Kotak Mahindra General Insurance Company Ltd. (Formerly Kotak Mahindra General Insurance Ltd.)
Registered Office: 27 BKC, C 27, G Block, Bandra Kurla Complex, Bandra East, Mumbai – 400051. Maharashtra, India.

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Kotak Health Care - Policy Wordings

PART II OF THE POLICY

This is a contract of insurance between You and Us which is subject to the receipt of the premium in full and the terms, conditions and exclusions of this Policy. This Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided by You in respect of the Insured Persons in the Proposal Form. Please inform Us immediately of any change in the address, state of health or any other changes affecting You or any Insured Person.

1. DEFINITIONS

For the purposes of this Policy, the terms specified below shall have the meaning set forth wherever appearing/specified in this Policy or related Extensions/Endorsements:

Where the context so requires, references to the singular shall also include references to the plural and references to any gender shall include references to all genders. Further any references to statutory enactment include subsequent changes to the same.

Term	Definition
Accident	is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
Admission	means the Insured Person's admission to a Hospital as an inpatient for the purpose of medical treatment of an Injury and/or Illness.
Alternative Treatments	are forms of treatments other than treatment “Allopathy” or “modern medicine” and include Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
Ambulance	means a road vehicle operated by a licensed/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
Base Annual Sum Insured	means the amount specified in the Policy Schedule which is Our maximum, total and cumulative liability for any and all Claims during the Policy Year in respect of all Insured Persons. If the Policy Period is more than one year, then the Base Annual Sum Insured will apply afresh to each Policy Year in the Policy Period, but any portion of the Base Annual Sum Insured which remains un-utilised in any Policy Year shall not be carried forward to any subsequent Policy Year in the Policy Period.
Any one illness	means continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where treatment may have been taken
Associated Medical Expenses	means Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioners (including surgeons, anesthetists and specialists) and costs of diagnostic tests.
Cashless Facility	means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre authorization approved.
Claim	means a demand made by You for payment of any benefit under the Policy in respect of an Insured Person.
Condition Precedent	shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
Congenital Anomaly	refers to 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.
Contribution	is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion of Base Annual Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.
Cumulative Bonus	shall mean any increase in the Base Annual Sum Insured granted by the insurer without an associated increase in premium.
Day care center	means any institution established for day care treatment of Illness and / or injuries or a medical set -up within a hospital and which has been registered 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:- 1) Has qualified nursing staff under its employment; 2) Has qualified medical practitioner (s) in charge; 3) Has a fully equipped operation theatre of its own where surgical procedures are carried out 4) Maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.
Day Care Treatment	refers to medical treatment, and/or Surgical Procedure which is: i) Undertaken under General or Local Anesthesia in a Hospital/Day care centre in less than 24 hrs because of technological advancement, and ii) Which would have otherwise required a Hospitalisation of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.
Dental treatment	is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

Dependants	means Your legally married spouse, Your natural or adopted dependent children and Your dependent parents.
Disclosure to information norm	means that the Policy shall be void and all premium paid hereon shall be forfeited to Us, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
Domiciliary Hospitalisation	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.
Emergency	shall mean a serious medical condition or symptom resulting from Injury or sickness which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an emergency anymore.
Emergency Care	means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, requires immediate care by a medical practitioner to prevent death or serious long term impairment to the insured person's health.
Family Floater	means a Policy described as such in the Policy Schedule where under You and Your dependents named in the Schedule are insured under this Policy as at the Policy Period Start Date. The Base Annual Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your dependents during each Policy Period.
Grace Period	means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-existing Condition/ Disease. Coverage is not available for the period for which no premium is received.
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 Regulations) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under: i) Has qualified nursing staff under its employment round the clock; ii) Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient 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 maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
Hospitalisation	means admission in a hospital for a minimum period of 24 in patient care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours
In-patient care	means treatment for which the insured person has to stay in a Hospital for more than 24 hours for a covered event.
Illness	means a sickness or disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment. i) **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. ii) **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:-it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests-it needs ongoing or long-term control or relief of symptoms- it requires your rehabilitation or for you to be specially trained to cope with it-it continues indefinitely-it comes back or is likely to come back.
Injury	means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
Insured Person(s)	means the individual(s) named in the Policy Schedule who are covered under this Policy. 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.
Maternity Expenses	shall include - i) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalisation); ii) Expenses towards lawful medical termination of pregnancy during the policy period.
Medical Advise	means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.
Medical Expenses	means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals

	or doctors in the same locality would have charged for the same medical treatment.
Medically Necessary	treatment is defined as 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.
Medical Practitioner	is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.The term Medical Practitioner would include physician, specialist, anaesthetist and surgeon but would exclude You and Your Immediate Family . "Immediate Family would comprise of Your spouse, dependent children, brother(s), sister(s) and dependent parent(s).
Network Provider	means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.
Newborn Baby	means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.
Non- Network	means any Hospital, day care centre or other provider that is not part of the network.
Notification / Intimation Of Claim	is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.
OPD treatment	is 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.
Plan	means the plan stated in the Policy Schedule which is applicable to all Insured Persons and specifies the amounts of benefits payable.
Policy	means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to You, what is excluded from the cover and the terms & conditions on which the Policy is issued to You.
Policy Period	means the period commencing from the Policy Period Start Date, Time and ending at the Policy Period End Date, Time of the Policy and as specifically appearing in the Policy Schedule.
Policy Schedule	means the schedule attached to and forming Part I of this Policy, mentioning the details of the Insured Persons, the Base Annual Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
Policy Year	means a period of twelve months beginning from the Policy Period Start Date and ending on the last day of such twelve-month period. For the purpose of subsequent years, "Policy Year" shall mean a period of twelve months beginning from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Policy Period End Date, as specified in the Policy Schedule.
Portability	means transfer by an Individual health insurance policyholder (including family floater cover) of the credit gained for pre-existing conditions and time bound exclusions if he/ she chooses to switch from one insurer to another.
Post-Hospitalisation Medical Expenses	means medical expenses incurred immediately after the Insured Person is discharged from the hospital, provided that: i) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and ii) The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.
Pre-existing Disease	means any condition, ailment or Injury or Illness or related condition(s) for which You had developed signs or symptoms, and / or were diagnosed and / or received medical advice / treatment, within 48 months prior to the first policy issued by the Insurer.
Pre-Hospitalisation Medical Expenses	means medical expenses incurred immediately before the Insured Person is Hospitalized, provided that: i) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and ii) The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.
Qualified Nurse	is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
Reasonable & Customary Charges	Reasonable 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.
Renewal	defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.
Room Rent	means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

Surgery or Surgical Procedure	means manual and/or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a Medical Practitioner.
Third Party Administrator (TPA)	means the services rendered by a TPA to an insurer under an agreement in connection with health insurance business but does not include the business of an insurance company or the soliciting either directly or indirectly, of health insurance business or deciding on the admissibility of a claim or its rejection.
Unproven/Experimental Treatment	means any treatment including drug experimental therapy which is not based on established medical practice in India.
You/Your/Policyholder	means the Policy holder named in the Policy Schedule.
We/ Our/Us	means the Kotak Mahindra General Insurance Company Limited. (Formerly known as Kotak Mahindra General Insurance Ltd.)

2. WHAT WE WILL PAY (SCOPE OF COVER OF BENEFITS AVAILABLE UNDER THE POLICY)

The Benefits available under this Policy are described below. Benefits will be payable subject to the terms, conditions and exclusions of this Policy and the availability of Base Annual Sum Insured and Cumulative Bonus and subject always to any sub-limits specified in respect of that Benefit and any limits applicable under the Plan in force for the Insured Person as specified in the Policy Schedule.

Our total liability under this Policy for payment of any and all Claims in the aggregate during each Policy Year of the Policy Period shall not exceed the sum of the Base Annual Sum Insured and the Cumulative Bonus (if any):

2.1 In-patient Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalisation during the Policy Period following an Illness or Injury for a minimum and continuous period of 24 hours that occurs during the Policy Period provided that:

(a) The Hospitalisation is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;

(b) The Medical Expenses incurred are Reasonable and Customary;

2.2 Day Care Treatment

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

(a) The Day Care Treatment is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;

(b) The Medical Expenses incurred are Reasonable and Customary ;

(c) We will only cover the Medical Expenses for those Day Care Treatments which are listed in Annexure II of this Policy. The complete list of Day Care Treatments covered is also available on Our website [www.kotakgeneralinsurance.com];

(d) We will not cover any OPD Treatment under this Benefit.

2.3 Pre-Hospitalisation Medical Expenses and Post Hospitalisation Medical Expenses

We will indemnify the Insured Person's Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses following an Illness or Injury that occurs during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under this Policy and the Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses relate to the same Illness/medical condition;

(b) We will not be liable to pay Pre-Hospitalisation Medical Expenses for more than 30 days preceding the Insured Person's Admission to Hospital for In-patient Care or Day Care Treatment;

(c) We will not be liable to pay Post-Hospitalisation Medical Expenses for more than 60 days immediately following the Insured Person's discharge from Hospital following In-patient Care or Day Care Treatment.

2.4 Ambulance Cover

We will indemnify the Reasonable and Customary Charges incurred up to the limit specified in the Policy Schedule towards transportation of the Insured Person by a registered healthcare or Ambulance service provider to a Hospital for treatment of an Illness or Injury following an Emergency provided that:

(a) The necessity of the use of the Ambulance is certified by the treating Medical Practitioner;

(b) We will also provide cover under this Benefit if the Insured Person is required to be transferred from one Hospital to another Hospital or diagnostic center for advanced diagnostic treatment where such facility is not available at the existing Hospital or the Insured Person is required to be moved to a better Hospital facility due to lack of available / adequate treatment facilities at the existing Hospital.

(c) The limit under Ambulance cover is applicable for each claim admitted under the policy.

