Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerawada, Pune - 411 006. Reg. No.: 113
For more details, log on to: www.bajajallianz.com | E-mail: bagichelp@bajajallianz.co.in or
Call at: Sales - 1800 209 0144 / Service - 1800 209 5858 (Toll Free No.)

My Health Care Plan

Policy Wordings

SECTION A) PREAMBLE

Whereas the insured described in the Policy Schedule hereto (hereinafter called the 'Insured') has made to Bajaj Allianz General Insurance Company Limited (hereinafter called the "Company" or "Insurer" or "Insurance Company") a proposal or Proposal as mentioned in the transcript of the Proposal, which shall be the basis of this Contract and is deemed to be incorporated herein, containing certain undertakings, declarations, information/particulars and statements, which is hereby agreed to be the basis of this Contract and be considered as incorporated herein, for the insurance Contract hereinafter contained and has paid the premium specified in the Policy Schedule hereto as consideration for such insurance Contract, now the Company agrees, subject to the Policy Schedule and the following terms, conditions, exclusions, and limitations of the Policy, and in excess of the amount of the Deductible, to indemnify the Insured in the manner and to the extent hereinafter stated.

SECTION B) DEFINITIONS- STANDARD DEFINITIONS

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

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

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

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

5. **Cashless facility**
   Cashless facility means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the

Network Provider by the Insurer to the extent of pre-authorization is approved.

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

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

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

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

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

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

12. **Deductible**
Deductible means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified amount (in INR) in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the Insurer. A deductible does not reduce the Sum Insured.
Deductible will be applicable either per year (Aggregate Deductible) or per claim, as specified in the Policy Schedule.

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

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

15. Domiciliary Hospitalization

Domiciliary hospitalization means medical treatment for an Illness/disease/injury, which in the normal course would require care, and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

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

16. Emergency Care

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

17. Grace Period

Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

18. Hospital

A hospital means any institution established for in-patient care and day care treatment of Illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii. has qualified medical practitioner(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
v. Maintains daily records of patients and makes these accessible to the Insurance Company's authorized personnel.

19. Hospitalization

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

20. Illness

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

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

21. Injury

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

22. Inpatient Care

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

23. Intensive Care Unit

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

24. ICU Charges

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

25. Kidney Failure Requiring Regular Dialysis

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

26. Maternity expenses

Maternity expenses means;

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

27. Medical Advice

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

28. Medical expenses

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

29. Medical Practitioner/Doctor/ Physician

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

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

30. Medically Necessary Treatment/Medical Treatment

Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

i. is required for the medical management of the illness or injury suffered by the Insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner,
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India

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

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

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

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

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

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

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

38. Pre-Existing Disease:
Pre-existing disease means any condition, ailment or injury or disease
a. That is/are diagnosed by a Physician within 48 months prior to the effective date of the Policy issued by the Insurer or its reinstatement Or
b. For which medical advice or treatment was recommended by, or received from, a physician/Medical Practitioner within 48 months prior to the effective date of the Policy issued by the Insurer or its reinstatement.

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

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

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

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

43. Renewal

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

44. Room rent

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

45. Surgery or Surgical Procedure

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

46. Unproven/Experimental treatment

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

SECTION B) DEFINITION- SPECIFIC DEFINITIONS

1. Act of Terrorism

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

2. Aggregate Deductible

Aggregate Deductible means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified amount (in INR) in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits/claims are payable by the Insurer. A deductible does not reduce the Sum Insured. The deductible is applicable in aggregate towards Hospitalisation expenses incurred during the Policy Period.

3. Alternative Treatments

Alternative treatments are forms of treatments other than treatment of “Allopathy” or “modern medicine” and includes only Ayurveda and Homeopathy in the Indian context.

4. Assisted reproductive technology

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

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

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

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

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

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

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

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

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

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

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

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

16. Obesity

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

- BMI greater than or equal to 25 is overweight
- BMI greater than or equal to 30 is obesity

17. Per Claim Deductible

Per claim deductible means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified amount (in INR) in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured. The deductible is applicable per claim towards hospitalisation expenses incurred during the policy period.

18. Proposal

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

19. Policy or Contract

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

20. Policy Period

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

21. Policy Year

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

22. Service Provider/s

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

23. Single Private room:

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

24. Specialist

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

25. Twin Sharing Room

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

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

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

SECTION C) COVERAGE

Scope of cover:
The Company hereby agrees to indemnify Insured in respect of Reasonable and Customary expenses in an admissible claim, for any or all of the following covers as opted, subject to the Sum Insured ("SI"), limits, Deductibles, co-payment, terms, conditions and definitions, exclusions contained or otherwise expressed in this Policy.

