POLICY WORDING

MY HEALTH CARE PLAN (PLAN 1)

SECTION A) PREAMBLE

Whereas the Proposer (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 shall be the basis of this Contract and is deemed to be incorporated herein, containing certain undertakings, declarations, information/particulars and statements, which is hereby agreed to be the basis of this Contract and be considered as incorporated herein, for the insurance Contract hereinafter contained and has paid the premium specified in the Policy Schedule hereto as consideration for such insurance Contract, now the Company agrees, subject to the Policy Schedule and the following terms, conditions, exclusions, and limitations of the Policy, and in excess of the amount of the Deductible, to indemnify the Insured in the manner and to the extent hereinafter stated.

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
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. 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 (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a Specialist Medical Practitioner.

26. 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.

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

28. 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

29. 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 or Ayurvedic and or such other authorities 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), 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

30. 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

31. 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.

32. 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.

33. 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.

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

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

36. 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.

37. 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.

38. 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.

39. 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.

40. 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.

41. 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.

42. 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.

43. 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.

44. Room rent

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

45. 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

46. 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. Assisted reproductive technology
Assisted reproductive technology includes medical procedures used primarily to address infertility. This subject involves procedures such as in vitro fertilization, intracytoplasmic sperm injection, cryopreservation of gametes or embryos, and/or the use of fertility medication.

5. 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.

6. 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.

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

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 and 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. 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.

13. Medical Consumable
Medical consumables and equipment includes 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.

14. Named Insured/ Insured/Insured Person/Insured Beneficiary:
Insured means the persons, or his Family Members, named in the Schedule provided that an Insured or his Family Members has attained the age of 3 months and is not older than 65 years of age at the commencement of the Policy Period.

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

16. 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

17. Per Claim Deductible
Per claim 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. The deductible is applicable per claim towards hospitalisation expenses incurred during the policy period.

18. 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.

19. 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.

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

21. 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 etc., shall be treated as a separate Policy Year.

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

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

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

25. Twin Sharing Room
Twin Sharing room means a Hospital room with two patient beds.

26. 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.

27. We, Our, Ours

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

SECTION C) COVERAGE

Scope of cover:

The Company hereby agrees to indemnify Insured 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 and definitions, exclusions contained or otherwise expressed in this Policy.

1. In-patient Hospitalisation Treatment

If You are Hospitalised for Inpatient 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 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, 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 Part I and Part II, 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.

2. Pre-Hospitalisation Medical Expense

We will indemnify you against the Reasonable and Customary Medical Expenses incurred, as per the option 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".

Please refer to Table of Benefits for plan wise options.

3. Post-Hospitalisation Medical Expense

We will indemnify You against the Reasonable and Customary Medical Expenses incurred, as per the option 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 are incurred in respect of the same Illness/Injury for which the earlier Hospitalisation was required,

ii. The Company has accepted an Inpatient Care claim under "In-patient Hospitalisation Treatment".

Please refer to Table of Benefits for plan wise options.

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 Inpatient 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. Day Care Treatment

We will indemnify You against the Reasonable and Customary Medical Expenses up to Inpatient Hospitalization Treatment Sum Insured for Day care procedures / surgeries taken as an Inpatient in a Hospital or Day care centre but not in the Outpatient department.

Indicative list of Day Care Treatments is given in Annexure I of this Policy document.

6. Organ donor expenses

We will indemnify You against the expenses incurred towards organ donor's treatment for harvesting of the donated organ up to Inpatient 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) BILL, and

ii. We have accepted an In-patient Hospitalisation treatment claim for the Insured Beneficiary/ies under "In-patient Hospitalisation Treatment".

iii. We will pay if Insured Beneficiary 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) Multiplier Benefit, Sum Insured Reinstatement, Recharge, Double Sum Insured Benefit will not be applicable for/under Organ donor expenses cover.

7. 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.

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. Maternity Package Expenses

A. Maternity Expenses

We will indemnify You against the Medical Expenses for the delivery of a baby (including caesarean section) and/or expenses related to medically recommended and lawful termination of pregnancy, limited to maximum 2 deliveries or termination(s) or either during the lifetime of the Insured Beneficiary,

i. Our maximum liability per delivery or termination shall be as per the Maternity Package limit specified in the Policy Schedule.
ii. We will pay the In-patient Medical Expenses of pre-natal (complete pre-natal period) and post-natal hospitalization (up to 90 days post-delivery) per delivery or termination up to the Maternity Package limit.
iii. The above cover will be subject to a waiting period as mentioned on the Policy Schedule which would apply from the date of issuance of the first My Health care Plan with Us.
iv. Maternity Package Expense Waiting Period mentioned on the Policy Schedule will decrease by 1 year if long term policy is opted and the entire premium is paid up front.
v. Fresh waiting period as specified on the Policy Schedule would apply for all the policies issued with continuity from other health indemnity product/plans where maternity expenses are not covered.
vi. This cover is applicable for Insured Beneficiary up to 45 years of age.

Please refer to Table of Benefits for plan wise coverages/options and waiting period.

B. Maternity expenses for Surrogacy

If the Insured Beneficiary has opted for maternity through surrogacy then We will indemnify for the maternity expenses incurred for the respective Surrogate mother provided that the necessary documents related to Surrogacy are furnished at the time of claims.

