provided that where there is an improvement in the risk profile, We may endeavour to recognize that for removal of loadings at the point of renewal.

vi. In case the product is withdrawn, the policyholder shall be provided with suitable alternative options for migration, as per applicable regulatory provisions.

7. Cancellation

(A) Cancellation by the Policyholder

The Policyholder can cancel this Policy by providing a written notice of 7 days. In such a case, the Company will refund the premium for the unexpired policy period as detailed below:

1. Cancellation of policy where full premium received at policy inception -
   - Annual Policy: The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the policy year.
   - Multi-year Policy:
     - For any policy year where the risk date has not yet started, the premium will be refunded without any deduction.
     - For any policy year where the risk has started, the premium will be refunded on a pro-rata basis for that policy year, provided no claim has been made during the policy year and in full for future policy years.

2. Cancellation of policy where Premium Received on Instalment Basis
The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the policy year.

(B) Additional Deductions - Notwithstanding the above, if (i) the risk under the Policy has already commenced, or (ii) only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then expenses incurred by the Company on medical examination of the Policyholder will also be deducted before refunding of premium.

(C) Cancellation by the Company
The Company may cancel the Policy at any time on the grounds of misrepresentation, non-disclosure of material facts, or fraud by the Policyholder/insured person, by providing 15 days' written notice. There will be no refund of premium for cancellations on these grounds.

(D) In case of any delay in refund of premium beyond stipulated 7 days, the Company shall refund such amounts along with interest, at a rate 2% above the bank rate on the refundable amount, from the date of receipt of the request for cancellation till the date of refund.

8. Portability
The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire Policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the Policy Renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Portability. Insurer is free to consider proposal for portability even if the policyholder has approached within 15 days from the Renewal date of the existing policy, but in all such cases acquiring insurer shall ensure that there is no break in policy.
For Detailed Guidelines on Portability, kindly refer the link:
https://irdai.gov.in/document detail? documentId=393128
(Please note referred link is of the IRDAI website and subject to change from time to time.)

9. Complete Discharge
Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

10. Possibility of Revision of Terms
The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are affected.

11. Moratorium Period
After completion of sixty continuous months of coverage (including portability and migration) no look back would be applied. This period of sixty months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co- payments and deductibles as per the policy contract.

12. Norms on Migration
The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company by applying for migration of the Policy Schedule at least 30 days before the Policy Renewal date as per IRDAI guidelines on Migration. If such Insured Person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on Portability, kindly refer the link:
https://irdai.gov.in/document detail? documentId=393128
(Please note referred link is of the IRDAI website and subject to change from time to time.)

13. Withdrawal of Policy
    i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured about the same 90 days prior to expiry of the Policy.
    ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of Renewal with all the accrued continuity benefits such as cumulative bonus, waiver of Waiting Period as per IRDAI guidelines, provided the Policy has been maintained without a break.

14. Fraud
    i. If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under the Policy, all benefits under the Policy and the premium paid shall be forfeited.
    ii. Any amount already paid against claims which are found fraudulent later under the Policy shall be repaid by all Insured person(s) named in Policy Schedule, who shall be jointly and severally liable for such repayment.
    iii. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the Insurer or to induce the Insurer to issue Policy:
        a. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
        b. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
        c. any other act fitted to deceive; and
        d. any such act or omission as the law specially declares to be fraudulent
    iv. The Company shall not repudiate the claim under Policy on the ground of Fraud, if the Insured Person can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer. Onus of disproving is upon the Insured Person, if alive, or beneficiaries.

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

16. Redressal of Grievance
    Bajaj General Insurance Limited has always been known as a forward-looking customer centric organization. We take immense pride in the spirit of service and the culture of keeping customer first in our scheme of things. In order to provide you with top-notch service on all fronts, we have provided you with multiple platforms via which you can always reach one of our representatives.

Level 1 In case you have any concern, you may please reach out to our Customer Experience Team through any of the following options: • Our Website www.bajajgeneralinsurance.com • Call us on our Toll free no 1800 209 5858 • Mail us on careforyou@bajajgeneral.com • Write to Bajaj General Insurance Limited Bajaj Insurance House, Airport Road, Yerwada Pune- 411006
Level 2 In case you are not satisfied with the response given to you by our team, you may write to our Grievance Redressal Officer at ggro@bajajgeneral.com

Level 3 If in case, your grievance is not resolved and you wish to talk to our care specialist, please Give a missed on +91 80809 45060 OR SMS to 575758 and our care specialist will call you back
If you are still not satisfied with the solutions provided, write to Head of Customer experience directly at head.customerservice@bajajgeneral.com
Grievance Redressal Cell for Senior Citizens Bajaj General introduces a dedicated team for all the senior citizens, so, no more wait time, no more standing in long queue. Senior citizens can now contact us on 1800-103-2529 or write to us at seniorcitizen@bajajgeneral.com
If you are still not satisfied with the decision of the Insurance Company, you may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. Detailed process along with list of Ombudsman offices are available at https://www.cioins.co.in/ombudsman. Note: Address and contact number of Governing Body of Insurance Council: Council for Insurance Ombudsmen,3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. E-mail: inscoun@cioins.co.in, Tel: 022 -69038800/69038812, Website: https://www.cioins.co.in
The contact details of the Ombudsman offices are mentioned in, https://www.bajajgeneralinsurance.com/download-documents/health-insurance/OMBUDSMAN-ADDRESS.pdf

17. Free Look Period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of Porting the Policy.

The Insured Person shall be allowed a period of thirty days from date of receipt of the Policy document to review the terms and conditions of the Policy, and to return the same if not acceptable.

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

i. A refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charges; or
ii. where the risk has already commenced and the option of return of the Policy Schedule is exercised by the Insured Person, a deduction towards the proportionate risk premium for Cover Period; or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such Cover Period.

18. Medical Underwriting

The Company may add a risk loading to the premium applicable for the person to be insured, based on the information provided in the proposal form and the health status of those person to be insured.

i. The maximum risk loading for any individual for all conditions put together will not exceed 200% per insured person.
ii. Such loading will be intimated to the customer and consent shall be taken before Policy is issued.
iii. This loading will take effect from the Policy's Commencement Date and will apply to any subsequent renewals with the Company.

SECTION E) GENERAL TERMS AND CONDITIONS – SPECIFIC TERMS AND CONDITIONS

1. Conditions Precedent

Where this Policy requires You to do or not to do something, then the complete satisfaction of that requirement by You or someone claiming on Your behalf is a precondition to any obligation We have under this Policy. If You or someone claiming on Your behalf fails to completely satisfy that requirement, then We may refuse to consider Your claim.

2. Insured Person

Only those persons named as the Insured Person(s) in the Policy Schedule shall be covered under the Policy. Cover under the Policy shall be withdrawn from any Insured Person upon such Insured Person giving 7 days written notice to be received by Us.

3. Additional Norms on Migration

Insured Person shall apply for migration of the Policy at least 30 days before the Policy Renewaldue date. All revised guidelines of IRDAI from time to time as to Migration shall apply.

4. Change of Sum Insured
Sum Insured can be changed (increased/ decreased) only at the time of Renewalor at any time, subject to underwriting by the Company. For any increase in SI, the Waiting Period shall start afresh only for the enhanced portion of the Sum Insured.

5. Notice & Communication
   i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
   ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
   iii. The Company shall communicate to the Insured Person at the address or through any other electronic mode mentioned in the Policy Schedule.

6. Endorsements (Changes in Policy)
This Policy constitutes the complete contract of insurance. This Policy cannot be changed by anyone (including an insurance agent or broker) except by the Insurer. Any change that the Insurer make will be evidenced by a written Endorsement signed and stamped by the Insurer.

7. Terms and conditions of the Policy
The terms and conditions contained herein and, in the Policy, Schedule shall be deemed to form part of the Policy and shall be read together as one document.

8. Automatic change in Coverage under the Policy
The coverage for the Insured Person(s) shall automatically terminate:
   i. In the case of his/ her (Insured Person) demise. However, the cover shall continue for the remaining Insured Beneficiaries till the end of Cover Period. The other Insured Beneficiaries may also apply to renew the Policy Schedule. In case, the other Insured Person is minor, the Policy Schedule shall be renewed only through any one of his/her natural guardian or guardians appointed by court. All relevant particulars in respect of such person (including his/her relationship with the Insured Person) must be submitted to the Company along with the application. Provided no claim has been made, and termination takes place on account of death of the Insured Person, pro-rata refund of premium of the deceased Insured Person for the balance period of the Policy Schedule will be effective.
   ii. Upon exhaustion of Sum Insured and cumulative bonus, for the Policy Year. However, the Policy is subject to Renewalon the due date as per the applicable terms and conditions.