2.5 Free Health Check-up

We will arrange for one free health check-up at Our Network Provider for each Insured Person that is above 18 years of Age, each Policy Year for the specified tests. Availing the Free Health Check-up will not impact the Base Annual Sum Insured or the Cumulative Bonus.

This will be offered regardless of any claim admitted/ registered in the Policy.

The present free health check-up will consist of the following tests for all eligible Insured Persons:

(a) CBC;

(b) MER;

(c) Serum Cholesterol;

(d) Serum Creatinine;

(e) SGPT /SGOT;

(f) ECG;

(g) Random Blood Sugar;

2.6 Cumulative Bonus

We will increase Your Base Annual Sum Insured by 10% at the end of the Policy Year if the Policy is renewed with Us provided that;

(a) If the Policy is a Family Floater Policy, then the Cumulative Bonus will accrue only if no claims have been made in respect of all the Insured Persons in the expiring Policy Year;

(b) If the Policy is an Individual policy, then Cumulative Bonus will accrue only if no claim has been made in the expiring Policy Year in respect of that Insured Person;

(c) The Cumulative Bonus under a Family Floater Policy will be available only to those Insured Persons who were Insured Persons in the immediately completed Policy Year;

(d) If any Claim is made under the Policy after a Cumulative Bonus has been applied under the Policy, then the accrued Cumulative Bonus under the Policy will reduce by 10% on the commencement of the next Policy Year or the next Renewal of the Policy (as applicable);

(e) The Cumulative Bonus will not accrue in excess of 50% of the Base Annual Sum Insured;

(f) If the Base Annual Sum Insured is increased at the time of Renewal, then the Cumulative Bonus will be calculated based on the Base Annual Sum Insured of the immediately completed Policy Year;

(g) If the Base Annual Sum Insured is reduced at the time of Renewal, then the applicable cumulative bonus will be applicable on the renewed policy Base Annual Sum Insured.

(h) Cumulative bonus will be carried forward to the next policy year, provided the Insured Person renews the policy before the expiry of the grace period.

(i) If the Policy Period is more than one year, then any Cumulative Bonus that has accrued for the Policy Year will be credited at the end of the Policy Year and shall be available for any claims made in the subsequent Policy Year.

3. WHAT WE WILL NOT PAY (EXCLUSIONS APPLICABLE UNDER THE POLICY)

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based upon, arising out of or howsoever attributable to any of the exclusions listed below. All waiting periods will apply individually to each Insured Person:

3.1 Pre-Existing Disease Waiting Period

Any Pre-Existing Disease will not be covered until 48 months of continuous coverage has elapsed for the Insured Person, since the inception of the first Policy with us. On Renewal of the Policy if an

increased Base Annual Sum Insured is requested then the elapsed period for Pre-Existing Diseases shall be limited to the Base Annual Sum Insured of the immediately completed Policy Period. This exclusion doesn't apply for Insured Person having any health insurance policy in India at least for a period of 48 continuous months, prior to taking this Policy and accepted under portability cover, as well as for three subsequent Renewals with Us without a break.

3.2 30 Day Waiting Period

Any Illness contracted or Medical Expenses incurred in respect of an Illness will not be covered during the first 30 days from the Policy Period Start Date. This exclusion does not apply to any Medical Expenses incurred as a result of Injury or to Renewals of the Policy with Us or to any Insured Person whose Policy has been accepted under the Portability Benefit under this Policy.

3.3 2 Year Waiting Period

Any Medical Expenses incurred on the treatment of any of the following illnesses/ conditions (whether medical or surgical and including Medical Expenses incurred on complications arising from such Illnesses/conditions) shall not be covered during the first 2 consecutive years from inception of the first Policy with Us or date of the Insured Person being included under the Policy, whichever is later:

(a) Cataract*;
(b) Benign Prostatic Hypertrophy;
(c) Myomectomy, Hysterectomy unless because of malignancy;
(d) All types of Hernia, Hydrocele;
(e) Fissures and/or Fistula in anus, haemorrhoids / piles;
(f) Arthritis, Gout, Rheumatism and Spinal Disorders;
(g) Joint eplacements unless due to Accident;
(h) Sinusitis and related disorders;
(i) Stones in the urinary and biliary systems;
(j) Dilatation and curettage, Endometriosis;
(k) All types of skin and internal Tumors / Cysts / Nodules / Polyps of any kind including breast lumps unless malignant;
(l) Dialysis required for chronic renal failure;
(m) Surgery on Tonsilitis, Adenoids and Sinuses;
(n) Gastric and Duodenal Erosions and Ulcers;
(o) Deviated Nasal Septum;
(p) Varicose Veins / Varicose Ulcers;

*Our maximum liability for any Claim for an Insured Person's cataract treatment shall not exceed INR 20,000 per eye, during each Policy Year of the Policy Period.

In the event that any of the above Illnesses/conditions are Pre-existing Diseases at the Policy Period Start Date or are subsequently found to be Pre-Existing Diseases, then that Illness/condition shall be covered in accordance with the terms, conditions and exclusions of the Policy after the completion of the Pre-Existing Diseases waiting period stated above.

3.4 Permanent Exclusions

(a) Costs of routine medical, eye or ear examinations preventive health check-ups, spectacles, laser surgery for correction of refractory errors, contact lenses, hearing aids, dentures or artificial teeth;
(b) Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnoea syndrome or continuous ambulatory peritoneal dialysis (C. A. P. D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively;
(c) Expenses incurred on all dental treatment unless necessitated due to an Accident;
(d) Any expenses incurred on personal comfort, cosmetics, convenience and hygiene related items and services;
(e) Any naturopathy treatment, acupressure, acupuncture, magnetic and such other therapies;
(f) Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident;
(g) Vaccination or inoculation of any kind, unless it is post animal bite;
(h) Sterility, venereal disease or any sexually transmitted disease;
(i) Intentional self-injury (whether arising from an attempt to commit suicide or otherwise) and Injury or Illness due to use, misuse or abuse of intoxicating drugs or alcohol;
(j) Any expenses incurred on treatment of mental Illness, stress, psychiatric or psychological disorders;
(k) Any aesthetic treatment, cosmetic surgery or plastic surgery including any complications arising out of or attributable to these, unless necessitated due to Accident or as a part of any Illness;
(l) Any treatment/surgery for change of sex or treatment/surgery /complications/Illness arising as a consequence thereof;
(m) Any expenses incurred on treatment arising from or traceable to pregnancy (including voluntary termination of pregnancy, childbirth, miscarriage, abortion or complications of any of these, including caesarean section) and any fertility, infertility, sub fertility or assisted conception treatment or sterilization or procedure, birth control procedures and hormone replacement therapy. However, this exclusion does not apply to ectopic pregnancy proved by diagnostic means and which is certified to be life threatening by the Medical Practitioner;
(n) Treatment relating to Congenital External Anomalies;
(o) Genetic disorder and stem cell implantation/surgery, harvesting, storage or any kind of treatment using stem cells;
(p) All expenses arising out of any condition directly or indirectly caused to or associated with Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind;
(q) Charges incurred at Hospital primarily for evaluative or diagnostic or observation purposes for which no active treatment is given, X-Ray or laboratory examinations or other diagnostic studies, not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, whether or not requiring Hospitalisation;
(r) Expenses on supplements, vitamins and tonics unless forming part of treatment for Injury or Illness as certified by the attending Medical Practitioner;
(s) Weight management services and treatment, vitamins and tonics related to weight reduction programs including treatment of obesity (including morbid obesity), any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition or rest cures;
(t) Costs incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose;
(u) Experimental, unproven or non-standard treatment which is not consistent with or incidental to the usual diagnosis and treatment of any Illness or Injury;
(v) Any Claim directly or indirectly related to criminal acts;
(w) Any expenses arising out of Domiciliary Hospitalisation; unless covered under extension 'Domiciliary Hospitalisation cover'
(x) Any treatment taken outside India;
(y) Any treatment taken from anyone not falling within the scope of definition of Medical Practitioner. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council;
(z) Any Illness or Injury resulting or arising from or occurring during the commission of continuing perpetration of a violation of law by the Insured Person with criminal intent;
(aa) Expenses related to donor screening, treatment, including surgery to remove organs from a donor in the case of transplant surgery; unless covered under extension 'Donor Expenses';
(bb)Non- allopathic treatment; unless covered under extension 'Alternative treatment'
(cc) Any consequential or indirect loss arising out of or related to Hospitalisation;
(dd) Any Injury or Illness directly or indirectly caused by or arising from or attributable to 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 nationalisation or requisition of or damage by or under the order of any government or public local authority;
(ee) Any Illness or Injury directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel;
(ff) All non-medical expenses listed in Annexure III of the Policy

4. CLAIM ADMINISTRATION

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

(a) On the occurrence or discovery of any Illness or Injury that may

give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed;

(b) The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payments that are brought about or contributed to as a consequence or failure to follow such directions, advice or guidance;

(c) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalisation records pertaining to the Insured Person's treatment and to investigate the facts surrounding the Claim;

(d) We/Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of such Claim;

(e) If the Insured Person suffers a relapse within 45 days of the date of discharge from Hospital for a Claim that has been made, then such Relapse shall be deemed to be part of the same Claim and all limits for Any One Illness under this Policy shall be applied as if they were part of a single claim.

5. CLAIMS PROCEDURE

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

5.1 For Cashless Facility

Cashless Facility is only available at a Network Provider. The complete list of Network Providers is available on Our website or can be obtained from Our call centre. In order to avail of Cashless Facility, the following procedure shall be followed:

(a) Pre-authorization for Planned Hospitalisation

At least 48 hours prior to a planned Hospitalisation, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that planned Hospitalisation. Each such request must be accompanied by all the following details:

(i) The Health Card We have issued to the Insured Person;
(ii) The Policy Number;
(iii) Name of the Policyholder;
(iv) Name and address of Insured Person in respect of whom the request is being made;
(v) Nature of the Illness/Injury and the treatment/surgery required;
(vi) Name and address of the attending Medical Practitioner;
(vii) Hospital where treatment/surgery is proposed to be taken;
(viii) Proposed date of Admission.