PART I: In-patient Hospitalisation Treatment

If You are Hospitalised for Inpatient Care on the advice of a Medical Practitioner because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then We will indemnify you against Reasonable and Customary Medical Expenses incurred for:

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

PART II- Super Top Up (In-patient Hospitalisation Treatment)

If You are hospitalized for Inpatient Care on the advice of a Medical Practitioner because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then We will indemnify You against Reasonable and Customary Medical Expenses incurred for below listed expenses, subject to Aggregate Deductible as specified on the Policy Schedule.

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

Aggregate Deductible is a cost sharing requirement under this policy that provides that the company will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the company. A deductible does not reduce the sum insured. The deductible is applicable in aggregate towards hospitalisation expenses incurred during the Policy Period.

Please refer to Table of Benefits for plan wise options.

Note (applicable to Part I and Part II):

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

Other Covers applicable to above Part I and/or Part II as mentioned-

1. Pre-Hospitalisation Medical Expenses (Applicable to Part I and Part II)

We will indemnify you against the Reasonable and Customary Medical Expenses incurred, as per the option specified on the Policy Schedule up to Inpatient Hospitalization Treatment Sum Insured, for a specific period immediately before the Insured beneficiary was Hospitalised, provided that

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

Please refer to Table of Benefits for plan wise options.

2. Post-Hospitalisation Medical Expenses (Applicable to Part I and Part II)

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

i. Such Medical Expenses are incurred in respect of the same Illness/Injury for which the earlier Hospitalisation was required,
ii. The Company has accepted an Inpatient Care claim under “In-patient Hospitalisation Treatment”.

Please refer to Table of Benefits for plan wise options.

3. Modern Treatment Methods and Advancement in Technologies (Applicable to Part I and Part II)

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

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

4. Day Care Treatment (Applicable to Part I and Part II)

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

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

5. Organ donor expenses (Applicable to Part I and Part II)

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

i. The organ donor is any person whose organ has been made available in accordance and in compliance with THE TRANSPLANTATION OF HUMAN ORGANS (AMENDMENT) BILL, and
ii. We have accepted an In-patient Hospitalisation treatment claim for the Insured Beneficiary/ies under “In-patient Hospitalisation Treatment”.
iii. We will pay if Insured Beneficiary is the receiver of the organ.

Specific Exclusion:

a) Pre and Post-Hospitalization expenses, and any other consequential medical expenses in respect of donor are not payable.
b) Multiplier Benefit, Sum Insured Reinstatement, Recharge, Double Sum Insured Benefit will not be applicable for/under Organ donor expenses cover.

6. Ayurvedic and Homeopathic Hospitalization Cover (Part I and Part II)

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

The following expenses are payable under this cover:

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

Specific Exclusion

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

7. Road Ambulance (Applicable to Part I and Part II)

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

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

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

8. Maternity Package Expenses (Applicable to Part I and Part II)

A. Maternityexpenses

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

i. Our maximum liability per delivery or termination shall be as per the Maternity Package limit specified in the Policy Schedule.

ii. We will pay the In-patient Medical Expenses of pre-natal (complete pre-natal period) and post-natal hospitalization (up to 90 days post-delivery) per delivery or termination up to the Maternity Package limit.

iii. The above cover will be subject to a waiting period as mentioned on the Policy Schedule which would apply from the date of issuance of the first My Health care Plan with *Us.*

iv. Maternity Package Expense Waiting Period mentioned on the Policy Schedule will decrease by 1 year if long term policy is opted and the entire premium is paid up front. However, for Policies issued with 12 months waiting period plan for Maternity Package Expenses, then waiting period will decrease by 3 months (i.e. 9 months waiting period will apply) if long term policy is opted and the entire premium is paid up front.

v. Fresh waiting period as specified on the Policy Schedule would apply for all the policies issued with continuity from other health indemnity product/plans where maternity expenses are not covered.

vi. This cover is applicable for Insured Beneficiary up to 45 years of age.

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

B. Maternity expenses for Surrogacy

If the Insured Beneficiary has opted for maternity through surrogacy then We will indemnify for the maternity expenses incurred for the respective Surrogate mother provided that the necessary documents related to Surrogacy are furnished at the time of claims.
All other terms and conditions would be as per the “A. Maternity expenses” above

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

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

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

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

Note: This cover is applicable for Insured Beneficiary up to 45 years of age.