9. Territorial Jurisdiction and Territorial Limit
   i. All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy/Policy Schedule shall be determined by the Indian court and according to Indian law.
   ii. All medical treatment for the purpose of the Policy Schedule will have to be taken in India only (except in case of optional cover - "International Cover-emergency care only" or "Global Cover" is opted).
   iii. Our liability to make any payment shall be to make payment within India and in Indian Rupees only.
   iv. The section headings of this Policy are included for descriptive purposes only and do not form part of this Policy for the purpose of its construction or interpretation.

10. Arbitration
Arbitration Clause shall not be applicable.

11. Discounts
   i. Loyalty Discount
   Discount of 5% shall be offered if the Insured Person is having any of the listed active Bajaj General Insurance Ltd.'s retail policy of Motor, Health, Home, Cyber and Pet Insurance with a minimum premium of INR 2500.

ii. Family Discount

10% family discount shall be offered if 2 eligible Family Members are covered under a single Policy and 15 % if more than 2 of any of the eligible Family Members are covered under a single Policy. Moreover, this family discount will be offered for both new policies as well as for Renewalpolicies. Family discount is not applicable to My Health Care Plan EDGE+ (Plan 9) Floater Policies.

iii. Employee Discount

20% discount on published premium rates will be applicable for the Company's employees & employees of group companies, employees of Corporate customers of Bajaj General Insurance Ltd. provided the Policy is booked in direct code. This discount shall also be applicable to Intermediaries of Bajaj General Insurance Ltd. for their own policies booked under Direct code, provided that the Intermediaries themselves are covered under the Policy.

iv. Online/Direct Business Discount

Discount of 5% will be offered in this product for policies underwritten through direct/online channel.
Note: this discount is not applicable for Employees who get employee discount.

v. Long Term Discount

Applicable in case of where the entire premium amount is paid in single payment for Policy Period of more than one year.

a. 4% discount is applicable if Policy is opted for 2 years.
b. 8% discount is applicable if Policy is opted for 3 years.
c. 9% discount is applicable if Policy is opted for 4 years.
d. 10.5% discount is applicable if Policy is opted for 5 years.

Note: This will not apply to Policies where premium is paid in instalments.

vi. Zone Discount

Below discount will be applicable based on residential address of the proposer or insured person.

- Residential address in Zone B: 15% on Zone A Premium.
- Residential address in Zone C: 25% on Zone A Premium.

There are three Zones for Premium payment:

- Zone A Delhi / NCR, Mumbai including (Navi Mumbai, Thane and Kalyan), Hyderabad and Secunderabad, Kolkata, Ahmedabad, Vadodara and Surat.
- Zone B Rest of India apart, from the states/UTs/cities classified under Zone A and Zone C, are classified as Zone B.
- Zone C Andaman & Nicobar Islands, Arunachal Pradesh, Bihar, Chandigarh, Chattisgarh, Goa, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Punjab, Sikkim, Tripura, Uttarakhand.

vii. Early Entry Discount

5% discount shall be offered if, Insured Proposer is opting the My Health Care Plan EDGE+ (Plan 9) long term policy prior to 35 years of age.

In policies where Proposer is also an Insured member, and his/her age is 35 years or below, this discount shall be extended to all other insured members also who are aged 35 years and below in the same policy.

This discount shall be applicable at inception of policy as well as at each subsequent renewal, irrespective of claims, until the Insured member/s completes 45 years of age.

Note: This discount will apply only if long term policy is opted. This will not apply to policies where premium is paid in instalments.

viii. Fitness Discount

The Insured person will be eligible for a Fitness Discount of 5%, if the below criteria is fulfilled.

1. The Insured member submits completion certificates of at least two 5km marathons run in the past 12 months prior to policy inception date.

This discount shall only be applicable at the onset of the Policy for the first time with Us.

12. Sum Insured Enhancement
    i. The Insured Person can apply for enhancement of Sum Insured at the time of renewal. You can apply for enhancement of Sum Insured by submitting a fresh proposal form to the Company.
    ii. The acceptance of enhancement of Sum Insured would be at the discretion of the Company, based on the health condition of the Insured Person(s) & claim history of the Policy.
    iii. All waiting periods as defined in the Policy shall apply for this enhanced Sum Insured limit from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

13. Inclusion of members under the Policy
    Where an Insured Person is added to this Policy, either by way of Endorsement or at the time of renewal, the pre-existing disease clause, exclusions and waiting periods will be applicable considering such Policy Year as the first year of Policy with the Company for that newly added Insured Person.

15. Paying a Claim
    i. You agree that We will only make payment when You or someone claiming on Your behalf has provided Us with necessary documentation and information.
    ii. We will make payment to You or Your Nominee. If there is no Nominee and You are incapacitated or deceased, We will pay Your heir, executor or validly appointed legal representative and any payment We make in this way will be a complete and final discharge of Our liability to make payment.
    iii. On receipt of all the documents and on being satisfied with regard to the admissibility of the claim as per Policy terms and conditions, the Company will settle the claim within 30 (thirty) days of the receipt of the last necessary document. Upon acceptance of an offer of settlement by the Insured Person, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured Person.
    iv. If the Insurer, for any reasons decides to reject the claim under the Policy the reasons regarding the rejection shall be communicated to the Insured Person in writing within 30 days of the last receipt of necessary documents. The Insured Person may take recourse to the Grievance Redressal procedure stated under Policy.

16. Basis of Claims Payment
    i. If You suffer a relapse within 45 days from the date when You last obtained medical treatment or consulted a Medical Practitioner and for which a claim has been made, then such relapse shall be deemed to be part of the same claim. This 45 days clause will not be applicable for Sum Insured Reinstatement.
    ii. The day care procedures listed below in this Policy are subject to the exclusions, terms and conditions of the Policy and will not be treated as independent coverage under the Policy.
    iii. We shall make payment in Indian Rupees only.

17. Cost Sharing and Sub limits
    a. Voluntary Co-payment
    i. If the co-payment option is opted, then a discount corresponding to the co-payment opted would be applicable.
    ii. If a claim has been admitted under In-patient Hospitalization Treatment then, the Insured shall bear a 5% or 10% or 15% or 20% of the eligible claim amount payable under this Policy and Our liability, if any, shall only be in excess of that sum and would be subject to the Sum Insured.
    b. Voluntary Aggregate Deductible
    If opted voluntarily and mentioned on the Policy Schedule that an Aggregate Deductible is opted, then Insured Person will be eligible for discount on the policy premium as per the table below.
    If Voluntary Aggregate Deductible is opted, We hereby agree to pay Reasonable & Customary Medical Expenses in respect of an admissible Hospitalization claim in excess of the Annual Aggregate Deductible as opted by Insured Person subject to the Sum Insured, limits, terms, conditions and definitions, exclusions contained or otherwise.

Deductible	Sum Insured	Individual Discount	Floater Discount	Deductible	Sum Insured	Individual Discount	Floater Discount
50,000	5,00,000	54%	47%	1,00,000	35,00,000	28%	17%
50,000	7,50,000	41%	32%	1,00,000	40,00,000	27%	16%
50,000	10,00,000	38%	29%	1,00,000	45,00,000	26%	15%
50,000	15,00,000	34%	24%	1,00,000	50,00,000	25%	14%
50,000	20,00,000	31%	21%	1,00,000	75,00,000	22%	10%
50,000	25,00,000	29%	18%	1,00,000	1,00,00,000	19%	7%
50,000	30,00,000	27%	16%	2,00,000	5,00,000	69%	64%
50,000	35,00,000	23%	11%	2,00,000	7,50,000	65%	60%
50,000	40,00,000	22%	10%	2,00,000	10,00,000	62%	56%
50,000	45,00,000	21%	9%	2,00,000	15,00,000	57%	51%
50,000	50,00,000	21%	9%	2,00,000	20,00,000	54%	47%
50,000	75,00,000	18%	6%	2,00,000	25,00,000	43%	34%
50,000	1,00,00,000	16%	3%	2,00,000	30,00,000	41%	32%
1,00,000	5,00,000	62%	56%	2,00,000	35,00,000	34%	24%
1,00,000	7,50,000	57%	51%	2,00,000	40,00,000	33%	23%
1,00,000	10,00,000	54%	47%	2,00,000	45,00,000	32%	22%
1,00,000	15,00,000	41%	32%	2,00,000	50,00,000	31%	21%
1,00,000	20,00,000	38%	29%	2,00,000	75,00,000	27%	16%
1,00,000	25,00,000	36%	26%	2,00,000	1,00,00,000	24%	13%
1,00,000	30,00,000	34%	24%	2,00,000	2,00,00,000	16%	3%

Note: Voluntary Co-payment is not applicable if Voluntary Aggregate Deductible is opted.