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/Our TPA will request additional information or documentation in respect of that request.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.

In Case of Claim Contact Us at:

24x7 Toll Free number: 1800 266 4545 or may write and e- mail at care@kotak.com

In the event of claims, please send the relevant documents to:
Family Health Plan (TPA) Ltd,
Srinilaya – Cyber Spazio
Suite # 101,102,109 & 110, Ground Floor,
Road No. 2, Banjara Hills,
Hyderabad, 500 034.

(b) Pre-authorization for Emergency Care

If the Insured Person has been admitted into Hospital for Emergency Care, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that Emergency Care within 24 hours of commencement of Hospitalisation. Each such request must be accompanied by all the following details:

(i) The Health Card We have issued to the Insured Person;
(ii) The Policy Number;
(iii) Name of the Policyholder;
(iv) Name and address of Insured Person in respect of whom the request is being made;
(v) Nature of the Illness/Injury and the treatment/surgery required;
(vi) Name and address of the attending Medical Practitioner;
(vii) Hospital where treatment/surgery is being taken;
(viii) Date of Admission.

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/ Our TPA will request additional information or documentation in respect of that request.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection. In circumstances where We/Our TPA refuse the request for pre-authorisation as there is insufficient Base Annual Sum Insured there is insufficient information to determine the admissibility of the request for pre-authorisation, a claim for reimbursement may be submitted to Us in accordance with the procedure set out below and We will consider the Claim in accordance with the policy terms, conditions and exclusions.

We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities in Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers on Our website or by calling Our call centre.

5.2. For Reimbursement Claims

We shall be given written notice of the Claim for reimbursement along with the following details at least within 30 days of the Insured Person's discharge from Hospital:

(a) The Policy Number;
(b) Name of the Policyholder;
(c) Name and address of the Insured Person in respect of whom the request is being made;
(d) Nature of Illness or Injury and the treatment/surgery taken;
(e) Name and address of the attending Medical Practitioner;
(f) Hospital where treatment/surgery was taken;
(g) Date of Admission and date of discharge;
(h) Any other information that may be relevant to the Illness/ Injury/ Hospitalisation.

If the Claim is not notified to Us within 30 days of the Insured Person's discharge from Hospital, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

6. CLAIM DOCUMENTS

We shall be provided the following necessary information and documentation in respect of all Claims within 30 days of the Insured Person's discharge from Hospital. For Claims under which the use of Cashless Facility has been approved, We will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:

(a) Duly completed Claim form signed by You and the Medical Practitioner (only for reimbursement claims);
(b) Original Pre – authorization request
(c) Copy of Pre – authorization approval letter
(d) Copy of the photo identity document of the Insured Person;
(e) Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner;
(f) Original bills from chemists supported by proper prescription;
(g) Original investigation test reports (including CT/MR/USG/ECG, as applicable) and payment receipts;
(h) Indoor case papers;
(i) Medical Practitioner's referral letter advising Hospitalisation in non-Accident cases and referral slip for all investigations carried out;
(j) Hospital discharge summary;
(k) FIR or MLC for Accident cases;
(l) Post mortem report (if applicable and conducted);
(m) Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

7. CLAIMS FOR PRE-HOSPITALISATION MEDICAL EXPENSES AND POST-HOSPITALISATION MEDICAL EXPENSES

(a) All Claims for Pre-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the Insured Person's discharge from Hospital along with the following information and documentation:

(i) Duly Completed Claim Form
(ii) Investigation Payment Receipt
(iii) Original Investigation Report

(iv) Original Pharmacy Bills
(v) Original Pharmacy Prescription
(vi) Copy of Discharge Summary

(b) All Claims for Post-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the completion of post hospitalisation period as mentioned in your plan. You need to send Medical Expenses being incurred along with the following information and documentation:

(i) Duly Completed Claim Form
(ii) Investigation Payment Receipt
(iii) Original Investigation Report
(iv) Original Pharmacy Bills
(v) Original Pharmacy Prescription
(vi) Copy of Discharge Summary

(c) If the Claim is not notified to Us within these specified timeframes, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

8. **CLAIM INVESTIGATION, SETTLEMENT & REPUDIATION**

(a) We may investigate claims at Our own discretion to determine the validity of a claim. This investigation will be conducted within 15 days of the date of assigning the claim for investigation and not later than 6 months from the date of receipt of claim intimation. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals/entities that are authorised by Us in writing.

(b) We shall settle or repudiate a Claim within 30 days of the receipt of the last necessary information and documentation. In case of suspected frauds, the last "necessary" documents will include the receipt of the investigation report from Our representatives.

(c) Payment for reimbursement claims will be made to You. In the unfortunate event of Your death, We will pay the Nominee named in the Policy Schedule or Your legal heir or legal representatives holding a valid succession certificate.

(d) In case of delay in payment, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us.

Claims falling in 2 policy periods: If the claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available Base Annual Sum Insured in the two Policy Periods, including the Deductibles for each Policy Period. The admissible claim amount shall be reduced to the extent of premium to be received for the Renewal/due date of premium of health insurance policy, if not received earlier.

PART III OF THE POLICY

General Terms and Conditions

1. Disclosure of Information

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or on non-disclosure in any material particulars in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a Claim being fraudulent or any fraudulent means or devices being used by You/Insured Person or any one acting on Your/Insured Person's behalf to obtain any benefit under this Policy.

2. Reasonable Care

You/Insured Persons shall take all reasonable steps to safeguard Your/Insured Person's interests against any Injury or Illness that may give rise to the any claim under the Policy.

3. Observance of terms and conditions

The due observance and fulfilment of the terms, conditions and endorsements of this Policy in so far as they relate to anything to be done or complied with by You, shall be a condition precedent to any of Our liability to make any payment under this Policy.

4. Material Change

Material information to be disclosed to Us includes every matter that You are aware of or could reasonably be expected to know that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk and the terms of acceptance of the risk.

5. Records to be maintained

You shall keep an accurate record containing all relevant medical records and shall allow Us to inspect such records. You shall exercise all necessary co-operation in obtaining the medical records from the Hospital, and furnish them, as We may require in relation to the Claim within 30 days of such request from Us.

6. No constructive Notice

Any knowledge or information of any circumstances or condition in Your connection in possession of any of Our personnel and not specifically informed to Us by You shall not be be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

7. Overriding effect of Part II of the Policy

The terms and conditions contained herein and in Part II of the Policy shall be deemed to form part of the Policy and shall be read as if they are specifically incorporated herein; however in case of any inconsistency of any term and condition with the scope of cover contained in Part II of the Policy, then the term(s) and condition(s) contained herein shall be read mutatis mutandis with the scope of cover/terms and conditions contained in Part II of the Policy and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

8. Contribution

Multiple Policies:

(i) If two or more policies are taken by an Insured during a period from one or more insurers, the contribution clause shall not be applicable where the cover/ benefit offered:

1. Is fixed in nature;

2. Does not have any relation to the treatment costs;

(ii) In case of multiple policies which provide fixed benefits, on the occurrence of the Insured event in accordance with the terms and conditions of the policies, the insurer shall make the claim payments independent of payments received under other similar policies.

(iii) If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the insurer shall not apply the contribution clause, but the Policy holder shall have the right to require a settlement of his claim in terms of any of his policies

1. In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim without insisting on the contribution clause as long as the claim is within the limits of and according to the terms of the chosen policy.

2. If the amount to be claimed exceeds the Base Annual Sum Insured under a single policy after considering the deductible or co-pays, the policy holder shall have the right to choose insurers by whom the claim to be settled. In such cases, the insurer may settle the claim with contribution clause.

Except in benefit policies, in cases where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the Hospitalisation costs in accordance with the terms and conditions of the policy.

9. Limitation of Liability

If a Claim is rejected or partially settled under the terms of the Policy and is not the subject of a pending suit or other proceedings within the applicable period specified under the Limitation Act 1963 (as amended and any other applicable law), the Claim shall be deemed to have been abandoned and Our liability in respect of it shall be extinguished.

10. Underwriting and Loadings

We may apply a risk loading up to a maximum 100% per Insured Person, on the premium payable (excluding statutory levis & taxes) based on declarations on proposal form, your health status. Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s). There will be no loadings based on individual claims experience.

We will inform You about the applicable risk loading or special condition through a counter offer letter and We will only issue the Policy once We receive your consent on the applicable additional premium.

In case of loading on 2 or more ailments, the loadings shall apply in conjunction, however maximum risk loading per individual shall not exceed 100% of Premium excluding applicable Taxes. In case policies accepted with loadings, waiting period for Pre-existing disease's as well as 2 year waiting period shall be applicable.

In case policies accepted with loadings, waiting period for Pre-Existing Disease Waiting Period (Section 3.1) as well as 2 Year Waiting Period (Section 3.3) shall continue to be applicable.

11. Free Look Period

All new individual health insurance policies except those with tenure of less than a year shall have a free look period. The free look period shall be applicable at the inception of the policy and:

1. The insured will be allowed a period of at least 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable
2. If the insured has not made any claim during the free look period, the insured shall be entitled to a refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or;
   a. Where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or;
   b. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

12. Cancellation/ termination

(i) For Policyholder's initiated cancellation, the Company would compute refund amount as pro-rata (for the unexpired duration) premium further deducted by 25% of computed refundable premium towards management expenses.

This is provided no claim has been made under the Policy.

(ii) No Refund is applicable when policy is cancelled by the Insurer on grounds of misrepresentation, fraud, nondisclosure or non-cooperation of the Insured.

13. Cause of Action/ Currency for payments

No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Policy. All Claims shall be payable in India and shall be in Indian Rupees only.

14. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed by both You and Us to be adjudicated or interpreted in accordance with Indian law and only competent Courts of India shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

15. Portability & Continuity Benefits

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

It is further agreed and understood that:

(a) You have been covered under an Indian health insurance policy from a non-life insurance company or Health Insurance company registered with IRDAI without any break;

(b) We should have received Your application for Portability with complete documentation at least 45 days before the expiry of your present period of insurance;

(c) If the Base Annual Sum Insured under the previous Policy is higher than the Base Annual Sum Insured chosen under this Policy, the applicable waiting periods under Section 3 shall be waived to the extent of the Base Annual Sum Insured and eligible cumulative bonus under the expiring policy with the previous insurer;

(d) In case the proposed Base Annual Sum Insured opted for under Our Policy is more than the insurance cover under the previous policy, then all applicable waiting periods under Sections 3 shall be applicable afresh to the extent of the amount by which the Base Annual Sum Insured under this Policy exceed the total of Base Annual Sum Insured and eligible cumulative bonus under the expiring health insurance policy;

(e) All waiting periods under Sections 3 shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

(f) Portability benefit will be offered to the extent of sum of previous Base Annual Sum Insured (if opted for), and Portability shall not apply to any other additional increased Base Annual Sum Insured.

(g) We may subject Your proposal to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be as per our underwriting practices and underwriting policy of the Company.

(h) There is no obligation on Us to insure all Insured Persons on the proposed terms, even if You have given Us all documentation.

(i) We should have received the database and claim history from the previous insurance company for Your previous policy.

Portability shall be allowed in the following cases:

(a) All Individual health insurance policies issued by non-life insurance companies including family floater policies

(b) Individual members, including the family members covered under any group health insurance policy of a non-life insurance company shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. One year thereafter, he, she shall be accorded the right mentioned in clause (a) above.

The Portability provisions will apply to You, if You wish to migrate \ from this Policy to any other health insurance policy on Renewals. In case You have opted to switch to any other insurer under Portability provisions and the outcome of acceptance of the Portability request is awaited from the new insurer on the date of renewal,

(a) We may upon Your request extend this Policy for a period of not less than one month at an additional premium to be paid on a pro-rata basis

(b) If during this extension period a claim has been reported, You shall be required to first pay the full premium so as to make the Policy Period of full 12 calendar months. Our liability for the payment of such claim shall commence only once such premium is received. Alternately We may deduct the premium for the balance period.

16. Grace Period & Renewal

(a) The Policy will automatically terminate at the end of the Policy Period and must be renewed within the Grace Period for continuity of cover.

(b) The Policy may be renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable to pay for any claim arising out of an Illness/Injury/Hospitalisation that occurred during the Grace Period. The provisions of Section 64VB of the Insurance Act 1938 shall be applicable. All policies Renewed within the Grace Period shall be eligible for continuity of cover.

(c) The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium.

(d) Renewals will not be denied except on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material facts or non-co-operation by You.

(e) If We have discontinued or withdrawn this product/plan You will have the option to renewal under the nearest substitute Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy which has been approved by IRDAI

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

(g) We may, revise the Renewal premium payable under the Policy or the terms of cover, provided that all such changes are approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premium will not alter based on individual claims experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.

(h) Alterations such as increase/ decrease in Base Annual Sum Insured or change in plan/product or addition/deletion of Insured Persons will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy. Underwriting in relation to acceptance of request for changes will be based mainly as per underwriting policy of the company. The terms and conditions of the existing policy will not be altered. Increase/ Enhancement of Base Annual Sum Insured shall be allowed up to maximum Base Annual Sum Insured available under the Plan.

(i) Any enhanced Base Annual Sum Insured applied on Renewal will not be available for an Illness or Injury already contracted under the preceding Policy Periods.

17. Special Provision for Insured Person who are Senior citizen

The premium charged for health Insurance products offered to Senior citizens shall be fair, justified, transparent and duly disclosed upfront. The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of policy.

18. Communications & Notices

Any communication, notice, direction or instruction given under this

Policy shall be in writing and delivered by hand, post, or facsimile to: In Your case, at Your last known address per Our records in respect of this Policy. In Our case, at Our address specified in the Policy Schedule.

No insurance agent, broker or any other person is authorised to receive any notice on Our behalf.

19. Customer Service

If at any time You require any clarification or assistance, You may contact Our offices at the address specified in the Policy Schedule, during normal business hours or contact Our call centre.

20. ECS/ Auto Debit Payment Facility

You are eligible for availing the ECS / Auto Debit payment facility for your premium payments under this Policy. This facility can be opted for automatic premium payment under this Policy for such premium paying term as availed by you under this Policy by submitting a duly signed ECS / Auto Debit mandate form. You may opt for any premium payment term as per your convenience but in accordance with the Policy terms and conditions. Please note that this facility may not be available for all the Banks at present however and you are requested to kindly visit website: www.kotakgeneralinsurance.com to check the updated list of all partner banks facilitating the ECS/Auto Debit facility from time to time. Additionally, the following conditions shall apply in case of ECS / Auto Debit facility opted by you

a. The premium payment under the Policy shall be subject to change on renewal which would be in accordance with the terms and conditions of the Policy

b. The Policy shall get cancelled in the event of failure of ECS transaction towards payment of premium under the Policy and/or non-receipt of premium within the Grace Period under the Policy

c. The renewal premium amount under the Policy shall be communicated to you in advance i.e. minimum 45 days before the renewal date

d. You have the right to withdraw the ECS /Auto Debit mandate by giving Us at least 15 days' notice before the due date of next premium due under the Policy

The term ECS / Auto Debit herein shall be governed by the Electronic Clearing Service (Debit) Procedural Guidelines issued by the Reserve Bank of India (as may be amended from time to time) and shall mean an electronic facility for effecting periodic insurance premium payment transactions in an automated manner.

21. Grievances

For resolution of any query or grievance, insured may contact the respective branch office of the Company or may call at 18002664545 or may write an e- mail at care@kotak.com.

For senior citizens, please contact the respective branch office of the Company or call at 18002664545 or may write an e- mail at seniorcitizen@kotak.com.

In case the insured is not satisfied with the response of the office, insured may contact the Grievance Officer of the Company at grievanceofficer@kotak.com.

In the event of unsatisfactory response from the Grievance Officer, he/she may, subject to vested jurisdiction, approach the Insurance Ombudsman for the redressal of grievance. The details of the Insurance Ombudsman is available at

website: www.kotakgeneralinsurance.com

The updated details of Insurance Ombudsman offices are also available on the website of Executive Council of Insurers:

www.ecoi.co.in/ombudsman.html

The details of the Insurance Ombudsman is available at Annexure I

Annexure I: Details of Insurance Ombudsman

Office Details	Jurisdiction of Office Union Territory, District
Ahmedabad: Office of the Insurance Ombudsman, 6th Floor, Jeevan Prakash Bldg, Tilak Marg, Relief Road, Ahmedabad - 380001. Tel.: 079 – 25501201/ 02/ 05/ 06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
Bengaluru: Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049. Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
Bhopal: Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL(M.P.)-462 003.Tel.:- 0755-2769201 / 2769202, Fax : 0755-2769203. Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh and Chattisgarh.
Bhubneshwar: Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455, Fax: 0674 - 2596429, Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
Chandigarh: Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468, Fax: 0172 - 2708274, Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana,Himachal Pradesh, Jammu & Kashmir, Chandigarh.
Chennai: Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453,Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284, Fax: 044 - 24333664, Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
New Delhi: Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
Guwahati: Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205, Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Hyderabad: Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122, Fax: 040 - 23376599. Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
Jaipur: Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363, Email: bimalokpal.jaipur@ecoi.co.in	Rajasthan.

Ernakulam: Office of the Insurance Ombudsman,2nd floor, Pulinat Building, Opp. Cochin Shipyard, M.G. Road, Ernakulum - 682 015. Tel.:- 0484-2358759 / 2359338, Fax:- 0484-2359336, Email: bimalokpal.ernakulum@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
Kolkata: Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340, Fax : 033 - 22124341, Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
Lucknow: Office of the Insurance Ombudsman,6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310. Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar..
Mumbai: Office of the Insurance Ombudsman,3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052. Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
Noida: Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector-15, Distt: Gautam Buddh Nagar, Noida, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253. Email:- bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
Patna: Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna - 800 006. Tel.: 0612-2680952. Email:- bimalokpal.patna@ecoi.co.in	Bihar and Jharkhand.
Pune: Office of the Insurance Ombudsman,Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth,Pune – 411 030. Tel.: 020 - 41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

EXTENSIONS/ ENDORSEMENTS WORDINGS

The following Extensions/Endorsements applicable under the Policy only if We have received the applicable premium due for that Extension/Endorsement in full and the Policy Schedule specifies that the Extension/Endorsement is in force for the Insured Person.

Benefits under the Extension/Endorsement will be applicable subject to the terms, conditions and exclusions of the Extension/Endorsement, the terms, conditions and exclusions of the Policy and the availability of Base Annual Sum Insured and Cumulative Bonus and subject always to any sub-limits specified in respect of that Extension/Endorsement and any limits applicable under the Plan in force for the Insured Person as specified in the Policy Schedule.

Extension HC 1 - Hospital Daily Cash

We will pay the Daily Cash Amount specified in the Policy Schedule f o r this Extension for each and every completed day of the Insured Person's Hospitalisation during the Policy Period provided that:

a) We have accepted a Claim for In-patient Treatment under the Policy;

b) The Insured Person's Hospitalisation extends for at least 3 consecutive days, in which case We will make payment under this Extension from the first day of Hospitalisation.

c) We shall not be liable to make payment for more than the maximum number of days per policy year specified in the Policy Schedule for this Extension.

d) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ floater).

e) The payment under this benefit is over and above the opted Base Annual Sum Insured.