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

9. Baby Care (Applicable to Part I only). (The Sum Insured for this cover would be over and above the In-patient Hospitalization Sum Insured)

We will indemnify You against Reasonable and Customary hospitalization expenses incurred for your new-born baby, for In-patient Hospitalization on the advice of a Medical Practitioner because of Illness or Injury sustained or contracted during the Policy Period.
The below listed expenses would be indemnified up to Baby Care Sum Insured specified in Policy Schedule:

i. Room rent, boarding expenses as per the Room limit/category specified on the Policy Schedule for In-patient Hospitalization Treatment
ii. If admitted in ICU, the Company will pay ICU expenses at actuals

iii. Nursing Expenses as provided by the Hospital
iv. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees
v. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, surgical appliances,
vi. Medicines & Drugs, Consumables, Dialysis, Chemotherapy, Radiotherapy, physiotherapy
vii. Relevant laboratory diagnostic tests, X-ray and such similar expenses that are medically necessary prescribed by the treating Medical Practitioner.

Specific conditions applicable to Baby Care

a) The above cover will be subject to a waiting period as mentioned on the Policy Schedule which would apply from the date of issuance of the first My Health care Plan with *Us.*

b) Baby Care Waiting Period mentioned on the Policy Schedule will decrease by 1 year if long term policy is opted and the entire premium is paid up front. However, for Policies issued with 12 months waiting period plan for Baby Care, the waiting period will decrease by 3 months (i.e. 9 months waiting period will apply) if long term policy is opted and the entire premium is paid up front.

c) The baby should be born during the Policy Period.

d) You should intimate Us about the birth of your baby within 90 days of delivery.

e) The Policy will cover the baby in subsequent renewals subject to payment of premium.

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

10. Out-patient Treatment Expenses (OPD) (Applicable to Part I and Part II)

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

I. Tele (Insta) Consultation Cover
II. Doctor Consultation Cover (In-clinic)
III. Doctor prescribed Investigations Cover – Pathology & Radiology Cover
IV. Annual Preventive Health Check-up cover

I. Tele (Insta) Consultation Cover

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

Specific conditions for Tele (Insta) Consultation Cover

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

Exclusions for Tele (Insta) Consultation Cover

1. Tele consultation outside the Digital platform of Insurer or service provider's application/website video/audio/chat consultation, in-clinic/physical consultation is not covered under this benefit of the product.
2. Teleconsultation benefit is not transferrable to any other beneficiary unless the beneficiary is covered under the Policy & has opted this coverage.
3. If the Tele Consultation is not availed in the Policy year during the Policy Period, the benefit cannot be carried forward to the subsequent policy year during the Policy Period.

4. Reimbursement of teleconsultation benefit is not permitted
5. Initial 30 days waiting period is applicable on tele-consultation required for illness during the first year of Policy Period. This waiting period is not applicable for renewals.
6. Pre-Existing Diseases Waiting Period (Code-Excl01)
   a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of specified number of months of continuous coverage after the date of inception of the first My Heath Care Plan and the Policy Schedule with Us.
   b) The PED waiting period as opted would be specified on the Policy Schedule.
   c) If the Insured Beneficiary is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations then Waiting Period for the same would be reduced to the extent of prior coverage.
   d) Coverage under the Policy after the expiry of the waiting period as specified in Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

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

If the Insured/Insured beneficiary/ies is suffering from any Illness or injury, he / she can consult Medical Practitioner/ Physician/Doctor in person from prescribed network centres of concerned Service Providers or on reimbursement basis with prior approval in non-network centres up to the limit as specified under this Policy read with Policy Schedule.

For this cover, any one of the below options will apply for pre-approved reimbursement as specified under the plan.

1. 20% co-payment for pre-approved reimbursement claims
2. Reimbursement as per the approval up to Sum Insured.

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

If the Insured/Insured beneficiary/ies is suffering from any Illness or injury, he / she can consult Medical Practitioner/ Physician/Doctor in person from prescribed network centres of concerned Service Providers up to the limit as specified under this Policy read with Policy Schedule. This is a cashless service.

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

Specific conditions for Doctor Consultation Cover (In-clinic)

1. Only 1 (one) active Doctor consultation is allowed at any given time and the Insured Beneficiary can book/utilize next consultation post completion of ongoing consultation.