Scenario-

Sum Insured: Rs 10 Lakhs; Aggregate Deductible Opted: Rs. 2 Lakhs						
Claims Details	Date of Hospitalisation	Total Claim Amount (in INR)	Deductible Utilization (in INR)	Balance Deductible (in INR)	Payable by insured (if any) (in INR)	Payable under My Health Care Plan EDGE+ (in INR)
Claim 1	10-May-26	1,50,000	1,50,000	50,000	1,50,000	0
Claim 2	10-Aug-26	3,00,000	50,000	0	50,000	2,50,000
Claim 3	10-Dec-26	7,50,000	0	0	0	7,50,000

c. Cataract

Our obligation to make payment in respect of surgeries for cataracts (after the expiry of the waiting period as specified in the Policy Schedule) shall be as specified in the Policy Schedule.
20% of the Sum Insured for each eye, subject to maximum of INR 100,000 for each of You.

i. For SI up to 10 Lac - 20% of SI max 1 Lac per eye.
ii. For SI above 10 Lac – Actual.

d. Co-payments

Co-payment	Limit
Voluntary co-payment	5%/10%/15%/20% of admissible claim amount
International Cover– Emergency Care only	Mandatory co-payment of 10%
Global Cover	Mandatory co-payment options of 10%, 20%, 30%, 40%, 50%

e. Deductible

Deductible	Options
Voluntary Aggregate Deductible	50,000/ 1Lakh / 2Lakh

f. Sub limits

Cover Name	Limit/Category
Cataract Limit	20% max upto 1 lakh per eye
	SI above 10 lakh cataract limits at Actuals
Family Visit	Sub-limit of 25,000 till 10 Lakhs Sum Insured
	Sub-limit of 50,000 for above 10 Lakhs

g. Other Limits

Name of Limit	Limit
Cost of Prescribed External Medical Aid	10% of Sum Insured, max up to 5 lakhs
Air Ambulance	Max up to 10 lakhs
Cumulative Bonus	25% upto 100%
Super Cumulative Bonus	50% upto 200% 50% upto 500% 100% upto 200% 100% upto 500% 100% upto 600%
Sum Insured Reinstatement	Unlimited
Major Illness and Accident Multiplier (Indemnity)	2 times of Sum Insured

18. Nationality
    i. Indian nationals residing in India would be considered for this Policy.
    ii. This Policy can be opted by Non-Resident Indians/ Overseas citizens of India (OCI) also and premium paid in Indian currency.

SECTION E) GENERAL TERMS AND CONDITIONS – OTHER TERMS AND ONDITIONS

18. Claims Procedure

All Claims will be settled by In house claims settlement team of the Company. However, the Company reserves right to engage TPA at any time, at the sole discretion of the Company.

If You meet with any Injury or suffer an Illness that may result in a claim, then as a condition precedent to Our liability, you must comply with the following:

A. Cashless Claims Procedure

Cashless treatment is available at Network Hospitals.

In order to avail of cashless treatment, the following procedure must be followed by You or your representative:

i. Prior to taking treatment and/or incurring Medical Expenses at a Network Hospital, You must call Us and request pre-authorization by way of the written form.

ii. In case of Planned hospitalization, You/the Insured Person/ Insured's representative shall intimate such admission before 48 hours of such hospitalization.

iii. In case of Emergency hospitalization, You/ Insured Person/ Insured's representative shall intimate such admission within 24 hours of such hospitalization.

iv. We offer Cashless Everywhere, even in hospitals which are not part of our network subject to hospitals fullfiing IRDAI definition of Hospital facility

v. On receipt of your pre-authorization form duly filled and signed by you, our representative then within 1 hour will respond with Approval, Rejection or more information.

vi. Once the final authorization request is received for discharge, the same will be processed within 3 hours from the final documents received.

vii. After considering Your request and after obtaining any further information or documentation We have sought, we may, if satisfied, send You or the Network Hospital, an authorisation letter.

viii. The authorisation letter, the ID card issued to You along with this Policy and any other information or documentation that We have specified must be produced to the Network Hospital identified in the pre-authorization letter at the time of Your admission to the same.

ix. If the procedure above is followed, you will not be required to directly pay for the bill amount in the Network Hospital that We are liable under In-Patient Hospitalisation Treatment above and the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.

ix. Pre- authorization does not guarantee that all costs and expenses will be covered. We reserve the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy.

B. Reimbursement Claims Procedure

If Pre-authorisation as per Cashless Claims Procedure for Cashless Facility above is denied by Us or if treatment is taken in a Hospital other than a Bajaj General Network Providers or if You do not wish to avail Cashless Facility, then:

i. You or someone claiming on Your behalf must inform Us in writing immediately within 48 hours of Hospitalisation in case of emergency Hospitalisation and 48 hours prior to Hospitalisation in case of planned Hospitalisation

ii. You must immediately consult a Medical Practitioner and follow the advice and treatment that he recommends.

iii. You must take reasonable steps or measures to minimize the quantum of any claim that may be made under this Policy.

iv. You must have Yourself examined by Our medical advisors if We ask for this, and as often as We consider this to be necessary at Our cost.

v. You or someone claiming on Your behalf must promptly and in any event within 30 days of discharge from a Hospital give Us the documentation as listed out in greater detail below and other information We ask for to investigate the claim or Our obligation to make payment for it.

vi. In the event of the death of the Insured Person, someone claiming on his behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if any) within 30 days

vii. If the original documents are submitted with the co-insurer, the Xerox copies attested by the co-insurer should be submitted.

Note:

1. In case You are claiming for the same event under an indemnity-based Policy of another insurer and are required to submit the original documents related to Your treatment with that particular insurer, then You may provide Us with the attested Xerox copies of such documents along with a declaration from the particular insurer specifying the availability of the original copies of the specified treatment documents with it.
2. Waiver of conditions (i) and (vi) may be considered in extreme cases of hardship where it is proved to Our satisfaction that under the circumstances in which You were placed, it was not possible for You or any other person to give notice or file claim within the prescribed time limit.

List of Claim documents:

1. Claim form with NEFT details & cancelled cheque duly signed by Insured Person.
2. Original/Attested copies of Discharge Summary / Discharge Certificate / Death Summary with Surgical & anesthetics notes.
3. Attested copies of Indoor case papers, if available.
4. Original/Attested copies Final Hospital Bill with break-up of surgical charges, surgeon's fees, OT charges etc.
5. Original Paid Receipt against the final Hospital Bill.
6. Original bills towards Investigations done / Laboratory Bills.
7. Original/Attested copies of Investigation Reports against Investigations done.
8. Original bills and receipts paid for the transportation from Registered Ambulance Service Provider. Treating Medical Practitioner certificate to transfer the Injured person to a higher medical Centre for further treatment (if Applicable).
9. Cashless settlement letter or other company settlement letter.
10. First consultation letter for the current ailment.
11. In case of implant surgery, invoice & sticker.

Additional documents for claim under Renewal Premium Waiver Benefit

1. Death certificate stating the reason of death.

Additional documents for claim under International Cover – Emergency Care only

1. Passport and Visa copy with Entry Stamp Overseas and exit Stamp from India
2. Release of Medical Information Form (ROMIF) BAJAJ and Assistance Provider (to be filled and signed by Insured) to obtain the medical records from facility.

Note- The list of documents given above is an indicative list and Insurer reserves rights for asking additional documents related to claim(s) in case required.