All other terms and conditions would be as per the "A. Maternity expenses" above

C. Complications of Assisted reproductive procedures/technology (ART)

If You are hospitalized for In-patient Care on the advice of a Medical Practitioner because of complications arising out of assisted reproductive procedures during the Policy Period, then We will indemnify You against the Reasonable and Customary Medical Expenses incurred up to Maternity Package limit specified in Policy Schedule.

We will also indemnify You against In-patient hospitalization expenses incurred, up to Maternity Package limit, because of complications arising out of assisted reproductive procedures, for the oocyte donor provided that

i. The Insured Beneficiary is the recipient of the oocyte.
ii. Necessary documents related to oocyte donation are furnished at the time of claims.

Note: This cover is applicable for Insured Beneficiary up to 45 years of age.
Please refer to Table of Benefits for plan wise coverages/options and waiting period.

10. Baby Care (The Sum Insured for this cover would be over and above the In- patient Hospitalization Sum Insured)

We will indemnify You against Reasonable and Customary hospitalization expenses incurred for your new-born baby, for In-patient Hospitalization on the advice of a Medical Practitioner because of Illness or Injury sustained or contracted during the Policy Period.

The below listed expenses would be indemnified up to Baby Care Sum Insured specified in Policy Schedule:

i. Room rent, boarding expenses as per the Room limit/category specified on the Policy Schedule for In-patient Hospitalization Treatment
ii. If admitted in ICU, the Company will pay 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, Consumables, Dialysis, Chemotherapy, Radiotherapy, physiotherapy
vii. Relevant laboratory diagnostic tests, X-ray and such similar expenses that are medically necessary prescribed by the treating Medical Practitioner.

Specific conditions applicable to Baby Care

a) The above cover will be subject to a waiting period as mentioned on the Policy Schedule which would apply from the date of issuance of the first My Health care Plan with Us.
b) Baby Care Waiting Period mentioned on the Policy Schedule will decrease by 1 year if long term policy is opted and the entire premium is paid up front.
c) The baby should be born during the Policy Period.
d) You should intimate Us about the birth of your baby within 90 days of delivery.
e) The Policy will cover the baby in subsequent renewals subject to payment of premium.

Please refer to Table of Benefits for plan wise coverages/options and waiting period.

11. Out-patient Treatment Expenses (OPD)

We will cover the Insured or Insured Beneficiary, in respect of an admissible claim during the Policy Period for any or all of the following covers if available under the specific plan of My Health Care Plan and as per limits specified in the Policy Schedule.
This is subject to the Policy terms, conditions and definitions, exclusions.

i. Tele (Insta) Consultation Cover
ii. Doctor Consultation Cover (In-clinic)
iii. Doctor prescribed Investigations Cover – Pathology & Radiology Cover
iv. Annual Preventive Health Check-up cover

I. Tele (Insta) Consultation Cover

If the Insured Beneficiary 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 via video, audio, or chat channel, where the Insured Beneficiary will be able to select the speciality 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.

Specific conditions for Tele (Insta) Consultation Cover

1. Only 1 (one) active Doctor consultation is allowed at any given time and the Insured Beneficiary can book/utilize next consultation post completion of ongoing consultation.
2. Each Insured Beneficiary is allowed to utilize a maximum of 5 consultations per day.
3. Insured Beneficiary can book/utilize a maximum of 15 online consultations per month.

Exclusions for Tele (Insta) Consultation Cover

1. Tele consultation outside the Digital platform of Insurer or 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 beneficiary unless the beneficiary is covered under the Policy & 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 during the Policy Period.
4. Reimbursement of teleconsultation benefit is not permitted
5. Initial 30 days waiting period is applicable on tele-consultation required for illness during the first year of Policy Period. This waiting period is not applicable for renewals.
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 My Heath Care Plan and the Policy Schedule with Us.
   b) The PED waiting period as opted would be specified on the Policy Schedule.
   c) If the Insured Beneficiary 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.

II. A. Doctor Consultation Cover (In-clinic) (Cashless and Reimbursement)

If the Insured/Insured beneficiary/ies 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 or on reimbursement basis with prior approval in non-network centres up to the limit as specified under this Policy read with Policy Schedule.

B. Doctor Consultation Cover (In-clinic) Cashless Service

If the Insured/Insured beneficiary/ies 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 Policy read with Policy Schedule. This is a cashless service.

If there is no facility of cashless Doctor Consultation in your location, then Insured Beneficiary/s can take a prior approval for consulting the Doctor/Medical Practitioner and claim the charges/consultation fees by way of reimbursement process as defined under claim process. Sub-limit of INR 500 for general physician and INR1,200 for specialists per consultation as specified under the plan.

Specific conditions for Doctor Consultation Cover (In-clinic)

1. Only 1 (one) active Doctor consultation is allowed at any given time and the Insured Beneficiary can book/utilize next consultation post completion of ongoing consultation.
2. Each Insured Beneficiary is allowed to utilize a maximum of 5 consultations per day, subject to the cover limit specified in the Policy Schedule.
3. Insured Beneficiary can book/utilize a maximum of 15 consultations per month.

Exclusions for Doctor Consultation Cover (In clinic)

1. Other expenses of investigations, medicines, procedures or any medical, non-medical items are not covered.
2. Doctor consultation cover is not transferrable to any other person unless the person is covered under the same Policy.
3. If the Doctor consultation is not availed in the Policy year during the Policy Period, the benefit cannot be carried forward to the subsequent Policy year
4. Initial 30 days waiting period is applicable for consultation required for Illness during the first year of this Policy. This waiting period is not applicable for renewals.
5. The plan does not cover yoga, naturopathy, reiki, acupuncture, acupressure, physiotherapy, psychiatric counselling, diet counselling.
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 My Heath Care Plan and the Policy Schedule with Us.
   b) The PED waiting period as opted would be specified on the Policy Schedule.
   c) If the Insured Beneficiary 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.