2. Each Insured Beneficiary is allowed to utilize a maximum of 5 consultations per day, subject to the cover limit specified in the Policy Schedule.

3. Insured Beneficiary can book/utilize a maximum of 15 consultations per month.

Exclusions for Doctor Consultation Cover (In clinic)

1. Other expenses of investigations, medicines, procedures or any medical, non-medical items are not covered.
2. Doctor consultation cover is not transferrable to any other person unless the person is covered under the same Policy.
3. If the Doctor consultation is not availed in the Policy year during the Policy Period, the benefit cannot be carried forward to the subsequent Policy year
4. Initial 30 days waiting period is applicable for consultation required for Illness during the first year of this Policy. This waiting period is not applicable for renewals.
5. The plan does not cover yoga, naturopathy, reiki, acupuncture, acupressure, physiotherapy, psychiatric counselling, diet counselling.

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

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

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

For this cover, any one of the below options will apply for pre-approved reimbursement as specified under the plan.

1. 20% co-payment for pre-approved reimbursement claims
2. Reimbursement as per the approval up to Sum Insured.

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

If the Insured/Insured Beneficiary/s is suffering from any Illness or Injury, he / she can avail the cashless service for investigations prescribed by a registered Medical Practitioner for pathology or radiology from prescribed network centres of the Service Provider up the limit as specified in the Policy Schedule. This is a cashless service.

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

Exclusions for Doctor Prescribed Lab and Radiology Cover

1. Any Lab or Radiology investigation which is not prescribed by a Medical Practitioner will not be covered.
2. Investigation cover is not transferrable to any other person unless the person is covered under the same Policy.
3. If the Investigation cover is not availed in the respective policy year, the benefit cannot be carried forward to the subsequent policy year after renewal.
4. Initial 30 days waiting period is applicable for investigations Cover- Pathology & Radiology expenses related to illness during the first year of Policy. This waiting period is not applicable for renewals.
7. Pre-Existing Diseases Waiting Period (Code-Excl01)
   a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of specified number of months of continuous coverage after the date of inception of the first My Heath Care Plan and the Policy Schedule with Us.
   b) The PED waiting period as opted would be specified on the Policy Schedule.
   c) If the Insured Beneficiary is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations then Waiting Period for the same would be reduced to the extent of prior coverage.
   d) Coverage under the Policy after the expiry of the waiting period as specified in Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

IV. Annual Preventive Health Check -up cover:

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

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

The list of tests above cannot be changed.

Exclusions for Annual Preventive Health Check -up cover

1. Preventive health check-up cannot be availed outside the prescribed list of hospitals or diagnostic centers.
2. Home collection facility will available only at selected locations. For locations where home sample collection is not available, the customer will have to physically go and take the tests.
3. The complete list of tests as given above has to be completed in a single appointment.
4. If the health check-up is not availed in the Policy Year during the Policy Period, the benefit cannot be carried forward to the subsequent Policy Year.
5. Reimbursement of preventive health check-up expenses is excluded from the scope of the Policy.
6. Initial 30 days waiting period is applicable for investigations related to Illness during the first year of Policy Period. This waiting period is not applicable for renewals.

   List of network Hospitals or diagnostic centres can be accessed from the Insurer's website for:
   - Doctor Consultation Cover (In clinic)
   - Doctor prescribed Investigations Cover – Pathology & Radiology Cover
   - Annual Preventive Health Check-up cover

11. Domiciliary Hospitalization (Applicable to Part I and Part II)

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

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

However, this coverage/benefit shall not cover the following

a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza,
b. Arthritis, Gout and Rheumatism,
c. Chronic Nephritis and Nephritic Syndrome,
d. Diarrhoea and all type of Dysenteries including Gastroenteritis,
e. Diabetes Mellitus and Insipidus,

f. Epilepsy,
g. Hypertension,
h. Psychiatric or Psychosomatic Disorders of all kinds,
i. Pyrexia of unknown origin
j. Vector-borne diseases

12. <u>Home Nursing Benefit (Applicable to Part I and Part II)</u>

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

a. Home Nursing must be recommended by treating Doctor with valid medical certificate stating the reason for providing Nursing Care at Home.
b. The benefit will not be paid for more than 10 weeks per Policy Year.
c. Claim for Home Nursing shall be paid only if we have paid a claim for In-patient hospitalization Treatment cover.
d. You were Hospitalized in preceding 10 days period for the same illness/injury.
e. A valid bill from the Nursing Bureau with number of days of service utilization along with dates should be provided at the time of claims.