Please send the documents on below address, Bajaj General Insurance Limited,
2nd Floor, Bajaj Finserv Building,
Behind Weikfield IT park,
Off Nagar Road, Viman Nagar, Pune-411014
Toll free: 1800-103-2529, 1800-209-5858

Annexure I: List of Day Care Procedures

ENT	
1.	Stapedotomy
2.	Myringoplasty (Type I Tympanoplasty)
3.	Revision stapedectomy
4.	Labyrinthectomy for severe Vertigo
5.	Stapedectomy under GA
6.	Ossiculoplasty
7.	Myringotomy with Grommet Insertion
8.	Tympanoplasty (Type III)
9.	Stapedectomy under LA
10.	Revision of the fenestration of the inner ear
11.	Tympanoplasty (Type IV)
12.	Endolymphatic Sac Surgery for Meniere's Disease
13.	Turbinectomy
14.	Removal of Tympanic Drain under LA
15.	Endoscopic Stapedectomy
16.	Fenestration of the inner ear
17.	Incision and drainage of perichondritis
18.	Septoplasty
19.	Vestibular Nerve section
20.	Thyroplasty Type I
21.	Pseudocyst of the Pinna - Excision
22.	Incision and drainage - Haematoma Auricle
23.	Tympanoplasty (Type II)
24.	Keratosis removal under GA
25.	Reduction of fracture of Nasal Bone
26.	Excision and destruction of lingual tonsils
27.	Conchoplasty
28.	Thyroplasty Type II
29.	Tracheostomy
30.	Excision of Angioma Septum
31.	Turbinoplasty
32.	Incision & Drainage of Retro Pharyngeal Abscess
33.	UvuloPalatoPharyngoPlasty
34.	Palatoplasty
35.	Tonsillectomy without adenoidectomy
36.	Adenoidectomy with Grommet insertion
37.	Adenoidectomy without Grommet insertion
38.	Vocal Cord lateralisation Procedure
39.	Incision & Drainage of Para Pharyngeal Abscess
40.	Transoral incision and drainage of a pharyngeal abscess
41.	Tonsillectomy with adenoidectomy
42.	Tracheoplasty Ophthalmology
43.	Incision of tear glands
44.	Other operation on the tear ducts

45.	Incision of diseased eyelids
46.	Excision and destruction of the diseased tissue of the eyelid
47.	Removal of foreign body from the lens of the eye.
48.	Corrective surgery of the entropion and ectropion
49.	Operations for pterygium
50.	Corrective surgery of blepharoptosis
51.	Removal of foreign body from conjunctiva
52.	Biopsy of tear gland
53.	Removal of Foreign body from cornea
54.	Incision of the cornea
55.	Other operations on the cornea
56.	Operation on the canthus and epicanthus
57.	Removal of foreign body from the orbit and the eye ball.
58.	Surgery for cataract
59.	Treatment of retinal lesion
60.	Removal of foreign body from the posterior chamber of the eye

Oncology	
61.	IV Push Chemotherapy
62.	HBI-Hemibody Radiotherapy
63.	Infusional Targeted therapy
64.	SRT-Stereotactic Arc Therapy
65.	SC administration of Growth Factors
66.	Continuous Infusional Chemotherapy
67.	Infusional Chemotherapy
68.	CCRT-Concurrent Chemo + RT
69.	2D Radiotherapy
70.	3D Conformal Radiotherapy
71.	IGRT- Image Guided Radiotherapy
72.	IMRT- Step & Shoot
73.	Infusional Bisphosphonates
74.	IMRT- DMLC
75.	Rotational Arc Therapy
76.	Tele gamma therapy
77.	FSRT-Fractionated SRT
78.	VMAT-Volumetric Modulated Arc Therapy
79.	SBRT-Stereotactic Body Radiotherapy
80.	Helical Tomotherapy
81.	SRS-Stereotactic Radiosurgery
82.	X-Knife SRS
83.	Gammaknife SRS
84.	TBI- Total Body Radiotherapy
85.	intraluminal Brachytherapy
86.	Electron Therapy
87.	TSET-Total Electron Skin Therapy
88.	Extracorporeal Irradiation of Blood Products

89.	Telecobalt Therapy
90.	Telecesium Therapy
91.	External mould Brachytherapy
92.	Interstitial Brachytherapy
93.	Intracavity Brachytherapy
94.	3D Brachytherapy
95.	Implant Brachytherapy
96.	Intravesical Brachytherapy
97.	Adjuvant Radiotherapy
98.	Afterloading Catheter Brachytherapy
99.	Conditioning Radiothearpy for BMT
100.	Extracorporeal Irradiation to the Homologous Bone grafts
101.	Radical chemotherapy
102.	Neoadjuvant radiotherapy
103.	LDR Brachytherapy
104.	Palliative Radiotherapy
105.	Radical Radiotherapy
106.	Palliative chemotherapy
107.	Template Brachytherapy
108.	Neoadjuvant chemotherapy
109.	Adjuvant chemotherapy
110.	Induction chemotherapy
111.	Consolidation chemotherapy
112.	Maintenance chemotherapy
113.	HDR Brachytherapy

Plastic Surgery	
114.	Construction skin pedicle flap
115.	Gluteal pressure ulcer-Excision
116.	Muscle-skin graft, leg
117.	Removal of bone for graft
118.	Muscle-skin graft duct fistula
119.	Removal cartilage graft
120.	Myocutaneous flap
121.	Fibro myocutaneous flap
122.	Breast reconstruction surgery after mastectomy
123.	Sling operation for facial palsy
124.	Split Skin Grafting under RA
125.	Wolfe skin graft
126.	Plastic surgery to the floor of the mouth under GA

Urology	
127.	AV fistula - wrist
128.	URSL with stenting
129.	URSL with lithotripsy
130.	CystoscopicLitholapaxy
131.	ESWL

132.	Haemodialysis
133.	Bladder Neck Incision
134.	Cystoscopy & Biopsy
135.	Cystoscopy and removal of polyp
136.	Suprapubiccystostomy
137.	percutaneous nephrostomy
138.	Cystoscopy and "SLING" procedure.
139.	TUNA- prostate
140.	Excision of urethral diverticulum
141.	Removal of urethral Stone
142.	Excision of urethral prolapse
143.	Mega-ureter reconstruction
144.	Kidney renoscopy and biopsy
145.	Ureter endoscopy and treatment
146.	Vesico ureteric reflux correction
147.	Surgery for pelvi ureteric junction obstruction
148.	Anderson hynes operation
149.	Kidney endoscopy and biopsy
150.	Paraphimosis surgery
151.	injury prepuce- circumcision
152.	Frenular tear repair
153.	Meatotomy for meatal stenosis
154.	surgery for fournier's gangrene scrotum
155.	surgery filarial scrotum
156.	surgery for watering can perineum
157.	Repair of penile torsion
158.	Drainage of prostate abscess
159.	Orchiectomy
160.	Cystoscopy and removal of FB

Neurology	
161.	Facial nerve physiotherapy
162.	Nerve biopsy
163.	Muscle biopsy
164.	Epidural steroid injection
165.	Glycerol rhizotomy
166.	Spinal cord stimulation
167.	Motor cortex stimulation
168.	Stereotactic Radiosurgery
169.	Percutaneous Cordotomy
170.	Intrathecal Baclofen therapy
171.	Entrapment neuropathy Release
172.	Diagnostic cerebral angiography
173.	VP shunt
174.	Ventriculoatrial shunt

Thoracic surgery	
175.	Thoracoscopy and Lung Biopsy
176.	Excision of cervical sympathetic Chain Thoracoscopic
177.	Laser Ablation of Barrett's oesophagus
178.	Pleurodesis
179.	Thoracoscopy and pleural biopsy
180.	EBUS + Biopsy
181.	Thoracoscopy ligation thoracic duct
182.	Thoracoscopy assisted empyaema drainage

Gastroenterology	
183.	Pancreatic pseudocyst EUS & drainage
184.	RF ablation for barrett'sOesophagus
185.	ERCP and papillotomy
186.	Esophagoscope and sclerosant injection
187.	EUS + submucosal resection
188.	Construction of gastrostomy tube
189.	EUS + aspiration pancreatic cyst
190.	Small bowel endoscopy (therapeutic)
191.	Colonoscopy, lesion removal
192.	ERCP
193.	Colonscopy stenting of stricture
194.	Percutaneous Endoscopic Gastrostomy
195.	EUS and pancreatic pseudo cyst drainage
196.	ERCP and choledochoscopy
197.	Proctosigmoidoscopy volvulus detorsion
198.	ERCP and sphincterotomy
199.	Esophageal stent placement
200.	ERCP + placement of biliary stents
201.	Sigmoidoscopy w / stent
202.	EUS + coeliac node biopsy