III. A. Doctor Prescribed Investigations Cover – Pathology & Radiology Expenses – Cashless and Reimbursement

If the Insured/Insured beneficiary/ies is suffering from any Illness or injury, he / she can avail investigation prescribed by a registered Medical Practitioner for pathology or radiology as a cashless service in network centres of our Service Providers or on reimbursement basis with prior approval in non-network centres up to the limit as specified under this Policy Schedule.

B. Doctor Prescribed Investigations Cover – Pathology & Radiology Expenses Cashless Service

If the Insured/Insured Beneficiary/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 the limit as specified in the Policy Schedule. This is a cashless service.

If there is no cashless facility in your location for Investigations Cover – Pathology & Radiology then Insured Beneficiary/s can take a prior-approval for the prescribed investigations and claim the expenses by way of reimbursement process as defined under claim process. The investigation expenses would be payable up to the limit specified on the Policy Schedule.

Note: A co-payment of 20% will be applicable on all reimbursement claims which are not pre-approved.

Exclusions for Doctor Prescribed Lab and Radiology Cover

1. Any Lab or Radiology investigation which is not prescribed by a Medical Practitioner will not be covered.
2. Investigation cover is not transferrable to any other person unless the person is covered under the same Policy.
3. If the Investigation cover is not availed in the respective policy year, the benefit cannot be carried forward to the subsequent policy year after renewal.
4. Initial 30 days waiting period is applicable for investigations Cover- Pathology & Radiology expenses related to illness during the first year of Policy. This waiting period is not applicable for renewals.
5. 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 My Heath Care Plan and the Policy Schedule with Us.
   b) The PED waiting period as opted would be specified on the Policy Schedule.
   c) If the Insured Beneficiary 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.

IV. Annual Preventive Health Check -up cover:

The Insured Beneficiary/ies can avail the Preventive health check-up once in every Policy Year as per the list given below on cashless basis only in the network centres of our Service Provider.

Test	Component
CBC	MCV, RBC Count, Platelet Count, Eosinophils, Basophils, MCHC, PCV, ESR, Haemoglobin, Lymphocytes, WBC Count, Peripheral Smear, RDW, Haematocrit, Leucocyte, Neutrophils
ESR	ESR
Liver function test	SGOT, SGPT, Bilirubin, GGT, Total Protein
Urine routine	Specific Gravity, Appearance, Bacteria, Urinary Bilirubin, Urine Blood, Urobilinogen, Bile Pigment, Bile Salt, Casts, Colour, Crystals, Epithelial Cells, Urinary Glucose, Urine Ketone, Urinary, Leucocytes (Pus Cells), Microalbumin, Mucus, Nitrite, Parasite, PH, Urinary Protein, Red Blood Cells, Volume, Yeast
Sugar Profile	Blood sugar – Fasting, HbA1C
Lipid profile	Total Cholesterol/HDL/LDL/Triglycerides
KFT	Blood Urea, Serum Creatinine
Thyroid	T3, T4, TSH

The list of tests 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 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 the Policy.
6. Initial 30 days waiting period is applicable for investigations related to Illness during the first year of Policy Period. This waiting period is not applicable for renewals.

List of network Hospitals or diagnostic centres can be accessed from the Insurer's website for:

- Doctor Consultation Cover (In clinic)
- Doctor prescribed Investigations Cover – Pathology & Radiology Cover
- Annual Preventive Health Check-up cover

12. Domiciliary Hospitalization

We will indemnify You against Reasonable and Customary Medical Expenses for Medical Treatment for an 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

13. Home Nursing Benefit

If we have paid a claim for In-patient hospitalization Treatment and on advice of the treating Doctor if a Registered Nurse is engaged for post-hospitalization care, We will pay fixed weekly benefit amount as specified in Policy Schedule for a period up to 10 weeks subject to the below conditions:

a. Home Nursing must be recommended by treating Doctor with valid medical certificate stating the reason for providing Nursing Care at Home.

b. The benefit will not be paid for more than 10 weeks per Policy Year.

c. Claim for Home Nursing shall be paid only if we have paid a claim for In-patient hospitalization Treatment cover.

d. You were Hospitalized in preceding 10 days period for the same illness/injury.

e. A valid bill from the Nursing Bureau with number of days of service utilization along with dates should be provided at the time of claims.

Please refer to Table of Benefits for plan wise coverage options.

14. Cost of Prescribed External Medical Aid

We will indemnify you against the Reasonable and Customary Expenses incurred for External Medical Aids prescribed by a treating Medical Practitioner for the specific illness or injury against which the claim is accepted by Us provided that We have accepted Insured Beneficiary's Claim under "In-patient Hospitalisation Treatment".

Please refer to Table of Benefits for plan wise coverage options.

Note- If this Cover is part of your plan, then Exclusion D. Specific Exclusion 5 is deemed to be inoperative for this cover.

15. Sum Insured Reinstatement

The In-patient Hospitalisation Treatment Sum Insured would be "reinstated" up to number of 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.

16. Airlift Cover

We will indemnify you against the Reasonable and Customary expenses incurred on airlift facility for life threatening health conditions which require transportation from Insured Beneficiary's location to a Hospital. This facility can be availed voluntarily. This cover is applicable only if available under the plan as specified in the Policy Schedule.