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

13. <u>Cost of Prescribed External Medical Aid (Applicable to Part I and Part II)</u>

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

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

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

14. <u>Sum Insured Reinstatement (Applicable to Part I only)</u>

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

i. The reinstated Sum Insured will be available for utilization for subsequent claim made by the Insured Beneficiary provided that the subsequent hospitalization is after a gap of at least 15 days from the date of discharge. This 15 days period is not applicable if the subsequent claim is for the other Insured Beneficiary.

ii. The reinstated Sum Insured can be used for claims made by the Insured in respect of the benefits stated in Inpatient Hospitalization Treatment

iii. For any claim under this benefit, the maximum liability per claim shall not exceed the In-patient Hospitalization Sum Insured.

iv. This benefit is applicable during each Policy year and will not be carried forward to the subsequent policy year/ renewals.

v. Sum Insured Reinstatement for floater policy will be at policy level.

vi. For individual Sum Insured policy, Sum Insured Reinstatement would be available on Insured Beneficiary level.

15. Recharge (Applicable to Part I only) (Applicable only if Sum Insured Opted is 5 Lac and above)

The In-patient Hospitalisation Treatment Sum Insured as specified in the Policy Schedule would be "recharged" in event of claim amount exceeding the limit of indemnity. This cover is applicable only if available under the plan as specified on the Policy Schedule.

i. The recharged limit would be 20% of the Sum Insured maximum up to INR 25 Lacs per Policy Year,

ii. The recharged Sum Insured will be available for utilization in the same claim made by the Insured Beneficiary.

iii. This benefit is applicable during each Policy year and would not be carried forward to the subsequent policy year/ renewals.

iv. For Floater policy, "Recharge" of Sum Insured would be available only once per Policy Year

v. For individual Sum Insured policy "Recharge" of Sum Insured would be available only once for each Insured Beneficiary per Policy Year.

16. Airlift Cover (Applicable to Part I and Part II)

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

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

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

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

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

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

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

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

17. Cumulative Bonus (Applicable to Part I only)

Cumulative Bonus ("CB") will be increased by specific amount as specified in the Policy Schedule in respect of each claim free policy year (no claims are reported), provided the Policy is renewed with the company without a break. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

Note:

i. In case where the policy is on individual basis, the CB shall be added and available individually to the Insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured person.

ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.

iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.

iv. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.

v. If a claim is made in the expiring Policy Year and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

Please refer to Table of Benefits for plan wise options.

18. Family Visit (Applicable to Part I and Part II)

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

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

ii. This coverage shall be provided only if treating Physician has advised and certified for necessity attendance of a Family Member or relative or friend and upon our satisfaction on the reason provided.

iii. Only domestic travel expenses will be paid.

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

19. Renewal Premium Waiver Benefit (Applicable to Part I and Part II)

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

20. Consumable Expenses (Applicable to Part I and Part II)

We will indemnify You against the Non-Medical Expenses/ consumables (as specified in Annexure IV) incurred during treatment of the Insured Beneficiary during the Policy Period up to Inpatient hospitalisation treatment Sum Insured, provided that the claim is admissible and payable under "In-patient Hospitalization Treatment" cover.

Part III OPTIONAL COVERS

In consideration of payment of additional premium by the Insured to the Company and realization thereof by the Company, it is hereby agreed that Insurer will pay benefit amount under cover or indemnify Insured against the Reasonable and Customary expenses, as the case may be, in respect of an admissible claim under any or all of the following Optional covers as opted subject to the Sum Insured, limits, Deductibles, co-payment, terms, conditions and definitions, exclusions contained or otherwise expressed in this Policy.

1. Loss of Income Cover (Applicable to Part I and Part II)

If this cover is opted and if the Insured Beneficiary is Hospitalized during the Policy Period for a minimum of 72 consecutive hours on the advice of a Doctor/ Medical Practitioner because of Accidental Injury and Any Illness/Any Illness excluding Infection as per the plan opted and mentioned on the Policy Schedule, then the Company will

make a weekly payment as per the amount shown under the heading "Loss of income" in the Policy Schedule, subject otherwise to all other terms, conditions and exclusions of the Policy.