General Surgery	
203.	Infected Keloid Excision
204.	Incision of a pilonidal sinus / abscess
205.	Axillary lymphadenectomy
206.	Wound debridement and Cover
207.	Abscess-Decompression
208.	Cervical lymphadenectomy
209.	infected sebaceous cyst
210.	Inguinal lymphadenectomy
211.	Incision and drainage of Abscess
212.	Suturing of lacerations
213.	Scalp Suturing
214.	Infected lipoma excision
215.	Maximal anal dilatation
216.	Piles a. Injection Sclerotherapy

	b. Piles banding
217.	Liver Abscess- catheter drainage
218.	Fissure in Ano- fissurectomy
219.	Fibroadenoma breast excision
220.	Oesophagealvarices Sclerotherapy
221.	ERCP - pancreatic duct stone removal
222.	Perianal abscess I&D
223.	Perianal hematoma Evacuation
224.	Fissure in anosphincterotomy
225.	UGI scopy and Polypectomyoesophagus
226.	Breast abscess I& D
227.	Feeding Gastrostomy
228.	Oesophagoscopy and biopsy of growth oesophagus
229.	UGI scopy and injection of adrenaline, sclerosants - bleeding ulcers
230.	ERCP - Bile duct stone removal
231.	Ileostomy closure
232.	Colonoscopy
233.	Polypectomy colon
234.	Splenic abscesses Laparoscopic Drainage
235.	UGI SCOPY and Polypectomy stomach
236.	Rigid Oesophagoscopy for FB removal
237.	Feeding Jejunostomy
238.	Colostomy
239.	Ileostomy
240.	colostomy closure
241.	Submandibular salivary duct stone removal
242.	Pneumatic reduction of intussusception
243.	Varicose veins legs - Injection sclerotherapy
244.	Rigid Oesophagoscopy for Plummer vinson syndrome
245.	Pancreatic Pseudocysts Endoscopic Drainage
246.	ZADEK's Nail bed excision
247.	Subcutaneous mastectomy
248.	Excision of Ranula under GA
249.	Rigid Oesophagoscopy for dilation of benign Strictures
250.	Eversion of Sac a. Unilateral b. Bilateral
251.	Lord's plication
252.	Jaboulay's Procedure
253.	Scrotoplasty
254.	Surgical treatment of varicocele
255.	Epididymectomy
256.	Circumcision for Trauma
257.	Meatoplasty
258.	Intersphincteric abscess incision and drainage
259.	Psoas Abscess Incision and Drainage
260.	Thyroid abscess Incision and Drainage

261.	TIPS procedure for portal hypertension
262.	Esophageal Growth stent
263.	PAIR Procedure of Hydatid Cyst liver
264.	Tru cut liver biopsy
265.	Photodynamic therapy or esophageal tumour and Lung tumour
266.	Excision of Cervical RIB
267.	268 laparoscopic reduction of intussusception
268.	Microdochectomy breast
269.	Surgery for fracture Penis
270.	Sentinel node biopsy
271.	Parastomal hernia
272.	Revision colostomy
273.	Prolapsed colostomy- Correction
274.	Testicular biopsy
275.	laparoscopic cardiomyotomy(Hellers)
276.	Sentinel node biopsy malignant melanoma
277.	laparoscopic pyloromyotomy (Ramstedt)

Orthopedics	
278.	Arthroscopic Repair of ACL tear knee
279.	Closed reduction of minor Fractures
280.	Arthroscopic repair of PCL tear knee
281.	Tendon shortening
282.	Arthroscopic Meniscectomy - Knee
283.	Treatment of clavicle dislocation
284.	Arthroscopic meniscus repair
285.	Haemarthrosis knee- lavage
286.	Abscess knee joint drainage
287.	Carpal tunnel release
288.	Closed reduction of minor dislocation
289.	Repair of knee cap tendon
290.	ORIF with K wire fixation- small bones
291.	Release of midfoot joint
292.	ORIF with plating- Small long bones
293.	Implant removal minor
294.	K wire removal
295.	POP application
296.	Closed reduction and external fixation
297.	Arthrotomy Hip joint
298.	Syme's amputation
299.	Arthroplasty
300.	Partial removal of rib
301.	Treatment of sesamoid bone fracture
302.	Shoulder arthroscopy / surgery
303.	Elbow arthroscopy
304.	Amputation of metacarpal bone

305.	Release of thumb contracture
306.	Incision of foot fascia
307.	calcaneum spur hydrocort injection
308.	Ganglion wrist hyalase injection
309.	Partial removal of metatarsal
310.	Repair / graft of foot tendon
311.	Revision/Removal of Knee cap
312.	Amputation follow-up surgery
313.	Exploration of ankle joint
314.	Remove/graft leg bone lesion
315.	Repair/graft achilles tendon
316.	Remove of tissue expander
317.	Biopsy elbow joint lining
318.	Removal of wrist prosthesis
319.	Biopsy finger joint lining
320.	Tendon lengthening
321.	Treatment of shoulder dislocation
322.	Lengthening of hand tendon
323.	Removal of elbow bursa
324.	Fixation of knee joint
325.	Treatment of foot dislocation
326.	Surgery of bunion
327.	intra articular steroid injection
328.	Tendon transfer procedure
329.	Removal of knee cap bursa
330.	Treatment of fracture of ulna
331.	Treatment of scapula fracture
332.	Removal of tumor of arm/ elbow under RA/GA
333.	Repair of ruptured tendon
334.	Decompress forearm space
335.	Revision of neck muscle (Torticollis release)
336.	Lengthening of thigh tendons
337.	Treatment fracture of radius & ulna
338.	Repair of knee joint Paediatric surgery
339.	Excision Juvenile polyps rectum
340.	Vaginoplasty
341.	Dilatation of accidental caustic stricture oesophageal
342.	PresacralTeratomas Excision
343.	Removal of vesical stone
344.	Excision Sigmoid Polyp
345.	SternomastoidTenotomy
346.	Infantile Hypertrophic Pyloric Stenosis pyloromyotomy
347.	Excision of soft tissue rhabdomyosarcoma
348.	Mediastinal lymph node biopsy
349.	High Orchidectomy for testis tumours
350.	Excision of cervical teratoma

351.	Rectal-Myomectomy
352.	Rectal prolapse (Delorme's procedure)
353.	Orchidopexy for undescended testis
354.	Detorsion of torsion Testis
355.	lap.Abdominal exploration in cryptorchidism
356.	EUA + biopsy multiple fistula in ano
357.	Cystic hygroma - Injection treatment
358.	Excision of fistula-in-ano

Gynaecology	
359.	Hysteroscopic removal of myoma
360.	D&C
361.	Hysteroscopic resection of septum
362.	thermal Cauterisation of Cervix
363.	MIRENA insertion
364.	Hysteroscopicadhesiolysis
365.	LEEP
366.	Cryocauterisation of Cervix
367.	Polypectomy Endometrium
368.	Hysteroscopic resection of fibroid
369.	LLETZ
370.	Conization
371.	polypectomy cervix
372.	Hysteroscopic resection of endometrial polyp
373.	Vulval wart excision
374.	Laparoscopic paraovarian cyst excision
375.	uterine artery embolization
376.	Bartholin Cyst excision
377.	Laparoscopic cystectomy
378.	Hymenectomy(imperforate Hymen)
379.	Endometrial ablation
380.	vaginal wall cyst excision
381.	Vulval cyst Excision
382.	Laparoscopic paratubal cyst excision
383.	Repair of vagina (vaginal atresia)
384.	Hysteroscopy, removal of myoma
385.	TURBT
386.	Ureterocoele repair - congenital internal
387.	Vaginal mesh For POP
388.	Laparoscopic Myomectomy
389.	Surgery for SUI
390.	Repair recto- vagina fistula
391.	Pelvic floor repair (excluding Fistula repair)
392.	URS + LL
393.	Laparoscopic oophorectomy

Critical care	
394.	Insert non- tunnel CV cath
395.	Insert PICC cath (peripherally inserted central catheter)
396.	Replace PICC cath (peripherally inserted central catheter)
397.	Insertion catheter, intra anterior
398.	Insertion of Portacath

NOTE:

i. Above mentioned list is a indicative list of procedures, any other surgeries/procedures requiring less than 24 hours hospitalisation due to technological advances will also be covered under this policy provided such procedures comply with the standard definition of Day Care Centre and Day Care treatment mentioned in the definitions.

ii. The standard exclusions and waiting periods are applicable to all of the above procedures depending on the medical condition/disease under treatment. Only 24 hours hospitalization is not mandatory.