Claim under this section shall be payable subject to the below conditions:

i. Such life-threatening condition is certified by the Medical Practitioner,

ii. We have accepted Insured Beneficiary's Claim under "In-patient Hospitalisation Treatment" or "Day Care Treatment" section of the Policy.

iii. Distance between Insured beneficiary's location and hospital is more than 200 kms.

iv. Pre-approval is mandatory for making a claim under this cover.

v. This cover is applicable only for Airlift facility availed within Indian Geographical limits.

Please refer to Table of Benefits for plan wise coverage options.

17. Cumulative Bonus

Cumulative Bonus ("CB") 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 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.

Please refer to Table of Benefits for plan wise options.

18. 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 for 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.

i. This claim would be admissible if claim is accepted by Us under "In-patient Hospitalisation Treatment".

ii. 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.

iii. Only domestic travel expenses will be paid.

Please refer to Table of Benefits for plan wise coverage options.

19. Renewal Premium Waiver Benefit

In event of death of the proposer (who is also an Insured Beneficiary during the Policy Period due to Accidental Injury or Illness, we will pay the renewal premium of My Health Care Plan for the dependant Insured Beneficiary/ies covered under the Policy for same coverages.
The renewal premium as per My Health Care Plan premium table is payable only for one Policy Year for the dependent Insured Beneficiary/ies 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.

20. Consumable Expenses

We will indemnify You against the Non-Medical Expenses/ consumables (as specified in Annexure IV) incurred during treatment of the Insured Beneficiary 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.

OPTIONAL COVERS

In consideration of payment of additional premium by the Insured to the Company and realization thereof by the Company, it is hereby agreed that Insurer will pay benefit amount under cover or indemnify Insured 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 and definitions, exclusions contained or otherwise expressed in this Policy.

1. Loss of Income Cover

If this cover is opted and if the Insured Beneficiary is Hospitalized during the Policy Period for a minimum of 72 consecutive hours on the advice of a Doctor/ Medical Practitioner because of Accidental Injury and Any Illness/Any Illness excluding Infection as per the plan opted and mentioned on the Policy Schedule, then the Company will make a weekly payment as per the amount shown under the heading "Loss of income" in the Policy Schedule, subject otherwise to all other terms, conditions and exclusions of the Policy.

The benefit amount pay-out is as per the below grid

Number of Days of per Hospitalization	No of weeks of Benefit paid
3 days to 5 days	1 week
6 days to 10 days	2 weeks
11 days to 20 days	4 weeks
21 days to 30 days	6 weeks
Above 30 days	8 weeks

Specific Conditions applicable to Loss of Income cover-

- The Company shall make weekly payment/s as per the above table subject to a maximum period of 25 weeks cumulatively during the Policy Year.
- Claim for Loss of Income shall be paid only if We have accepted a claim for In-patient Treatment under Policy in respect of the same Hospitalization.

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 up to number of 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. 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, Maternity Package expenses 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, Recharge, Cumulative Bonus, Super Cumulative Bonus, Major Illness and Accident Multiplier or Double Sum Insured Benefit accrued cannot be used for payment of claims under International Cover – Emergency Care only.

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

SECTION D) 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 specified number of months of continuous coverage after the date of inception of the first My Heath Care Plan 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 Beneficiary 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.

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 specified number of months of continuous coverage after the date of inception of the first My Health Care Plan 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.
b) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increased.
c) If any of the specified disease/procedure falls under the Waiting Period specified for Pre-Existing diseases, then the longer of the two Waiting Periods shall apply.
d) The Waiting Period for below listed conditions shall apply even if contracted after the Risk Inception Date of Policy Schedule or declared and accepted without a specific exclusion.
e) If the Insured Beneficiary is continuously covered without any break as defined under the applicable norms on Portability stipulated by IRDAI, then Waiting Period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures is as below:

1. Any type gastrointestinal ulcers	17. Cataracts
2. Any type of fistula	18. Macular Degeneration
3. Benign prostatic hypertrophy	19. Hernia of all types
4. All types of sinuses	20. Fissure in ano
5. Haemorrhoids, piles	21. Hydrocele
6. Dysfunctional uterine bleeding	22. Fibromyoma
7. Endometriosis	23. Hysterectomy
8. Uterine Prolapse	24. Stones in the urinary and biliary systems
9. Surgery on ears/tonsils/ adenoids/ paranasal sinuses	25. Surgery on all internal or external tumours /cysts/ nodules/polyps of any kind including breast lumps except malignancy
10. Diseases of gall bladder including cholecystitis	26. Pancreatitis
11. All forms of Cirrhosis	27. Gout and rheumatism
12. Surgery for varicose veins and varicose ulcers	28. Chronic Kidney Disease
13. Alzheimer's Disease	29. Joint replacement surgery
14. Surgery for vertebral column disorders (unless necessitated due to an Accident)	30. Surgery to correct deviated nasal septum
15. Hypertrophied turbinate	31. Congenital internal diseases or anomalies
16. 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 Beneficiary 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.

4. Maternity Package Expenses Waiting Period

Any treatment arising from or traceable to pregnancy, child birth including caesarean section and/or any treatment related to pre and postnatal care and complications arising out of Pregnancy and Childbirth until the specified period of continuous coverage has elapsed since the inception of the first My Health Care Plan with Us.