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

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

<u>Specific Conditions applicable to Loss of Income cover-</u>

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

2. <u>Procedure wise sub limit (Applicable to Part I only)</u>

If this cover is opted, the sub limits as per the below table would be applicable for the claims made under the respective procedures. This sub-limit on In-patient Hospitalization Sum Insured is applicable for Hospitalization expenses including Pre and Post Hospitalization expenses, provided that claim(s) is admissible as "In-patient Hospitalisation Treatment" under this Policy, subject otherwise to all other terms, conditions and exclusions of the Policy.

Type of Procedure	**Sub Limit (Per Policy Year)**
Coronary Artery Bypass Grafting CABG	50% of SI max up to 2 Lac
Percutaneous Transluminal Coronary Angioplasty PTCA (per event hospitalisation)	50% of SI max up to 1.5 Lac
Total Knee Replacement with Prosthesis (per knee)	50% of SI max up to 1.5 Lac
Hysterectomy	50% of SI max up to 1 Lac

3. <u>Surgery Only cover (Applicable to Part I and Part II)</u>

If this cover is opted and if You are Hospitalised for Inpatient Care on the advice of a Medical Practitioner because of Illness or Injury sustained or contracted during the Policy Period, then We will indemnify Insured against Reasonable and Customary Medical Expenses, incurred for surgical treatment, as listed below, subject otherwise to all other terms, conditions and exclusions of the policy:

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

4. <u>Air Ambulance (Applicable to Part I and Part II)</u>

If this cover is opted by the Insured, it is hereby agreed and declared that My Health Care Plan is extended to pay the expenses incurred for ambulance transportation in an airplane or helicopter for rapid ambulance transportation from the site of first occurrence of the Illness / Accident to the nearest Hospital during Policy Period which directly

and independently of all other causes results in emergency life threatening health conditions provided such hospitalization claim is admissible under the My Health Care Plan. The claim under this cover would be reimbursed up to the actual expenses subject to a maximum limit as specified under the Air Ambulance Cover in the Policy Schedule, subject otherwise to all other terms, conditions and Exclusions of the Policy.

Claim under this section shall be payable only when:

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

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

iii. Up to the maximum of Sum Insured Limit per Policy Year as per the option specified on the policy schedule for this cover.

iv. This cover is applicable only for Air Ambulance facility availed within the Indian Geographical limits.

v. Return transportation to the Insured's home by air ambulance is excluded.

vi. Such air ambulance should have been duly licensed to operate as such by competent authorities of the Government/s.

5. Major Illness and Accident Multiplier (Indemnity) (Applicable to Part I only)

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

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

6. International Cover – Emergency Care only (Applicable to Part I only)

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

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

Specific Conditions for International Cover – Emergency Care only

a. The Injury or Illness should occur while the Insured Person is outside India.

b. The treatment must commence immediately on diagnosis of the Illness or occurrence of the Injury.

c. A mandatory co-payment of 10% is applicable which will be in addition to any other co-payment/deductible if any applicable in the policy.

d. The benefit is available for 45 continuous days from date of travel in a Single trip and 180 days on a cumulative basis as whole in a Policy year.

e. The Medical Expenses payable shall be limited to Inpatient hospitalization treatment only. Pre and post hospitalization expenses, day care treatment, Maternity Package expenses are not covered under the purview of this cover.

f. The payment of any claim under this cover will be based on the rate of exchange as on the date of loss published by the Reserve Bank of India and shall be used for conversion of foreign currency into Indian Rupees for payment of claims.

g. The Insured person has to inform us within 24 hours of occurrence of the emergency condition and take prior approval for Medical Treatment.

h. Reinstatement, Recharge, Cumulative Bonus, Super Cumulative Bonus, Major Illness and Accident Multiplier or Double Sum Insured Benefit accrued cannot be used for payment of claims under International Cover – Emergency Care only.

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

7. **Hospital Daily Cash Benefit (Applicable to Part I and Part II)**

If You are Hospitalised for Inpatient Care on the advice of a Medical Practitioner because of Illness or Injury sustained or contracted during the Policy Period, then We will pay:

i. The Daily Allowance as specified on the Policy Schedule for each continuous and completed period of 24 hours of Hospitalization necessitated solely by reason of the said Accidental Bodily Injury or Illness for a maximum period as specified in Policy Schedule for each hospitalization, or
ii. Two times the Daily Allowance as specified on the Policy Schedule for each continuous and completed period of 24 hours required to be spent by the Insured or named Insured in the Intensive Care Unit of a Hospital during any period of Hospitalization necessitated solely by reason of the said Accidental Bodily Injury or Illness for a maximum period of 7 days for each hospitalization

8. **Fracture Care (Applicable to Part I and Part II)**

In consideration of payment of additional premium by the Insured to the Company and realization thereof by the Company, it is hereby agreed and declared that in case of any Accidental Bodily Injury sustained by Insured person during Policy Period which directly and independently of all other causes results in Fracture/s of Bone/s, then the Company will pay the such percentage (as shown in the **Fractures and Dislocations Benefit Schedule** below) of Sum Insured as specified under the respective section of the Policy Schedule, subject otherwise to all other terms, conditions and Exclusions of the Policy.