Annexure II: For Consumables Plus

List I: List of Non-Medical Items

SL No	Item	
1	BABY FOOD	Not Payable
2	BABY UTILITIES CHARGES	Not Payable
3	BEAUTY SERVICES	Not Payable
4	BELTS/ BRACES	Not Payable
5	BUDS	Not Payable
6	COLD PACK/HOT PACK	Not Payable
7	CARRY BAGS	Not Payable
8	EMAIL I INTERNET CHARGES	Not Payable
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
10	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
11	LAUNDRY CHARGES	Not Payable
12	MINERAL WATER	Not Payable
13	SANITARY PAD	Not Payable
14	TELEPHONE CHARGES	Not Payable
15	GUEST SERVICES	Not Payable
16	CREPE BANDAGE	Not Payable
17	DIAPER OF ANY TYPE	Not Payable
18	EYELET COLLAR	Not Payable
19	SLINGS	Not Payable
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Not Payable
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Not Payable
22	TELEVISION CHARGES	Not Payable
23	SURCHARGES	Not Payable
24	ATTENDANT CHARGES	Not Payable
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Not Payable
26	BIRTH CERTIFICATE	Not Payable
27	CERTIFICATE CHARGES	Not Payable
28	COURIER CHARGES	Not Payable
29	CONVEYANCE CHARGES	Not Payable
30	MEDICAL CERTIFICATE	Not Payable
31	MEDICAL RECORDS	Not Payable
32	PHOTOCOPIES CHARGES	Not Payable
33	MORTUARY CHARGES	Not Payable
34	WALKING AIDS CHARGES	Not Payable
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable

36	SPACER	Not Payable
37	SPIROMETRE	Not Payable
38	NEBULIZER KIT	Not Payable
39	STEAM INHALER	Not Payable
40	ARMSLING	Not Payable
41	THERMOMETER	Not Payable
42	CERVICAL COLLAR	Not Payable
43	SPLINT	Not Payable
44	DIABETIC FOOT WEAR	Not Payable
45	KNEEBRACES (LONG/ SHORT/ HINGED)	Not Payable
46	KNEE IMMOBILIZER/S HOULDER IMMOBILIZER	Not Payable
47	LUMBOSACRAL BELT	Not Payable
48	NIMBUSBED ORWATER OR AIRBEDCHARGES	Not Payable
49	AMBULANCE COLLAR	Not Payable
50	AMBULANCE EQUIPMENT	Not Payable
51	ABDOMINAL BINDER	Not Payable
52	PRIVATE NURSES CHARGES - SPECIAL	Not Payable
53	SUGAR FREE TABLETS	Not Payable
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Not Payable
55	ECG ELECTRODES	Not Payable
56	GLOVES	Not Payable
57	NEBULISATION KIT	Not Payable
58	ANY KITWITH NO DETAILS MENTIONED [DELIVERYKIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
59	KIDNEY TRAY	Not Payable
60	MASK	Not Payable
61	OUNCE GLASS	Not Payable
62	OXYGEN MASK	Not Payable
63	PELVIC TRACTION BELT	Not Payable
64	PAN CAN	Not Payable
65	TROLLY COVER	Not Payable
66	UROMETER, URINE JUG	Not Payable
68	VASOFIX SAFETY	Not Payable

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

Sr No	Item
1	BABY CHARGES (UNLESS SPECIFIED /INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CARDLE CHARGES
6	COMB
7	EAU-DE-COLOGNE/ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK

16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINEFCTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES/ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCTDENTAL EXPENSES / MT SC. CHARGES (NOT EXPLATNED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

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

21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

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

Annexure III: For Consumable Expenses Cover
List Of Non-Medical Items

Sr No	Item
1	Belts/ Braces
2	Cold Pack/Hot Pack
3	Leggings
4	Crepe Bandage
5	Eyelet Collar
6	Slings
7	Blood Grouping And Cross Matching Of Donors Samples
8	Service Charges Where Nursing Charges Also Charged
9	Surcharges
10	Mortuary Charges
11	Walking Aids Charges
12	Oxygen Cylinder (For Usage Outside The Hospital)
13	Spacer
14	Spirometre
15	Nebulizer Kit
16	Steam Inhaler
17	Arm sling
18	Thermometer

19	Cervical Collar
20	Splint
21	Knee Braces (Long/ Short/ Hinged)
22	Knee Immobilizer/Shoulder Immobilizer
23	Lumbosacral Belt
24	Nimbus Bed Or Water Or Air Bed Charges
25	Ambulance Collar
26	Ambulance Equipment
27	Abdominal Binder
28	Ecg Electrodes
29	Gloves
30	Any Kit With No Details Mentioned [Delivery Kit, Orthokit, Recovery Kit, Etc]
31	Kidney Tray
32	Mask
33	Ounce Glass
34	Oxygen Mask
35	Pelvic Traction Belt
36	Pan Can
37	Trolly Cover
38	Urometer, Urine Jug
39	Vasofix Safety

Annexure IV- Description of procedures listed and Sub-limits applicable to individual procedures under Fetal Flourish

1. Amniocentesis:
   Procedure: A needle is inserted through the mother's abdomen into the amniotic sac to collect amniotic fluid.
   Timing: Usually performed from 16 weeks of gestation onwards.
   Indications: To detect chromosomal abnormalities (e.g., Down syndrome), genetic disorders, neural tube defects, and infections.

   Inclusions –
   Diagnostic testing for chromosomal abnormalities (Down's, Edwards, Patau), Genetic metabolic disorders in individuals with a positive family history, Severe structural anomaly detected on ultrasound, Maternal age >35 with high-risk screening, Recurrent unexplained miscarriages where chromosomal analysis is indicated, Congenital infection screening (TORCH, CMV).

   Exclusions -
   - Repeat testing for parental reassurance only.
   - Complications management beyond procedure (e.g., maternal infection not covered separately).
   - Litigation-related testing (paternity disputes).
   - Experimental testing not included in standard guidelines.
   - Procedures without prior screening justification.

2. Chorionic Villus Sampling (CVS):
   Procedure: A sample of chorionic villi (tiny projections from the placenta) is taken either through the cervix (transcervical) or the abdomen (transabdominal).
   Timing: Usually performed between 11 to 14 weeks of gestation (from date assigned by ultrasound).
   Indications: To diagnose chromosomal abnormalities and genetic disorders earlier in pregnancy compared to amniocentesis.

   Inclusions –

Genetic testing for early detection of chromosomal abnormalities, Indications based on abnormal first-trimester screen, Confirmatory testing for known parental genetic mutation, Recurrent genetic disorder history in family.

Exclusions –
- Repeat procedures after inadequate sampling without indication.
- Complications such as miscarriage management beyond primary cover.
- Testing outside recommended gestational age window.
- Investigational genetic studies not approved by medical boards.
- Procedures without prior screening justification.

3. Percutaneous Umbilical Blood Sampling (PUBS) or Cordocentesis:
Procedure: A needle is inserted through the mother's abdomen into the umbilical cord to obtain fetal blood.
Timing: Usually performed after 18 weeks of gestation.
Indications: To diagnose and treat fetal blood conditions, infections, and certain genetic disorders; also used for fetal blood transfusions.

Inclusions –
Diagnosis of fetal anemia, Intrauterine infection confirmation, Genetic and metabolic testing where amniocentesis/CVS is inconclusive, Guidance for intrauterine transfusion, Evaluation of platelet alloimmunization.

Exclusions -
- Non-standard investigational uses.
- Repeated cordocentesis for poor sampling unless indicated.
- Complications requiring neonatal intensive care beyond prenatal cover.
- Procedures without prior screening justification.