The Maternity Package Expenses Waiting Period as opted would be specified on the Policy Schedule. Maternity Package Expense waiting period mentioned on the Policy Schedule will decrease by 1 year if long term Policy is opted and the entire premium is paid up front.

This exclusion will not apply to Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.

5. Baby Care Waiting Period

In-patient Hospitalization treatment expenses of your new born baby (born during the Policy Period), shall be excluded until the expiry of specified period of continuous coverage, after the date of inception of the first My Health Care Plan with Us.

The Baby Care waiting period as opted would be specified on the Policy Schedule.
Baby Care waiting period mentioned on the Policy Schedule will decrease by 1 year if long term Policy is opted and the entire premium is paid up front.

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 Beneficiary 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 Beneficiary 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 waiting period stands deleted if Maternity Package Expenses is covered under the respective plan of My Health Care Plan.

SECTION D) EXCLUSIONS - 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 Injury to natural teeth and also requiring Hospitalisation.
2. Medical Expenses where Inpatient care is not warranted and does not require supervision of qualified nursing staff and qualified medical practitioner round the clock
3. 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 Schedule.
4. The cost of spectacles, contact lenses, hearing aids, dentures, artificial teeth and similar expenses.
5. External medical equipment of any kind used at home as post Hospitalisation care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition.
6. 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.
7. Intentional self-Injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol).
8. 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.

9. All non-medical Items as per Annexure II.
10. Any medical treatment received outside India is not covered under this Policy except in case of optional cover - "International Cover-emergency care only" is opted.
11. Circumcision unless required for the treatment of Illness or Accidental bodily Injury.
12. Treatment for any other system other than modern medicine (allopathy) and AYUSH therapies.

Exclusions specific to OPD cover

Exclusions for Tele (Insta) Consultation Cover

1. Tele consultation outside the Digital platform of Insurer or 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 beneficiary unless the beneficiary is covered under the Policy & 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 during the Policy Period.
4. Reimbursement of teleconsultation benefit is not permitted.
5. Only 1 (one) active Doctor consultation is allowed at any given time and the Insured member can book next consultation post completion of ongoing consultation.
6. Each Insured person is allowed to utilize a maximum of 5 consultations per day.
7. Insured member can book a maximum of 15 online consultations per month.
8. Initial 30 days waiting period is applicable on tele-consultation required for illness during the first year of Policy Period. This waiting period is not applicable for renewals.
9. 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 My Heath Care Plan and the Policy Schedule with Us.
    b) The PED waiting period as opted would be specified on the Policy Schedule.
    c) If the Insured Beneficiary 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 Consultation Cover (In clinic)

1. Other expenses of investigations, medicines, procedures or any medical, non-medical items are not covered.
2. Doctor consultation cover is not transferrable to any other person unless the person is covered under the same Policy.
3. If the Doctor consultation is not availed in the Policy year during the Policy Period, the benefit cannot be carried forward to the subsequent Policy year
4. Initial 30 days waiting period is applicable for consultation required for Illness during the first year of this Policy. This waiting period is not applicable for renewals.
5. The plan does not cover yoga, naturopathy, reiki, acupuncture, acupressure, physiotherapy, psychiatric counselling, diet counselling.
6. Only 1 (one) active Doctor consultation is allowed at any given time and the Insured member can book next consultation post completion of ongoing consultation.
7. Each Insured member is allowed to utilize a maximum of 5 consultations per day, subject to the cover limit specified in the Policy Schedule.
8. Insured person can book a maximum of 15 consultations per month.

9. 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 My Heath Care Plan and the Policy Schedule with Us.
   b) The PED waiting period as opted would be specified on the Policy Schedule.
   c) If the Insured Beneficiary 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 Lab and Radiology Cover

1. Any Lab or Radiology investigation which is not prescribed by a Medical Practitioner will not be covered.
2. Investigation cover is not transferrable to any other person unless the person is covered under the same Policy.
3. If the Investigation cover is not availed in the respective policy year the benefit cannot be carried forward to the subsequent policy year after renewal.
4. Initial 30 days waiting period is applicable for investigations Cover- Pathology & Radiology expenses related to illness during the first year of Policy. This waiting period is not applicable for renewals.
5. 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 My Heath Care Plan and the Policy Schedule with Us.
   b) The PED waiting period as opted would be specified on the Policy Schedule.
   c) If the Insured Beneficiary 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.
5. Reimbursement of preventive health check-up expenses is excluded from the scope of the Policy.
6. Initial 30 days waiting period is applicable for investigations related to Illness during the first year of Policy Period. This waiting period is not applicable for renewals.

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.

2. Condition Precedent to Admission of Liability
The terms and conditions of the Policy must be fulfilled by the Insured Beneficiary for 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 Beneficiary during a period from the same or one or more insurers to indemnify medical treatment costs, the Insured Beneficiary 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 Beneficiary 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 Beneficiary 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 Beneficiary shall have the right to choose Insurer from whom he/she wants to claim the balance amount.

iv. Where an Insured Beneficiary has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured Beneficiary 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 Beneficiary 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 Beneficiary, 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 Beneficiary 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 Beneficiary 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 Beneficiary 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 Beneficiary 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 Beneficiary 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 Beneficiary is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Beneficiary 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 Beneficiary 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 Beneficiary, 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 Beneficiary 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 Beneficiary 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 Beneficiary does not believe to be true;
   b. the active concealment of a fact by the Insured Beneficiary 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 Beneficiary/ beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer. Onus of disproving is upon the Insured Beneficiary, if alive, or beneficiaries.