For an Accidental Injury where more than one of the circumstances described in the **Fractures and Dislocations** Benefit Schedule is met, we will pay the claim for only one of the benefits, whichever is high.

Note:
"Open Fracture" is a fracture where the broken bone(s) penetrate(s) the skin.

"Closed Fracture" is a fracture where the broken bone(s) do(es) not penetrate the skin

Fractures and Dislocations Benefit Schedule	
Description	**Percentage of Sum Assured**
A) Hip or Pelvis (excluding thigh or coccyx)	
1. Open Fracture of more than one bone	100%
2. Open Fracture of one bone	50%
3. Closed Fracture of more than one bone	25%
4. Closed Fracture one bone	15%
B) Thigh or Lower Leg	
5. Open Fracture of more than one bone	60%
6. Open Fracture of one bone	45%
7. Closed Fracture of more than one bone	25%
8. Closed Fracture one bone	15%
C) Elbows, Arm (including wrist but excluding Colles type fractures)	
9. Open Fracture of more than one bone	45%
11. Closed Fracture of more than one bone	20%
12. Closed Fracture one bone	15%
D) Colles type fracture of the lower arm[8]	
13. Open Fracture	25%
14. Closed Fracture	10%
E) Skull	

15. Fracture of the skull needing surgical Intervention	60%
16. Fracture of the skull not needing surgical Intervention	20%
F) Shoulder Blade, Rib(s), Knee cap, Sternum, Hand (excluding fingers and wrist), Foot (excluding toes or heel)	
17. Open Fracture	30%
18. Closed Fracture	15%
G) Spinal Column (Vertebrae but excluding coccyx)	
19. All compression fractures	40%
20. All spinous, transverse process of pedicle fractures	40%
21. Permanent Spinal Cord damage	40%
22. All vertebral fractures	15%
H) Lower Jaw	
23. Open Fracture	25%
24. Closed Fracture	10%
I) Cheekbone, Clavicle, Coccyx, Upper Jaw, Nose, Toe(s), Finger(s), Ankle, Heel	
25. Open Fracture of more than one bone	15%
26. Open Fracture of one bone	12%
27. Closed Fracture of more than one bone	4%
28. Closed Fracture one bone	2%
K) Dislocations requiring surgery under anesthesia	
33. Spine	35%
34. Back (Excluding slipped disc)	35%

35. Hip	25%
36. Knee (Left or right)	20%
37. Wrist (Left or right)	15%
38. Elbow (Left or right)	15%
39. Ankle (Left or right)	10%
40. Shoulder blade (Left or right)	10%
41. Collarbone	10%
42. Fingers (Left or right hand)	5%
43. Toes (Left or right foot)	5%
44. Jaw	5%
L) Internal Injuries	
45. Internal injuries resulting in open abdominal or Thoracic Surgery	25%
46. Intracranial haemorrhage and/ or physical brain injury	25%

9. **Super Cumulative Bonus (Applicable to Part I only)**

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

Specific Condition for Super Cumulative Bonus

i. If the In-Patient Hospitalization treatment claim paid amount (in a single or multiple claims) does not exceed INR 100,000 in a Policy Year then the Super Cumulative Bonus, if any, accrued under this Cover will not be reduced at renewal. The Super Cumulative Bonus would be maintained as per the expiring policy.

ii. In case where the Policy is on individual Sum Insured basis, the SCB shall be accrued and available individually to the Insured Beneficiary if no claim has been reported in respect of that Insured Beneficiary. In case of claim, SCB in respect of the Insured Beneficiary who has made the claim shall be reduced at the same rate at which it has accrued, subject to Point i. above.

iii. In case where the Policy is on floater Sum Insured basis, the SCB shall be accrued and available to the Family on floater basis, provided no claim has been reported from any member of the Family. In case of claim, SCB shall be reduced at the same rate at which it has accrued, subject to Point i. above

iv. In case the accrued SCB reduces, the Sum Insured will be maintained and will not be reduced in the renewal policy year.

v. SCB shall be available only if the Policy is renewed/ premium paid within the Grace Period.

vi. If the Sum Insured has been reduced at the time of Renewal, the applicable SCB shall be reduced in the same proportion to the Sum Insured in current Policy. If the Sum Insured under the Policy has been increased at the time of Renewal the SCB shall be calculated on the Sum Insured of the last completed Policy Year.

vii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium then any awarded accrued SCB shall be withdrawn, subject to Point i. above.

viii. This clause does not alter the annual character of this insurance.