4. Fetal Tissue Biopsy:
Procedure: A sample of fetal tissue is obtained using a needle inserted through the mother's abdomen.
Timing: Varies depending on the condition being investigated.
Indications: To diagnose specific genetic disorders or structural abnormalities.

Inclusions –
Suspected fetal metabolic disorders requiring tissue confirmation.

Exclusions –
- Research-based procedures.
- Experimental therapies not listed in guidelines.
- Repeated biopsy without justification.
- Complication management outside fetal care.
- Procedures without prior screening justification.

5. Amnioinfusion:
Procedure: Saline or another fluid is infused into the amniotic sac via a needle through the abdomen.
Timing: Performed during pregnancy when there is a need to improve ultrasound imaging of the fetus.
Indications: To treat conditions like oligohydramnios (low amniotic fluid) and to improve ultrasound imaging of the fetus.

Inclusions –
Severe oligohydramnios with fetal compromise, Meconium dilution to prevent aspiration.

Exclusions –
- Repeated infusion for borderline cases without fetal distress.
- Associated maternal complications beyond immediate procedure.
- Non-standard solutions/experimental infusions.
- Procedures without prior screening justification.

6. Amnio-reduction
Procedure: Removal of excess amniotic fluid using a needle inserted into the amniotic sac under ultrasound guidance.
Timing: Usually performed in the second trimester, especially in cases of polyhydramnios or twin-to-twin transfusion syndrome (TTTS).
Indications: To relieve maternal symptoms, reduce uterine overdistension, and improve placental perfusion or manage TTTS.

Inclusions –
Twin-to-Twin Transfusion Syndrome (TTTS) with severe polyhydramnios, Polyhydramnios causing maternal respiratory compromise, Symptomatic relief in maternal distress, Ultrasound-guided therapeutic drainage.

Exclusions -
- Repeated procedures beyond guideline thresholds.
- Out-of-protocol interventions not supported by evidence.
- Experimental use outside TTTS/polyhydramnios.
- Procedures without prior screening justification.

7. Thoracoamniotic Shunt for Fetal Pleural Effusion
Condition: Accumulation of fluid in the fetal chest cavity (pleural effusion) can compress the lungs and heart.
Procedure: A shunt is placed to drain the fluid from the chest cavity into the amniotic sac.
Timing: Varies depending on the severity and progression of the effusion.
Benefits: Relieves pressure on the lungs and heart, improving fetal development and survival.

Inclusions –
Severe fetal pleural effusion with lung compression, Hydrops due to thoracic fluid accumulation.

Exclusions -
- Procedures without documented compromise.
- Replacements due to displacement unless medically justified.
- Non-standard devices.
- Procedures without prior screening justification.

8. Fetoscopy:
Procedure: A small camera (fetoscope) is inserted into the uterus through a small incision in the abdomen.
Timing: Typically performed after 18 weeks of gestation.

Inclusions –
Direct visualization for targeted fetal interventions, Entry for therapeutic procedures (laser, biopsy).

Exclusions –
- Experimental visualizations.
- Repeated procedures without indication.
- Complications unrelated to primary indication.
- Procedures without prior screening justification.

9. Fetoscopic Laser Surgery for Twin-to-Twin Transfusion Syndrome (TTTS):
Condition: TTTS is a condition that affects identical twins sharing a placenta where blood flow between the twins is imbalanced.
Procedure: Using a fetoscope, a laser is used to coagulate the abnormal blood vessels connecting the twins' circulations.
Timing: Typically performed between 16 and 26 weeks of gestation.
Benefits: Improves outcomes by balancing blood flow and reducing the risk of heart failure and other complications.

Inclusions –
Monochorionic twin pregnancies with TTTS, Laser coagulation of placental anastomoses / chorioangiomas.

Exclusions -
- Dichorionic pregnancies.
- Repeat procedures outside guideline-based recurrence.
- Procedures without prior screening justification.

10. Fetal Reduction

a. First Trimester Reduction

Procedure: Injection of potassium chloride into the heart of one or more fetuses under ultrasound guidance to reduce the number of fetuses in a multi-Fetal pregnancy.
Timing: Typically done between 11-14 weeks of gestation.
Indications: To reduce risks associated with high-order multiple pregnancies, including preterm birth, low birth weight, and maternal complications.

Inclusions –
High-order multiple pregnancies (≥3 fetuses), Maternal/fetal compromise due to crowding, Selective reduction in anomalous fetuses. (Genetic + Structural).

Exclusions –
- Elective reduction in uncomplicated twins.
- Procedures beyond recommended gestation window.
- Procedures without prior screening justification.

b. Selective Fetal Reduction (SFR) / Second Trimester Reduction

Procedure: SFR must be performed using a Vaso-occlusive technique only: Radiofrequency Ablation (RFA) or Bipolar Cord Occlusion (BCO) of the affected twin's umbilical cord.
Timing: The procedure is covered when performed during the second trimester, typically between 16 and 27 weeks of gestation, determined by the treating Fetal Medicine specialist.
Benefits: The primary goal is to improve the survival and reduce the risk of severe neurological injury to the remaining healthy co-twin, and to increase the gestational age at delivery.

Inclusions -
Covered for MCDA twin pregnancies complicated by severe pathologies, including severe Selective Fetal Growth Restriction (sFGR Type II/III), advanced Twin-to Twin Transfusion Syndrome (TTTS Stage III/IV), Twin Reversed Arterial Perfusion Sequence (TRAP), or major discordant fetal anomalies.

Exclusions -
- The use of chemical agents (e.g., Potassium Chloride/KCl injection),
- Procedures performed outside an accredited Fetal Therapy Center.
- Elective reduction without a severe medical indication.

11. Surgeries for neural tube defects

Procedure: Neural Tube Defects: Open or fetoscopic surgical repair of defects such as myelomeningocele (spina bifida).
Timing: NTD Repair: Usually between 19–26 weeks of gestation.

Inclusions –
Open or fetoscopic repair of spina bifida, Severe obstructive uropathy requiring shunt placement.

Exclusions –
- Mild anomalies not requiring intervention.
- Experimental procedures outside guidelines.
- Repeat surgeries for non-progressive defects.
- Requests without documented functional compromise.
- Procedures without prior screening justification.

12. Fetal Cystoscopic Surgery
Procedure: Fetal Cystoscopic Surgery for - Vesico-amniotic Shunt: Placement of a catheter between the Fetal bladder and amniotic cavity to relieve urinary tract obstruction.
Timing: Typically performed in the late first or early second trimester.

Inclusions –
Severe obstructive uropathy requiring shunt placement.

Exclusions –
- Mild anomalies not requiring intervention.
- Experimental procedures outside guidelines.
- Repeat surgeries for non-progressive defects.
- Requests without documented functional compromise.
- Procedures without prior screening justification.

13. Fetoscopic Endotracheal Occlusion (FETO) for Congenital Diaphragmatic Hernia (CDH):
Condition: CDH is a defect where abdominal organs herniate into the chest cavity, affecting lung development
Procedure: A balloon is placed in the fetal trachea to promote lung growth by blocking fluid from escaping the lungs. A second procedure is required later to remove the balloon.
Timing: Occlusion is typically performed between 27+0 and 29+6 weeks of gestation for severe cases. Balloon removal is performed in a second procedure, usually between 32 and 34 weeks of gestation, to allow for maturation before birth.
Benefits: Enhances lung development, improving survival rates and respiratory outcomes after birth.

Inclusions –
Severe congenital diaphragmatic hernia with poor prognosis, Fetoscopic balloon tracheal occlusion.

Exclusions –
- Cases with non-isolated CDH (major co-existing structural or chromosomal anomalies).
- Multiple gestations.
- Maternal contraindications (e.g., severe obesity, placenta previa).
- Short cervix (≤ 15mm).
- Mild/moderate CDH.
- Experimental balloon designs not approved.
- Repeat attempts without clear indication.
- Non-standard gestational age windows.
- Procedures without prior screening justification.

14. Amniotic Band Syndrome (ABS) Surgery:
Condition: ABS occurs when fibrous bands in the amniotic sac constrict fetal parts, leading to deformities or amputations.
Procedure: Using a fetoscope, the constricting bands are cut to release the affected fetal parts.
Timing: Varies depending on the severity and location of the bands.
Benefits: Prevents further damage and preserves the function and development of the affected parts.