Extension HC 2 - Convalescence Benefit

We will pay the amount specified in the Policy Schedule for this Extension if the Insured Person is Admitted in Hospital for a minimum period of 10 consecutive days provided that:

a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalisation;

b) We shall not be liable to make payment under this Extension in respect of an Insured Person more than once during the Policy Year.

c) This benefit is applicable on an individual basis irrespective of type of policy (Individual / floater).

d) The payment under this benefit is over and above the opted Base Annual Sum Insured.

Extension HC 3 - Domiciliary Hospitalisation Cover

We will indemnify the Medical Expenses incurred on the Insured Person's Domiciliary Hospitalisation during the Policy Period following an Illness or Injury that occurs during the Policy Period up to the limits of the opted Base Annual Sum Insured (subject to availability of opted Base Annual Sum Insured), provided that:

a) We will cover medical expenses of an Insured person for treatment of a disease, illness or injury taken at home which would otherwise have required hospitalisation or since the Insured person's condition did not allow a hospital transfer or a hospital bed was unavailable. This is provided that the condition for which treatment is required continues for at least 3 days and is on the advice of a medical practitioner.

b) The domiciliary Hospitalisation is Medically Necessary and follows the written advice of a Medical Practitioner

c) The Medical Expenses incurred are Reasonable and Customary Charges;

d) The Insured Person's Domiciliary Hospitalisation extends for at least 3 consecutive days in which case We will pay Medical Expenses under this Extension from the first day of Domiciliary Hospitalisation;

e) In case of Individual policy, this payout will available on Individual basis and In case of floater the payout will be available on floater basis.

f) The payment under this benefit is within the opted Base Annual Sum Insured.

g) We will not indemnify any Pre-Hospitalisation Medical Expenses or Post-Hospitalisation Medical Expenses under this Extension;

h) We shall not indemnify any Medical Expenses incurred for the treatment of any of the following Illnesses/conditions:

i) Asthma;

ii. Bronchitis;

iii. Chronic Nephritis and Chronic Nephritic Syndrome;

iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis;

v. Diabetes Mellitus and Insipidus;

vi. Epilepsy;

vii. Hypertension;

viii. Influenza, cough and cold;

ix. All psychiatric or psychosomatic disorders;

x. Pyrexia of unknown origin for less than 10 days;

xi. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;

xii. Arthritis, Gout and Rheumatism.

Exclusion 3.4(w) of the Policy Wordings stands deleted to the extent of this Extension only.

Extension HC 4 - Donor Expenses

We will indemnify the In-patient Hospitalisation Medical Expenses towards the donor for harvesting the organ up to the limits of the opted Base Annual Sum Insured (subject to availability of opted Base Annual Sum Insured), provided that:

a. The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules;

b. The organ donated is for the use of the Insured Person who has been asked to undergo an organ transplant on Medical Advise;

c. We have accepted a Claim for In-patient Treatment under the Policy in respect of the Insured Person;

d. In case of Individual policy, this payout will available on Individual basis and In case of floater the payout will be available on floater basis.

e. The payment under this benefit is within the opted Base Annual Sum Insured.

f. We will not cover expenses towards the donor in respect of:

(i) Any Pre-Hospitalisation Medical Expenses or Post-Hospitalisation Medical Expenses;

(ii) Costs directly or indirectly associated to the acquisition of the organ;

(iii) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

Exclusion 3.4(aa) of the Policy Wordings stands deleted to the extent o f this Extension only.

Extension HC 5 - Alternative Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Alternative Treatment up to INR 50,000/- (subject to availability of opted Base Annual Sum Insured), provided that:

(a) The Alternative Treatment is administered by a Medical Practitioner;

(b) The Insured Person is admitted to Hospital as an Inpatient for the Alternative Treatment to be administered.

(c) In case of Individual policy, this payout will available on Individual basis and In case of floater the payout will be available on floater basis.

(d) The payment under this benefit is within the opted Base Annual Sum Insured.

Exclusion 3.4(bb) of the Policy stands deleted to the extent of this Extension only.

Extension HC 6 - Critical Illness Cover

If the Insured Person is first diagnosed to be suffering from any of the following Critical Illnesses during the Policy Period, We will pay the Critical Illness Sum Insured specified in the Policy Schedule for this Extension, provided that:

(a) On payment of additional premium, cover would be provided to each individual on the opted limit of amount (Sum Insured) for the policy period. This cover would be applicable on individual sum insured basis;

(b) We shall not be liable to accept any Claim under this Extension if it pertains to any Critical Illness diagnosed within 90 days of the commencement of the first Policy Period of this Extension with Us;

(c) We shall not be liable to make payment under this Extension more than once in respect of any Insured Person across all Policy Periods;

(d) Payment under this Extension will not impact the opted Base Annual Sum Insured or the Cumulative Bonus (if any).

(e) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ floater).

(f) The payment under this benefit is over and above the opted Base Annual Sum Insured.

(g) Once a claim has been accepted and paid for a particular Critical illness, this extension shall cease in respect of that Insured Person, but shall continue to be in force for other Insured Persons.

(h) Notwithstanding any provision to the contrary in the Policy, under this Extension alone We will cover Claims occurring worldwide;

(i) In the event of a Claim arising under this Extension, We shall be given written notice of the Claim within 30 days from the date of the first diagnosis of the Critical Illness and We shall be provided the following information and documentation:

i) The Claim documents stated in the Policy, provided that We will accept duly certified copies of the listed documents if the originals are required to be submitted to any other insurance company;

ii) Written confirmation of the diagnosis of the Critical Illness from the treating Medical Practitioner;

"Critical Illness" for the purpose of this Extension means the following:

1) CANCER OF SPECIFIED SEVERITY

(i) A malignant tumor characterized by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, Lymphoma and Sarcoma.

(ii) The following are excluded -

(a) Tumours showing the malignant changes of Carcinoma in situ & Tumours which are histologically described as premalignant or non invasive, including but not limited to:

Carcinoma in situ of breasts, Cervical Dysplasia CIN-1, CIN-2 & CIN-3.

(b) Any skin cancer other than invasive Malignant Melanoma

(c) All Tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progress to at least clinical TNM classification T2N0M0

(d) Papillary Micro - Carcinoma of the Thyroid less than 1 cm in diameter

(e) Chronic Lymphocyctic Leukaemia less than RAI stage 3

(f) Microcarcinoma of the bladder

(g) All Tumours in the presence of HIV infection.

2) OPEN CHEST CABG

(a) The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by Coronary Artery Bypass Graft (CABG). The diagnosis must be supported by a Coronary Angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

(b) The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

ii. Any key-hole or laser surgery.

3) FIRST HEART ATTACK OF SPECIFIED SEVERITY

(a) The first occurrence of Myocardial Infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

(b) The following are excluded:

i. Non-ST-segment Elevation Myocardial Infarction (NSTEMI) with elevation of Troponin I or T
ii. Other acute Coronary Syndromes
iii. Any type of Angina Pectoris.

4) KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular Renal Dialysis (Hemodialysis or Peritoneal Dialysis) is instituted or Renal Transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

5) MAJOR ORGAN /BONE MARROW TRANSPLANT

(a) The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

(b) The following are excluded:

a. Other stem-cell transplants
b. Where only islets of langerhans are transplanted

6) STROKE RESULTING IN PERMANENT SYMPTOMS

(a) Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosisin an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinicalsymptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

(b) The following are excluded:

i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

7) PERMANENT PARALYSIS OF LIMBS

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

8) OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echo cardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not Limited to, balloon valvotomy/valvuloplasty are excluded.

9) COMA OF SPECIFIED SEVERITY

(a) A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

(i) No response to external stimuli continuously for at least 96 hours;
(ii) Life support measures are necessary to sustain life; and
(iii) Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

b) The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

10) MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS

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

11) MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

1. The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

(a) Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis; and

(b) There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months; and well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.

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

12) BENIGN BRAIN TUMOR

(a) A benign tumour in the brain where all of the following conditions are met:

(i) It is life threatening;
(ii) It has caused damage to the brain;
(iii) It has undergone surgical removal or, if inoperable, has caused a Permanent neurological deficit such as (but not restricted to) characteristic symptoms of increased intracranial pressure such as papilloedema, mental seizures andsensorimpairment; and For the purpose of this benefit, the word “Permanent” shall mean beyond the hope of recovery with current medical knowledge and technology;
(iv) Its presence must be confirmed by a Neurologist or Neurosurgeon acceptable to Us and supported by findings on Magnetic Resonance Imaging (MRI), Computerised Tomography, or other reliable imaging technique.

(b) The following conditions are not covered:

(i) Cysts;
(ii) Granulomas;
(iii) Vascular malformations
(iv) Haematoma;
(v) Meningiomas
(vi) Tumours of the pituitary gland or spinal cord; and
(vii) Tumours of acoustic nerve (acoustic neuroma)

13) AORTA GRAFT SURGERY

The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of “Aorta” shall mean the thoracic and abdominal aorta but not its branches.

(a) The following conditions are excluded:

(i) Surgery performed using only minimally invasive or intra-arterial techniques.
(ii) Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.

(b) The diagnosis to be evidenced by any two of the following:

(i) Computerized tomography (CT) scan
(ii) Magnetic Resonance Imaging (MRI) scan
(iii) Echocardigraphy (an ultrasound of the heart)
(iv) Angiography (Injecting X ray dye)
(v) Abdominal ultrasound

14) THIRD DEGREE (OR MAJOR) BURNS

Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Insured Person's body and evidenced by specific results based on the Lund Browder Chart or equivalent burn area calculator. The condition should be confirmed by a specialist Medical Practitioner (Surgeon).

Burns arising due to self-infliction are excluded.

15) PRIMARY PULMONARY ARTERIAL HYPERTENSION

Primary Pulmonary Hypertension with substantial right ventricular enlargement with the diagnosis established by a consultant pulmonologist or cardiologist using clinical

examination and laboratory procedures, including cardiac catheterisation, resulting in permanent physical impairment of Class IV level of the New York Heart Association (NYHA) Classification of Cardiac Impairment.