15. Nomination

The Insured Beneficiary 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 Beneficiary. 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 Beneficiary. In the event of death of the Insured Beneficiary, 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 Beneficiary 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 Mr. Jerome Vincent 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 Mr. Ankit Goenka, 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 Beneficiary 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 Beneficiary has not made any claim during the Free Look Period, the Insured Beneficiary shall be entitled to,

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Beneficiary 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 Beneficiary, 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

18. 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.

19. Insured Beneficiary

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

20. Additional Norms on Migration

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

21. Change of Sum Insured

Sum Insured can be changed (increased/ decreased) only at the time of Renewal or 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.

22. 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 Beneficiary at the address or through any other electronic mode mentioned in the Policy Schedule.

23. Endorsements (Changes in Policy)

i. 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.

24. 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.

25. Automatic change in Coverage under the Policy

The coverage for the Insured Beneficiary(s) shall automatically terminate:

i. In the case of his/ her (Insured Beneficiary) 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 Beneficiary 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 Beneficiary) 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 Beneficiary, pro-rata refund of premium of the deceased Insured Beneficiary 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 Renewal on the due date as per the applicable terms and conditions.

26. 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" 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.

27. Arbitration

Arbitration Clause shall not be applicable.

28. Discount

i. 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

ii. Family Discount

10% family discount shall be offered if 2 Family Members are covered under a single Policy and 15% family discount shall be offered if more than 2 of any of the Family Members are covered under a single Policy. family discount will be offered for both new policies as well as for renewal policies. Family discount is not applicable to Floater Policies.

iii. Long Term Discount
   a. 4% discount is applicable if Policy is opted for 2 years
   b. 8% discount is applicable if Policy is opted for 3 years
   Note: This will not apply to Policies where premium is paid in instalments.

iv. 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.

v. 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 Policies where employee discount is given.

vi. Loyalty Discount
   Discount of 5% shall be offered if the insured member 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.

vii. Wellness Discount
   At each renewal of My Health Care Plan with Us, you will be entitled for a wellness discount subject to below mentioned criteria being fulfilled by You during the preceding Policy Year. The below mentioned criteria should be fulfilled each year in case of long-term policies.

Sr. No	Health Parameter	Reading	
1	Health Risk Assessment	Complete the online health risk assessment	
2	HbA1c (%)	Up to 6.5%	
3	Fasting Blood Sugar	Up to 120 mg/dl	
4	Blood Pressure (mm of Hg)	Systolic Up to 140	Diastolic Up to 90
5	Body Mass Index (BMI)	18 – 25	
6	Serum Cholesterol	200mg/dl	
7	Steps Count	5,000 steps daily – 20 days every month	
8	Hemoglobin	Male-13-18mg/dl Female-11-15mg/dl	

Parameters Achieved	Discount Offered
4 or 5 out of 8	5%
6 or 7 out of 8	7.5%
8 out of 8	10%

Wellness Eligibility Criteria:

1. Wellness discount is applicable for members age 25 years and above
2. If the Insured person meets 4 or 5 out of 8 criteria, he/she is eligible for 5% discount, 6 or 7 out of 8 criteria he /she is eligible for 7.5% discount & meets with 8 criteria she / she is eligible for 10% discount.
3. If an Insured meets 8 out of 8 above mentioned parameters and in addition he/she walks for 10,000 steps for 20 days every month then they will be eligible for additional discount of 2.5%.

4. In Floater Policies, discount will be offered basis the average of number of Parameters Achieved by all Insured members age 25 years & above.

$$\text{Discount under Floater Policy} = \frac{\text{Total No. of Parameters achieved by eligible members}}{\text{Total No. of eligible members in the family}}$$

viii. Early Entry Discount

5% discount shall be offered if, Insured Proposer is opting the My Health Care Plan 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.

ix. 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.

x. Voluntary co-payment Discount

a. In the Voluntary co-payment option is opted, then a discount corresponding to the co-payment opted would be applicable.

b. If a claim has been admitted under In-patient Hospitalization Treatment then, the Insured shall bear a 5% or 10% or 15% or 20% (proportion to extent to discount availed) 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.

29. Deductions in case of cancellation/return of Policy.

Notwithstanding anything contained in any other clause in this Policy, where (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 return/cancellation is exercised by the Insured Beneficiary under clause 17, then in addition to deductions under Section 17 of this Policy, expenses incurred by the Company on medical examination of the Insured Beneficiary and the stamp duty charge will also be deducted before refund of premium to Insured.

30. Claims Procedure for all covers except Out Patient Expense Cover (OPD)

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:

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.

x. 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.

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 Beneficiary, 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. Condition (v) is applicable to all covers.
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.
3. Condition (vii) related: 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.

List of Claim documents:

1. Claim form with NEFT details & cancelled cheque duly signed by Insured Beneficiary
2. Original Discharge Summary / Discharge Certificate / Death Summary with Surgical & anaesthetics notes
3. Attested copies of Indoor case papers, if available
4. Original 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 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, if applicable
10. First consultation letter for the current ailment.
11. In case of implant surgery, submit 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

SERVICE DELIVERY PROCESS FOR OUT PATIENT AND PREVENTIVE HEALTH CHECK UP COVER

Tele-consultation (Insta Consultation) Service Delivery Process:

- Start by downloading the Caringly Yours app/Service Providers digital application.
- Sign-up using the registered mobile number.
- Add policy in the "Manage policy" section.
- Under my "Active Plans", select the purchased product/Plan.
- Select doctor benefit option.
- Select member and choose "Tele (Insta) Consultation" option
- Choose specialization and submit.
- The doctor will join the call for instant consultation.