Inclusions –
Documented limb constriction risk, Fetal survival/end-organ compromise due to bands, Fetoscopic release procedures.

Exclusions –
- Mild bands without compromise.
- Cosmetic-only correction.
- Repeated attempts with low success likelihood.
- Experimental techniques.
- Procedures without prior screening justification.

15. Fetal Aortic Valvuloplasty for Severe Aortic Stenosis:
Condition: Severe aortic stenosis can lead to underdevelopment of the left ventricle (hypoplastic left heart syndrome).
Procedure: A balloon is inserted into the fetal heart to open the narrowed aortic valve.
Timing: Usually performed between 20 and 30 weeks of gestation.
Benefits: Improves blood flow through the heart, promoting normal development of the left ventricle.

Inclusions –
Severe aortic stenosis with evolving hypoplastic left heart syndrome, Ultrasound-guided intrauterine balloon dilation.

Exclusions –
- Mild/moderate stenosis.
- Repeat dilations without progression.
- Procedures outside recommended gestation.
- Experimental catheter techniques.
- Procedures without prior screening justification.

16. Intra-uterine transfusion (IUT)
Procedure: Transfusion of compatible red blood cells directly into the Fetal umbilical vein or peritoneal cavity under ultrasound guidance.
Timing: Typically initiated after 18 weeks of gestation and may be repeated every 1–3 weeks until term.

Inclusions –
Severe fetal anemia (MCA PSV MoM > 1.5) (Rh isoimmunization, parvovirus), Platelet transfusion in alloimmune thrombocytopenia, Cordocentesis-guided transfusion, Blood product preparation, cross-matching, and procedure, Multiple transfusions as medically required (upto 2).

Exclusions -
- Elective transfusions for borderline anemia. (MCA PSV MoM < 1.5).
- Requests without documented cause.
- Use of untested/unapproved donor sources.
- Complications requiring NICU beyond fetal procedure cover
- Procedures without prior screening justification.

Table of sub-limits:

Procedure	Sub-limits (INR)
Amniocentesis	40,000
Chorionic Villus Sampling (CVS)	40,000
Percutaneous Umbilical Blood Sampling (PUBS) / Cordocentesis	15,000
Fetal Tissue Biopsy	20,000
Amnioinfusion	10,000
Amnio-reduction	15,000
Thoracoamniotic Shunt for Fetal Pleural Effusion	1,00,000
Fetoscopy	1,00,000
Fetoscopic Laser Surgery for TTTS	1,00,000
Fetal Reduction	50,000
Surgeries for Neural Tube Defects	1,00,000
Fetal Cystoscopic Surgery	1,00,000
Fetoscopic Endotracheal Occlusion (FETO) for CDH	1,00,000
Amniotic Band Syndrome (ABS) Surgery	1,00,000
Fetal Aortic Valvuloplasty for Severe Aortic Stenosis	1,00,000
Intra-uterine transfusion (IUT)	40,000

Annexure V:

List of Invasive Tests (excluded from Doctor Prescribed Investigations Cover – Pathology & Radiology expenses) related to Health Prime Rider:

Sr. No.	Invasive Test Names
1	USG guided kidney biopsy
2	Tru-cut biopsy breast
3	Excision biopsy of any lump
4	Prostate needle biopsy
5	Fine Needle Aspiration Cytology- FNAC
6	Pleural fluid cytology
7	Pleural Biopsy
8	Pleuroscopic Biopsy
9	Endometrial Biopsy
10	Upper GI Endoscopy
11	Upper GI Endoscopic Biopsy
12	Colonoscopy
13	Colonoscopy Biopsy
14	Diagnostic Laparoscopy
15	Office Hysteroscopy
16	Cystoscopy
17	Cystoscopy with bladder biopsy
18	Urethroscopy
19	MRI guided breast biopsy
20	MRI Fusion Biopsy
21	USG guided biopsy of abdominal organs
22	USG guided biopsy of pelvic organs
23	Core biopsy of Brest
24	Incisional biopsy of breast
25	Bronchoscopy
26	Bronchoscopy guided biopsy
27	CT Angiography
28	Coronary Angiography
29	CT guided lung biopsy
30	CT guided bone biopsy
31	CT guided biopsy of growth- Abdomen/ Chest/ Pelvic/ Paraspinal region
32	Lumbar Puncture
33	CSF biopsy
34	CSF liquid biopsy
35	Oral biopsy
36	ENT Endoscopic biopsy
37	Lymph node biopsy
38	Hysteroscopy biopsy

Annexure VI: ICD specific for Mental Illness

ICD Codes	Description
F00-F09	Organic, including symptomatic, mental disorders
F20-F29	Schizophrenia, schizotypal and delusional disorders
F30-F39	Mood [affective] disorders
F40-F48	Neurotic, stress-related and somatoform disorders
F50-F59	Behavioral syndromes associated with physiological disturbances and physical factors
F60-F69	Disorders of adult personality and behavior
F80-F89	Disorders of psychological development
F90-F98	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99	Unspecified mental disorder

Table of Benefits

My Health Care Plan	
Inbuilt Cover	EDGE+ (Plan 9)
In-Patient Hospitalization Expenses	5/7.5/10/15/20/25/30/3 5/40/45/50/75 lakhs and 1/2/3/4/5 Crore
Room Rent	Single Private A/c ICU -At actuals
Pre-Hospitalisation Medical Expense	60 days
Post-Hospitalisation Medical Expense	90 days
Modern Treatment Methods and Advancement in Technologies	Up to SI
AYUSH Hospitalization Cover	Up to SI
Day Care Treatment	Up to SI
Organ Donor Expenses	Up to SI
Road Ambulance	Up to SI
Domiciliary Hospitalization	Up to SI
Family Visit	Sub-limit of 25,000 till 10 Lakhs SI and 50,000 for above 10 Lakhs
Cumulative Bonus	25% upto 100%
Sum Insured Reinstatement	Unlimited
RenewalPremium Waiver Benefit	Yes

Waiting Period	
Pre-Existing Diseases Waiting Period	36 months
Specified disease/procedure Waiting Period	24 months
Initial Waiting period	30 days

Optional covers	
Air Ambulance	Emergency helicopter/airplane evacuation from the site of illness/accident to the nearest hospital (within India). Max up to 10 lakhs
Major Illness and Accident Multiplier (Indemnity)	Enhances your Sum Insured to 2 times for listed critical illnesses.
Double Sum Insured Benefit	Doubles of your base In-patient Sum Insured, usable across multiple admissible claims in that policy year.
Cost of Prescribed External Medical Aid	Reimbursement for medically prescribed external aids post an admissible In-patient claim like braces, supports, devices and more. 10% of SI, max up to 5 lakhs.
Super CB	50% up to 200% 50% up to 500% 100% up to 200% 100% up to 500% 100% up to 600%
International Cover- Emergency Care Only	Covers In patient emergencies abroad
Consumables Expenses	Up to In-patient SI

Add-on/ Riders	
Global Cover	For SI above 10 Lakhs Planned & Emergency (with co-pay - 10%, 20%, 30%, 40%, 50%)
Consumables Plus	For SI above 10 lakhs Up to In-patient SI
Smart Tenure	Consolidates annual base Sum Insured across a multi-year policy. Applicable for Individual Policy

StepUp Benefit	Once in a lifetime option to enhance Sum Insured to the next available slab at first Renewal(R1), with continuity of waiting period on the enhanced slab if the previous year was claim free.
Health Limitless (For SI 10 lakhs & above)	One-claim without any limit
NRInsure	35% discount on premium for NRIs/OCIs who reside abroad for the entire policy year (proof of documents required and Indian bank account needed).
Insta Shield	Get covered from 31st day for hospitalization (including pre/post) due to listed lifestyle conditions like asthma, hypertension, hyperlipidemia, diabetes mellitus, obesity, and hypothyroidism.
Fetal Flourish	Lump sum payment towards 16 in-utero procedures for the unborn baby up to INR 2,00,000 per maternity event.
HPR	HPR - All options
Age Shield	Pay entry age premium until a claim is paid

Variation Available	
Options Available for Room Rent	Twin Sharing
	Single Pvt Ac (Default)
	Actuals
Options Available for Change in PED waiting Period	1 year
	2 years
	3 years (Default)
Options Available for Change in Specific Disease waiting Period	1 year
	2 years