(a) The diagnosis must be supported by all three (3) of the following criteria:
  (i) Mean pulmonary artery pressure > 40 mmHg; and
  (ii) Pulmonary vascular resistance > 3 mmHg / L / min; and
  (iii) Normal pulmonary wedge pressure < 15 mmHg.

(b) The diagnosis to be proved by following tests:
  (i) Ventilation perfusion or V/Q scanning
  (ii) Arterial blood gas measurements
  (iii) Pulmonary function tests
  (iv) X-rays of the chest
  (v) Right-sided cardiac catheterization

(c) Secondary Pulmonary Hypertension is completely excluded. Examples are secondary pulmonary hypertension caused by the followings:
  (i) Liver cirrhosis and portal hypertension
  (ii) HIV infection
  (iii) Systemic connective tissue disease
  (iv) Lung disease
  (v) Chronic hypoventilation
  (vi) Pulmonary thromboembolic disease
  (vii) Diseases of the left side of the heart
  (viii) Congenital heart disease

(d) New York Heart Classification:
  (i) Class I: Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea or angina pain.
  (ii) Class II: Patients with cardiac disease results in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea or angina pain.
  (iii) Class III: Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or anginal pain.
  (iv) Class IV: Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure,

  or the angina syndrome may be present even at rest. If any physical activity is undertaken, discomfort increases.

16) END STAGE LIVER DISEASE/FAILURE

(a) End Stage Liver Disease/Failure evidenced by all of the following:
  (i) Permanent jaundice; (bilirubin > 2micromol/l)
  (ii) Uncontrollable Ascites; and
  (iii) Albumin<3.5g/dl
  (iv) Prothrombin time <70% of the normal for the age & gender
  (v) Hepatic Encephalopathy
  (vi) Oesophageal or Gastric Varices and portal hypertension.

(b) The following are excluded:
  (i) Child-Pugh-Stage A
  (ii) Liver disease due to alcohol or drug misuse

17) DEAFNESS OR LOSS OF HEARING

Total and irreversible loss of hearing in both ears as a result of Illness or Injury persisting for at least 6 months. The diagnosis must be supported by audiometric and sound-threshold tests provided and certified by an Ear, Nose, Throat (ENT) specialist." Total Loss" means loss of at least 80 decibels in all frequencies of hearing in both the ears. The deafness must not be correctable by aides or surgical procedures

18) LOSS OF SPEECH

Total and permanent loss of the ability to produce intelligible speech as a result of irreversible damage to the larynx or its nerve supply from the speech centres of the brain caused by injury, tumour or sickness. Medical evidence must be supplied by an appropriate specialist to confirm laryngeal dysfunction and that the loss of speech has lasted for more than 6 months continuously.

All psychiatric causes of loss of speech are excluded. No benefit will be payable if, in general medical opinion, a device, or implant could result in the partial or total restoration of speech.

Extension HC 7 - Maternity Benefit

We will indemnify the Medical Expenses incurred up to the Maternity Benefit Sum Insured specified in the Policy Schedule for this Extension for the delivery of the Insured Person's child (including caesarian section) during Hospitalisation or the Medically Necessary and lawful medical termination of pregnancy during the Policy Period provided that:

(a) We shall not be liable to make any payment under this Extension until the waiting period specified in the Policy Schedule for this Extension has expired;

(b) The cover shall be available to the Insured between 18 to 45 years where the Insured should have been continuously covered for at least 36 months with this optional extension.

(c) We shall not be liable to more than 2 deliveries or terminations across all Policy Periods with Us;

(d) We will cover pre-natal and post-natal expenses up to the amount specified in the Policy Schedule for this Extension provided that We have accepted a Claim for delivery/termination under this Extension;

(e) Payment under this Extension will not impact the opted base annual sum Insured or the Cumulative Bonus (if any);

(f) This benefit is applicable on an individual basis irrespective of type of policy (Individual / floater).

(g) The payment under this benefit is over and above the opted Base Annual Sum Insured.

(h) We will not indemnify any Pre-Hospitalisation Medical Expenses or Post-Hospitalisation Medical Expenses under this Extension;

(i) Ectopic pregnancy shall not be covered under this Extension, but any Claims will be considered under In-patient Treatment;

Exclusion 3.4(m) of the Policy Wordings stands deleted to the extent of this Extension only.

Extension HC 8 - New Born Baby Cover

We will indemnify the Medical Expenses incurred on the Hospitalisation of the Insured Person's New Born Baby during the Policy Period up to the limits of the Base Annual Sum Insured (subject to availability of Base Annual Sum Insured). Subject to the terms and conditions of the Policy, We will cover the New Born Baby beyond 90 days on payment of requisite

Premium for the New Born Baby into the Policy by way of an endorsement or at the next Renewal, whichever is earlier.

(a) In case of Individual policy, this payout will available on Individual basis and In case of floater the payout will be available on floater basis.

(b) The payment under this benefit is within the opted Base Annual Sum Insured.

(c) Any pre and post Hospitalisation expenses for the new born shall not be covered under this benefit.

Extension HC 9 - Compassionate Visit

We will indemnify the costs of a return (to and fro) economy class domestic air ticket for one of the Insured Person's Immediate Relative to travel from the place of the Immediate Relative's residence to the Hospital where the Insured Person is hospitalized, in case of the Insured Person's Hospitalisation extends beyond 5 consecutive days.

This benefit is payable, provided a claim is admitted under this policy. For the purpose of this Extension, the term "Immediate Relative" would mean the Insured Person's spouse, dependent children or dependent parents.

Extension HC 10 - Restoration of Sum Insured

We will provide a 100% restoration of the opted Base Annual Sum Insured once in a Policy Year if the opted Base Annual Sum Insured and the Cumulative Bonus (if any) is insufficient as a result of previous Claims in that Policy Year, provided that:

(a) The restored Base Annual Sum Insured will only be available for future Claims under the Policy and not in respect of any Claims for any Illness (including its complications) in respect of which a Claim has already been accepted in that Policy Year;

(b) No Cumulative Bonus will apply on the restored Base Annual Sum Insured;

(c) The restored Base Annual Sum Insured will apply to all Insured Persons on the same basis as the opted Base Annual Sum Insured;

(d) Benefit under this extension is applicable only for basic covers but not for any optional extensions

(e) Any restored Base Annual Sum Insured which is not utilized in a Policy Year shall not be carried forward to any subsequent Policy Year;

(f) We shall not restore the Base Annual Sum Insured more than once in any Policy Year;

(g) Restoration of Sum Insured will be in addition to opted Base Annual Sum Insured.

(h) In case of Individual policy, payment under this cover shall be available on Individual basis and In case of floater the payment shall be will be available on floater basis.

Extension HC 11 - Double Sum Insured for Hospitalisation due to Accident

We will indemnify Medical Expenses incurred in respect of the Insured Person's Hospitalisation during the Policy Period in respect of an Injury sustained solely and directly due to an Accident which occurs during the Policy Period upto twice the opted Base Annual Sum Insured provided that:

(a) In calculating the amount available to the Insured Person under this Extension, We shall deduct any amount previously paid from twice the opted Base Annual Sum Insured during the Policy Year;

(b) The amount calculated under this Extension shall not be available for Medical Expenses incurred for treatment of any other Injury or Illness;

(c) The amount calculated under this Extension shall not be available for payment of benefits under any provision other than the In-patient Treatment cover under the Policy;

(d) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ floater).

(e) The payment under this benefit is over and above the opted Base Annual Sum Insured.

(f) If this amount is un-utilised (in whole or in part) in any Policy Year, it shall not be carried forward to any subsequent Policy Year.

Extension HC 12 - Cap on Room Rent

If We accepted a Claim for In-patient Hospitalisation under the Policy and if the Insured Person incurs Room Rent that is higher than the eligible Room Rent as specified in the Policy Schedule then We will be liable to pay only a rateable proportion of the Medical Expenses incurred in the proportion of the difference between "the Room Rent and the Associated Medical Expenses" of the eligible Room Rent and "the Room Rent and the Associated Medical Expenses" actually incurred, provided that Reasonable and Customary costs incurred on medicines/pharmacy, medical consumables and medical implants will be reimbursed based on the actual amounts incurred.

Under this optional extension the insured is entitled for a discount in base premium as entitled on opting the Cap on Room Rent.