Doctor consultation Service Delivery process

- Start by downloading the Caringly Yours app /Service Providers digital application.
- Sign-up using the registered mobile number.
- Add policy in the "Manage policy" section.
- Under my "Active Plans", select the purchased product/Plan.
- Select doctor benefit option.
- Select member and choose In-Clinic or Hospital visit
- Select the doctor/clinic or hospital from available network.
- Enter estimated amount

- Enter the date of redemption and confirm.
- SMS with voucher link shared on the registered mobile number.
- Share the voucher code to avail cashless doctor consultation benefit at respective hospital.
- In case the estimated amount is lower than the actual consultation amount, balance amount will be reinstated in the OPD Sum Insured
- Similarly, in case the estimated amount is higher than the actual consultation amount, voucher will be generated for balance amount and will be deducted from OPD Sum Insured.

Doctor prescribed Investigations Cover – Pathology & Radiology Service Delivery Process

- Start by downloading the Caringly Yours app. / Service Providers digital application.
- Sign-up using the registered mobile number.
- Add policy in the "Manage policy" section.
- Under my "Active Plans", select the purchased product/Plan.
- Select Lab benefit option.
- Select member and choose book prescribed tests.
- Select lab/hospital from available network and enter estimated amount
- Enter the date of redemption and confirm.
- SMS with voucher link shared on the registered mobile number.
- Share the voucher code to avail cashless doctor consultation benefit at respective hospital.
- In case the estimated amount is lower than the actual test amount, balance amount will be reinstated in the OPD Sum Insured.
- Similarly, in case the estimated amount is higher than the actual test amount, voucher will be generated for balance amount and will be deducted from OPD Sum Insured.

Reimbursement Process with Pre-approval for Doctor consultation and Doctor prescribed Investigations Cover

- Pre-approval for Doctors & diagnostic centres not available at the prescribed cashless network.
- Pre-approval needs to be taken at non-serviceable locations. Reimbursement requests without Pre-approval will not be accepted for processing.
- Under “Active Plans”, select the purchased product/plan
- Click on “Utilize” to view your available benefits
- Click on the service card.
- Ex: if you have Doctor Consultation/ Lab & Radiology benefit and want to request authorization for a visit to doctor/lab of your choice and claim refund post visit, click on “Doctor” service card/ “Lab” service card.
- Scroll down to view the section “Avail benefits at doctor/lab/hospital of your choice”
- Click on exact benefit card for which you wish to authorize visit for example: Click on Lab & Radiology benefit to authorize visit to lab of your choice
- View the coverages and guidelines of filing a claim
- Click on “Request Authorization”
- Turn on the Device Location
- Fill the form1:
  i. Select Member name you want to book the lab test for.
  ii. Select the lab you are planning to visit
- Click Next
- Fill the form2:
  i. Enter the date of visit you are planning to visit
  ii. Enter the estimated amount for the visit
- Select Next
- Confirm the Pre-Auth.
- Now visit the Lab at the informed date of visit.
- After the visit, come back within 30 days of visit date at Transaction History page and select the Authorized ticket for which pre-auth was taken

- In the reimbursement form page1:
  i. Enter the Invoice amount in the form
  ii. Enter the Date of visit in the form
- Click Next
- Fill the Form page2:
  i. Upload the Supporting Documents of the visit: Invoice and Reports/Prescription of the visit
  ii. Submit the form.
- Visit the provider on the appointment date mentioned
- Post the visit, begin filing the claim for the completed appointment. Reimbursement journey can be started by Navigating to transaction history page of the respective plan and click on "Submit Claim" of respective authorized ticket Or navigate to the service page (Doctor/Labs/Hospital) where request for authorization was taken in the respective plan and click on "Submit Claim" of respective authorized ticket
- Verify previously filled details
- Edit actual date of appointment and actual claim amount
- Upload the invoice and the other supporting documents as required
- Enter the UPI ID or Bank Account details
- Review the details and documents properly before clicking on the final submit button
- Click on "Submit" to finally submit the claim
- Keep note of the Transaction ID for keeping a track of the claim in future
- Insured member/s can visit the Transaction History section in future to view the updates in the claim status
- The claim will be reimbursed within defined TAT as communicated during authorization

Preventive Health Check -up Service Delivery process

- Start by downloading the Caringly Yours app. / Service Providers digital application.
- Sign-up using the registered mobile number.
- Under my "Active Plans", select the purchased product/Plan.
- Select Lab benefit option.
- Select member and choose preventive health check-up.
- Select the hospital/lab from available network.
- Home collection facility is 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.
- Enter the date of redemption and confirm.
- SMS with voucher link shared on the registered mobile number.
- Share the voucher code to avail cashless Preventive Health Check-up benefit

31. 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 Beneficiary, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured Beneficiary.

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 Beneficiary in writing within 30 days of the last receipt of necessary documents. The Insured Beneficiary may take recourse to the Grievance Redressal procedure stated under Policy.

32. 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.

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.

33. Cost Sharing

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

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

ii. For SI above 10 Lac – Actual.

34. Nationality

- Indian nationals residing in India would be considered for this Policy.
- This Policy can be opted by Non-Resident Indians also and premium paid in Indian currency.

35. Sum Insured Enhancement:

i. The Insured Beneficiary 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 Beneficiary(s) & claim history of the Policy.

iii. All Waiting Periods as defined in the Policy read with Policy Schedule 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.