Annexure II: List of Day Care Surgeries

Sr. No	Operations on the eyes
1	Incision of tear glands
2	Other operations on the tear ducts
3	Incision of diseased eyelids
4	Excision and destruction of diseased tissue of the eyelid
5	Operations on the canthus and epicanthus
6	Corrective surgery for entropion and ectropion
7	Corrective surgery for blepharoptosis
8	Removal of a foreign body from the conjunctiva
9	Removal of a foreign body from the cornea
10	Incision of the cornea
11	Operations for pterygium
12	Other operations on the cornea
13	Removal of a foreign body from the lens of the eye
14	Removal of a foreign body from the posterior chamber of the eye
15	Removal of a foreign body from the orbit and eyeball
16	Operation of cataract
	Operations on the nose & the nasal sinuses
17	Excision and destruction of diseased tissue of the nose
18	Operations on the turbinates (nasal concha)
19	Other operations on the nose
20	Nasal sinus aspiration
21	Foreign body removal from nose
	Microsurgical operations on the middle ear
22	Stapedotomy
23	Stapedectomy
24	Revision of a stapedectomy
25	Other operations on the auditory ossicles
26	Myringoplasty (Type -I Tympanoplasty)
27	Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
28	Revision of a tympanoplasty
29	Other microsurgical operations on the middle ear
	Other operations on the middle & internal ear
30	Myringotomy
31	Removal of a tympanic drain
32	Incision of the mastoid process and middle ear
33	Mastoidectomy
34	Reconstruction of the middle ear
35	Other excisions of the middle and inner ear
36	Fenestration of the inner ear
37	Revision of a fenestration of the inner ear
38	Incision (opening) and destruction (elimination) of the inner ear
39	Other operations on the middle and inner ear

	Operations on the tongue
40	Incision, excision and destruction of diseased tissue of the tongue
41	Partial glossectomy
42	Glossectomy
43	Reconstruction of the tongue
44	Other operations on the tongue

	Operations on the nose & the nasal sinuses
45	External incision and drainage in the region of the mouth, jaw and face
46	Incision of the hard and soft palate
47	Excision and destruction of diseased hard and soft palate
48	Incision, excision and destruction in the mouth
49	Plastic surgery to the floor of the mouth
50	Palatoplasty
51	Other operations in the mouth

	Operations on the tonsils & adenoids
52	Transoral incision and drainage of a pharyngeal abscess
53	Tonsillectomy without adenoidectomy
54	Tonsillectomy with adenoidectomy
55	Excision and destruction of a lingual tonsil
56	Other operations on the tonsils and adenoids

	Operations on the salivary glands & salivary ducts
57	Incision and lancing of a salivary gland and a salivary duct
58	Excision of diseased tissue of a salivary gland and a salivary duct
59	Resection of a salivary gland
60	Reconstruction of a salivary gland and a salivary duct
61	Other operations on the salivary glands and salivary ducts

	Operations on the breast
62	Incision of the breast
63	Operations on the nipple

	Operations on the skin & subcutaneous tissues
64	Incision of a pilonidal sinus
65	Other incisions of the skin and subcutaneous tissues
66	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
67	Local excision of diseased tissue of the skin and subcutaneous tissues
68	Other excisions of the skin and subcutaneous tissues
69	Simple restoration of surface continuity of the skin and subcutaneous tissues
70	Free skin transplantation, donor site
71	Free skin transplantation, recipient site
72	Revision of skin plasty
73	Other restoration and reconstruction of the skin and subcutaneous tissues.
74	Chemosurgery to the skin.
75	Destruction of diseased tissue in the skin and subcutaneous tissues

	Operations on the digestive tract
76	Incision and excision of tissue in the perianal region
77	Surgical treatment of anal fistulas
78	Surgical treatment of haemorrhoids
79	Division of the anal sphincter (sphincterotomy)
80	Other operations on the anus
81	Ultrasound guided aspirations
82	Sclerotherapy etc.

	Operations of bones and joints
83	Surgery for ligament tear
84	Surgery for meniscus tear
85	Surgery for hemoarthrosis/ pyoarthrosis
86	Removal of fracture pins/ nails
87	Removal of metal wire
88	Closed reduction on fracture, luxation
89	Reduction of dislocation under GA
90	Epiphyseolysis with osteosynthesis
91	Trauma surgery and orthopaedics
92	Incision on bone, septic and aseptic
93	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
94	Suture and other operations on tendons and tendon sheath

	Operations on the female sexual organs
95	Incision of the ovary
96	Insufflation of the fallopian tubes
97	Other operations on the Fallopian tube
98	Dilatation of the cervical canal
99	Conisation of the uterine cervix
100	Other operations on the uterine cervix
101	Incision of the uterus (hysterotomy)
102	Therapeutic curettage
103	Culdotomy
104	Incision of the vagina
105	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
106	Incision of the vulva
107	Operations on Bartholin's glands (cyst)

	Operations on the prostate & seminal vesicles
108	Incision of the prostate
109	Transurethral excision and destruction of prostate tissue
110	Transurethral and percutaneous destruction of prostate tissue
111	Open surgical excision and destruction of prostate tissue
112	Radical prostatovesiculectomy
113	Other excision and destruction of prostate tissue
114	Operations on the seminal vesicles

115	Incision and excision of periprostatic tissue
116	Other operations on the prostate
	Operations on the scrotum & tunica vaginalis testis
117	Incision of the scrotum and tunica vaginalis testis
118	Operation on a testicular hydrocele
119	Excision and destruction of diseased scrotal tissue
120	Plastic reconstruction of the scrotum and tunica vaginalis testis
121	Other operations on the scrotum and tunica vaginalis testis
	Operations on the testes
122	Incision of the testes
123	Excision and destruction of diseased tissue of the testes
124	Unilateral orchidectomy
125	Bilateral orchidectomy
126	Orchidopexy
127	Abdominal exploration in cryptorchidism
128	Surgical repositioning of an abdominal testis
129	Reconstruction of the testis
130	Implantation, exchange and removal of a testicular prosthesis
131	Other operations on the testis
	Operations on the spermatic cord, epididymis und ductus deferens
132	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
	Operations on the spermatic cord, epididymis and ductus deferens
133	Excision in the area of the epididymis
134	Epididymectomy
135	Reconstruction of the spermatic cord
136	Reconstruction of the ductus deferens and epididymis
137	Other operations on the spermatic cord, epididymis and ductus deferens
	Operations on the penis
138	Operations on the foreskin
139	Local excision and destruction of diseased tissue of the penis
140	Amputation of the penis
141	Plastic reconstruction of the penis
142	Other operations on the penis
	Operations on the urinary system
143	Cystoscopical removal of stones
	Other Operations
144	Lithotripsy
145	Coronary angiography
146	Haemodialysis
147	Radiotherapy for Cancer
148	Cancer Chemotherapy
149	Endoscopic polypectomy

Annexure III: List of Expenses Generally Excluded ('Non-admissible Expenses') in Hospitalisation Policy

GUIDELINES ON STANDARDISATION IN HEALTH INSURANCE IRDA CIRCULAR No IRDA/HLT/CIR/036/02/2013 DATED 20.02.2013

Sr.	Items	Suggestions
	A. Toiletries/ Cosmetics/ Personal Comfort or Convenience Items	
1	Hair Removing Cream	Not Payable
2	Baby Charges (unless specified/indicated)	Not Payable
3	Baby Food	Not Payable
4	Baby Utilites Charges	Not Payable
5	Baby Set	Not Payable
6	Baby Bottles	Not Payable
7	Brush	Not Payable
8	Cosy Towel	Not Payable
9	Hand Wash	Not Payable
10	Moisturiser Paste Brush	Not Payable
11	Powder	Not Payable
12	Razor	Payable
13	Shoe Cover	Not Payable
14	Beauty Services	Not Payable
15	Belts/ Braces	Essential and Should be Paid at least Specifically for Cases who have undergone surgery of Thoracic or Lumbar Spine
16	Buds	Not Payable
17	Barber Charges	Not Payable
18	Caps	Not Payable
19	Cold Pack/Hot Pack	Not Payable
20	Carry Bags	Not Payable
21	Cradle Charges	Not Payable
22	Comb	Not Payable
23	Disposable Razor Charges (For Site Preparations)	Payable
24	Eau-De-Cologne / Room Freshners	Not Payable
25	Eye Pad	Not Payable
26	Eye Sheild	Not Payable
27	Email / Internet Charges	Not Payable
28	Food Charges (other than Patient's Diet Provided by Hospital)	Not Payable
29	Foot Cover	Not Payable
30	Gown	Not Payable
31	Leggings	Essential in Bariatric and Varicose Vein Surgery and may be considered for at least these conditions where Surgery itself is Payable.

32	Laundry Charges	Not Payable
33	Mineral Water	Not Payable
34	Oil Charges	Not Payable
35	Sanitary Pad	Not Payable
36	Slippers	Not Payable
37	Telephone Charges	Not Payable
38	Tissue Paper	Not Payable
39	Tooth Paste	Not Payable
40	Tooth Brush	Not Payable
41	Guest Services	Not Payable
42	Bed Pan	Not Payable
43	Bed Under Pad Charges	Not Payable
44	Camera Cover	Not Payable
45	Cliniplast	Not Payable
46	Crepe Bandage	Not Payable/ Payable by the Patient
47	Curapore	Not Payable
48	Diaper Of Any Type	Not Payable
49	DVD, CD Charges	Not Payable (However if CD is specifically sought by Insurer/TPA then Payable)
50	Eyelet Collar	Not Payable
51	Face Mask	Not Payable
52	Flexi Mask	Not Payable
53	Gause Soft	Not Payable
54	Gauze	Not Payable
55	Hand Holder	Not Payable
56	Hansaplast/ Adhesive Bandages	Not Payable
57	Infant Food	Not Payable
58	Slings	Reasonable costs for one sling in case of Upper Arm Fractures may be considered

B. Items Specifically Excluded in Policies		
59	Weight Control Programs/ Supplies/ Services	Exclusion in Policy unless otherwise specified
60	Cost of Spectacles/ Contact Lenses/ Hearing Aids Etc.,	Exclusion in Policy unless otherwise specified
61	Dental Treatment Expenses that do not require Hospitalisation	Exclusion in Policy unless otherwise specified
62	Hormone Replacement Therapy	Exclusion in Policy unless otherwise specified
63	Home Visit Charges	Exclusion in Policy unless otherwise specified
64	Infertility/ Subfertility / Assisted Conception Procedure	Exclusion in Policy unless otherwise specified
65	Obesity (including Morbid Obesity) Treatment if Excluded in Policy	Exclusion in Policy unless otherwise specified
66	Psychiatric & Psychosomatic Disorders	Exclusion in Policy unless otherwise specified
67	Corrective Surgery for Refractive Error	Exclusion in Policy unless otherwise specified
68	Treatment of Sexually Transmitted Diseases	Exclusion in Policy unless otherwise specified
69	Donor Screening Charges	Exclusion in Policy unless otherwise specified
70	Admission/Registration Charges	Exclusion in Policy unless otherwise specified
71	Hospitalisation for Evaluation/ Diagnostic Purpose	Exclusion in Policy unless otherwise specified
72	Expenses for Investigation/ Treatment irrelevant to the Disease for which admitted or diagnosed	Exclusion in Policy not payable unless otherwise specified
73	Any Expenses when the Patient is diagnosed with Retro Virus + or suffering from /HIV/ Aids etc is detected/ directly or indirectly	Not Payable as per HIV/ AIDS Exclusion
74	Stem Cell Implantation/ Surgery & Storage	Not Payable except Bone Marrow Transplantation where covered by Policy