36. Inclusion of members under the Policy:

Where an Insured Beneficiary is added to the 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 the newly added Insured Beneficiary.

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:

List 1: List of Non-Medical Items

Sr No	Item
1	Baby Food
2	Baby Utilities Charges
3	Beauty Services
4	Buds
5	Carry Bags
6	Email / Internet Charges
7	Food Charges (Other Than Patient's Diet Provided By Hospital)
8	Laundry Charges
9	Mineral Water
10	Sanitary Pad
11	Telephone Charges
12	Guest Services
13	Diaper of Any Type
14	Television Charges
15	Attendant Charges
16	Extra Diet of Patient (Other Than That Which Forms Part of Bed Charge)
17	Birth Certificate
18	Certificate Charges
19	Courier Charges
20	Conveyance Charges
21	Medical Certificate
22	Medical Records
23	Photocopies Charges
24	Diabetic Foot Wear
25	Private Nurses Charges - Special Nursing Charges
26	Sugar Free Tablets
27	Creams Powders Lotions (Toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals 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: 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

Annexure IV:

List Of Non-Medical Items Payable Under Consumable Expenses Cover

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

Table of Benefits

My Health Care Plan	
Cover	Plan 1
In-Patient Hospitalization Expenses	3/4/5/7.5/10/15/20/25/30/3 5/40/45/50/75 lacs and 1/2/3/4/5 Crore
Room rent for 3 Lac to 10 Lac SI	Single Pvt AC Room
Room rent for Above 10 Lacs SI	Actuals
Pre-hospitalization Medical Expenses	60 days
Post-hospitalization Medical Expenses	90 days
Modern Treatment Methods and Advancement in Technologies	Up to Sum Insured
Day Care Treatment	Up to Sum Insured
Organ Donor	Up to Sum Insured
AYUSH Cover	Up to Sum Insured
Road Ambulance	Up to Sum Insured
Maternity Package expenses **1. Maternity expenses** **2. Maternity expenses for Surrogacy** **3. Complications of Assisted reproductive technique**	For SI 3 and 4 Lac – Not covered
	For SI 5 Lac to 10 Lac –INR 50,000
	For SI 15 Lac to 20 Lac- INR 75,000
	For SI above 20 Lacs – INR 1,00,000
Baby care	For SI up to 4 Lac- 1 Lac
	For SI 5 Lac to 10 Lac- 5 Lac
	For SI 15 Lac to 50 Lac- 10 Lac
	For SI above 50 Lac- 15 Lac
Out-Patient Treatment (OPD) Expenses	a) Insta-Consultation (Instant Teleconsultation) Cover
	b) Doctor Consultation Cover (in clinic)- Limit-50% of OPD SI
	c) Doctor Prescribed investigation/ pathology and Radiology Cover-
	d) Annual Preventive Health check-up cover - (1 voucher) for individual (2 vouchers) for Floater
Domiciliary Hospitalization	Up to Sum Insured
Home Nursing Benefit (max 10 weeks)	For SI up to 50 Lac- 5,000/week
	For SI above 50 Lac- 10,000/week
Cost of Prescribed External Medical Aid	For SI up to 10 Lac- 10,000
	For SI 15 Lac to 50 Lac- 25,000
	For SI above 50 Lac- 50,000
Sum Insured Reinstatement (Available for same illness)	For SI less than 5 lacs - Once
	For SI 5 lacs and above - Unlimited
Airlift Cover	For SI 75 Lac to 1 Crore - Limit for Air Lift up to INR 10 Lac
	For SI Above 1 Crore - Limit for Air Lift up to INR 20 Lac
Cumulative bonus (reduces in case of claim)	For SI 3 & 4 lacs - 25% Per Annum max 100%
	For SI 5 Lac and above- 50% Per Annum max 100%
Family Visit	For SI upto 10 lacs- upto INR 25,000
	For SI More than 10 lacs – Upto INR 50,000
Renewal premium waiver benefit in case of death of proposer	Applicable
Consumables cover	Up to In-patient SI

Waiting Period	
Waiting Periods	Plan 1
Pre-Existing Diseases Waiting Period	36 months
Specified disease/procedure Waiting Period	24 months
Initial Waiting period	30 days
Maternity Expenses waiting period	36 months (will decrease by 1 year if premium for long term policy is paid upfront)
Baby Care waiting period	36 months (will decrease by 1 year if premium for long term policy is paid upfront)

OPTIONAL COVERS AVAILABLE IN MY HEALTH CARE PLAN
1. Loss of Income Cover (Applicable to Part I and Part II)
2. Major Illness and Accident Multiplier (Indemnity) (Applicable to Part I only)
3. International Cover – Emergency Care only (Applicable to Part I only)

Options Available for Room Rent	General Ward
	Twin Sharing
	Single Pvt Ac
	Actual
	1% of SI max up to 5000
	1.5% of SI max 7500
	2% of SI max up to 7500

Options Available for Pre-Hospitalization Expenses	0 days
	15 days
	30 days
	60 days
	90 days
	180 days
	240 days (this option will be available for SI 5 Lac and above only)

Options Available for Post Hospitalization Expenses	0 days
	15 days
	30 days
	60 days
	90 days
	180 days
	240 days (this option will be available for SI 5 Lac and above only)

Options Available for Change in PED waiting Period	1 year
	2 years
	3 years

Options Available for Change in Specific Disease waiting Period	1 year
	2 years
	3 years