C. Items Which form Part of Hospital Services where Separate Consumables are not Payable but the Service is		
75	Ward and Theatre Booking Charges	Payable Under OT Charges, Not Payable Separately
76	Arthroscopy & Endoscopy Instruments	Rental Charged By The Hospital Payable.Purchase of Instruments Not Payable.
77	Microscope Cover	Payable Under OT Charges, Not Payable Separately
78	Surgical Blades,Harmonic Scalpel, Shaver	Payable Under OT Charges, Not Payable Separately
79	Surgical Drill	Payable Under OT Charges, Not Payable Separately
80	Eye Kit	Payable Under OT Charges, Not Payable Separately
81	Eye Drape	Payable Under OT Charges, Not Payable Separately
82	X-Ray Film	Payable Under Radiology Charges, Not as Consumable
83	Sputum Cup	Payable Under Investigation Charges, Not as Consumable
84	Boyles Apparatus Charges	Part Of Ot Charges, Not Seperately
85	Blood Grouping and Cross Matching of Donors Samples	Part Of Cost Of Blood, Not Payable
86	Antiseptic & Disinfectant Lotions	Not Payable-Part of Dressing Charges
87	Band Aids, Bandages, Sterile Injections, Needles, Syringes	Not Payable - Part of Dressing Charges
88	Cotton	Not Payable-Part of Dressing Charges
89	Cotton Bandage	Not Payable-Part of Dressing Charges
90	Micropore/ Surgical Tape	Not Payable-payable by the Patient when Prescribed, otherwise included as Dressing Charges
91	Blade	Not Payable
92	Apron	Not Payable -Part of Hospital Services /Disposable Linen to be Part of OT/ ICU Charges

93	Torniquet	Not Payable (service is charged by Hospitals, Consumables cannot be separately charged)
94	Orthobundle, Gynaec Bundle	Part of Dressing Charges
95	Urine Container	Not Payable
D. Elements of Room Charge		
96	Luxury Tax	Policy Exclusion - Not Payable. If there is no Policy Exclusion, then Actual Tax Levied by Government is Payable - Part of Room Charge for Sub Limits
97	HVAC	Part of Room Charge Not Payable Separately
98	House Keeping Charges	Part of Room Charge Not Payable Separately
99	Service Charges where Nursing Charge also charged	Part of Room Charge Not Payable Separately
100	Television & Air Conditioner Charges	Payable Under Room Charges Not if separately levied
101	Surcharges	Part of Room Charge Not Payable Separately
102	Attendant Charges	Not Payable - Part of Room Charges
103	IM/ IV Injection Charges	Part of Nursing Charges, Not Payable
104	Clean Sheet	Part of Laundry / housekeeping Not Payable Separately
105	Extra Diet of Patient(other than that which forms part of Bed Charge)	Not Payable. Patient Diet Provided by Hospital is Payable
106	Blanket/Warmer Blanket	Not Payable- Part of Room Charges
E. Administrative or Non-medical Charges		
107	Admission Kit	Not Payable
108	Birth Certificate	Not Payable
109	Blood Reservation Charges and Ante Natal Booking Charges	Not Payable
110	Certificate Charges	Not Payable
111	Courier Charges	Not Payable
112	Convenyance Charges	Not Payable
113	Diabetic Chart Charges	Not Payable
114	Documentation Charges / Administrative Expenses	Not Payable
115	Discharge Procedure Charges	Not Payable
116	Daily Chart Charges	Not Payable
117	Entrance Pass / Visitors Pass Charges	Not Payable
118	Expenses Related to Prescription on Discharge	To be Claimed by Patient under Post -Hospitalisation where admissible
119	File Opening Charges	Not Payable
120	Incidental Expenses / Misc. Charges (not Explained)	Not Payable
121	Medical Certificate	Not Payable
122	Maintainance Charges	Not Payable
123	Medical Records	Not Payable
124	Preparation Charges	Not Payable
125	Photocopies Charges	Not Payable
126	Patient Identification Band / Name Tag	Not Payable
127	Washing Charges	Not Payable
128	Medicine Box	Not Payable
129	Mortuary Charges	Payable Upto 24 Hrs, Shifting Charges Not Payable
130	Medico Legal Case Charges (MLC Charges)	Not Payable
F. External Durable Devices		
131	Walking Aids Charges	Not Payable
132	Bipap Machine	Not Payable
133	Commode	Not Payable
134	CPAP/ CPAD Equipments Device	Not Payable
135	Infusion Pump - Cost	Not Payable
136	Oxygen Cylinder (for Usage outside the Hospital)	Not Payable
137	Pulseoxymeter Charges Device	Not Payable
138	Spacer	Not Payable
139	Spirometre	Not Payable
140	SPO2 Probe	Not Payable
141	Nebulizer Kit	Not Payable
142	Steam Inhaler	Not Payable
143	Armsling	Not Payable
144	Thermometer	Not Payable (paid By Patient)
145	Cervical Collar	Not Payable
146	Splint	Not Payable
147	Diabetic Foot Wear	Not Payable
148	Knee Braces (Long/ Short/ Hinged)	Not Payable
149	Knee Immobilizer/Shoulder Immobilizer	Not Payable
150	Lumbo Sacral Belt	Essential and should be paid at least specifically for cases who have undergone Surgery of Lumbar Spine
151	Nimbus Bed or Water or Air Bed Charges	Payable for any ICU Patient requiring more than 3 Days in ICU; All Patients with Paraplegia /Quadriplegia for any reason and at Reasonable Cost of approximately Rs 200/Day
152	Ambulance Collar	Not Payable
153	Ambulance Equipment	Not Payable
154	Microsheild	Not Payable

155	Abdominal Binder	Essential and should be Paid at least in Post Surgery Patients of Major Abdominal Surgery Including TAH, LSCS, Incisional Hernia Repair, Exploratory Laparotomy for Intestinal Obstruction, Liver Transplant Etc.
G. Items Payable If Supported By A Prescription		
156	Betadine \ Hydrogen Peroxide \ Spirit \ Disinfectants Etc	May be Payable when prescribed for Patient, Not Payable for Hospital use in OT or Ward or for dressings ward or for dressings
157	Private Nurses Charges- Special Nursing Charges	Post Hospitalisation Nursing Charges Not Payable
158	Nutrition Planning Charges - Dietician Charges- Diet Charges	Patient Diet provided by Hospital is Payable
159	Sugar Free Tablets	Payable -Sugar Free variants of admissable medicines are not Excluded
160	Cream Powder Lotion (Toileteries are Not Payable, only Prescribed Medical Pharmaceuticals Payable)	Payable when Prescribed
161	Digene Gel	Payable when Prescribed
162	ECG Electrodes	Upto 5 Electrodes are Required for every case visiting OT or ICU. For longer stay in ICU, may Require a Change and at least one set every second day must be Payable.
163	Gloves	Sterilized Gloves Payable / Unsterilized Gloves not payable
164	HIV Kit	Payable - Pre-Operative Screening
165	Listerine/ Antiseptic Mouthwash	Payable When Prescribed
166	Lozenges	Payable When Prescribed
167	Mouth Paint	Payable When Prescribed
168	Nebulisation Kit	If used during Hospitalisation is Payable Reasonably
169	Novarapid	Payable When Prescribed
170	Volini Gel/ Analgesic Gel	Payable When Prescribed
171	Zytee Gel	Payable When Prescribed
172	Vaccination Charges	Routine Vaccination Not Payable / Post Bite Vaccination Payable
H. Part of Hospital's own Costs and not Payable		
173	AHD	Not Payable - Part of Hospital's Internal Cost
174	Alcohol Swabes	Not Payable - Part of Hospital's Internal Cost
175	Scrub Solution/ Sterillium	Not Payable - Part of Hospital's Internal Cost
I. OTHERS		
176	Vaccine Charges for Baby	Not Payable
177	Aesthetic Treatment / Surgery	Not Payable
178	TPA Charges	Not Payable
179	Visco Belt Charges	Not Payable
180	Any Kit with no details mentioned [Delivery Kit, Orthokit, Recovery Kit, Etc]	Not Payable
181	Examination Gloves	Not Payable
182	Kidney Tray	Not Payable
183	Mask	Not Payable
184	Ounce Glass	Not Payable
185	Outstation Consultant's/ Surgeon's Fees	Not Payable, Except For Telemedicine Consultations Where Covered by Policy
186	Oxygen Mask	Not Payable
187	Paper Gloves	Not Payable
188	Pelvic Traction Belt	Should be Payable in case of PIVD requiring traction as this is generally not reused

189	Referal Doctor's Fees	Not Payable
190	Accu Check (Glucometery/ Strips)	Not Payable. Pre-Hospitilasation or Post-Hospitalisation / Reports and Charts Required/ Device Not Payable
191	Pan Can	Not Payable
192	Sofnet	Not Payable
193	Trolly Cover	Not Payable
194	Urometer, Urine Jug	Not Payable

195	Ambulance	Payable - Ambulance from home to Hospital or inter-hospital shifts is Payable/ RTA - As Specific Requirement for critical injury is Payable
196	Tegaderm / Vasofix Safety	Payable - Maximum of 3 in 48 Hrs and then 1 in 24 Hrs
197	Urine Bag	Payable where medicaly necessary till a reasonable cost - Maximum 1 Per 24 Hrs
198	Softovac	Not Payable
199	Stockings	Essential for case like CABG etc. Where it should be paid.

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