10. <u>Double Sum Insured Benefit (Applicable to Part I only) (Applicable only if Sum Insured Opted is 5 Lac and above)</u>

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

i. This cover shall be applied only once during each Policy Year and any unutilized amount, in whole or in part will not be carried forward to the subsequent Policy Year.

ii. The cover can be utilized for any number of claims admissible under the Policy during the Policy Year.

iii. The cover will be applicable only after exhaustion of In-patient Hospitalisation Sum Insured.

iv. In case of family floater policy, the cover will be available on floater basis for all Insured persons covered under the Policy and will operate in accordance with the above conditions.

v. For individual Sum Insured policy, Double Sum Insured benefit would be available on each Insured Beneficiary level.

SECTION D) EXCLUSIONS - STANDARD EXCLUSIONS

I. Exclusion Name: Waiting Period

1. Pre-Existing Diseases Waiting Period (Code-Excl01)

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

2. Specified disease/procedure Waiting Period (Code-Excl02)

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of specified number of months of continuous coverage after the date of inception of the first My Health Care Plan and the Policy Schedule with Us. This exclusion shall not be applicable for claims arising due to an Accident.
The Specified Disease/Procedure Waiting Period as opted would be specified on the Policy Schedule.
b) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increased.

c) If any of the specified disease/procedure falls under the Waiting Period specified for Pre-Existing diseases, then the longer of the two Waiting Periods shall apply.
d) The Waiting Period for below listed conditions shall apply even if contracted after the Risk Inception Date of Policy Schedule or declared and accepted without a specific exclusion.
e) If the Insured Beneficiary is continuously covered without any break as defined under the applicable norms on Portability stipulated by IRDAI, then Waiting Period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures is as below:

1. Any type gastrointestinal ulcers	2. Cataracts,
3. Any type of fistula	4. Macular Degeneration
5. Benign prostatic hypertrophy	6. Hernia of all types
7. All types of sinuses	8. Fissure in ano
9. Haemorrhoids, piles	10. Hydrocele
11. Dysfunctional uterine bleeding	12. Fibromyoma
13. Endometriosis	14. Hysterectomy
15. Uterine Prolapse	16. Stones in the urinary and biliary systems
17. Surgery on ears/tonsils/ adenoids/ paranasal sinuses	18. Surgery on all internal or external tumours/cysts/ nodules/polyps of any kind including breast lumps except malignancy
19. Diseases of gall bladder including cholecystitis	20. Pancreatitis
21. All forms of Cirrhosis	22. Gout and rheumatism
23. Surgery for varicose veins and varicose ulcers	24. Chronic Kidney Disease
25. Alzheimer's Disease	26. Joint replacement surgery
27. Surgery for vertebral column disorders (unless necessitated due to an Accident)	28. Surgery to correct deviated nasal septum
29. Hypertrophied turbinate	30. Congenital internal diseases or anomalies
31. Treatment for correction of eye sight due to refractive error recommended by Ophthalmologist for medical reasons with refractive error greater or equal to 7.5	32. Bariatric Surgery

3. 30-day Waiting Period (Code-Excl03)

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

4. Maternity Package Expenses Waiting Period

Any treatment arising from or traceable to pregnancy, child birth including caesarean section and/or any treatment related to pre and postnatal care and complications arising out of Pregnancy and Childbirth until the

specified period of continuous coverage has elapsed since the inception of the first My Health Care Plan with Us.

The Maternity Package Expenses Waiting Period as opted would be specified on the Policy Schedule. Maternity Package Expense waiting period mentioned on the Policy Schedule will decrease by 1 year if long term Policy is opted and the entire premium is paid up front.
However, for Policies issued with 12 months waiting period for Maternity Package Expenses, the waiting period will decrease by 3 months (i.e. 9 months waiting period will apply) if long term Policy is opted and the entire premium is paid up front.

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

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

The Baby Care waiting period as opted would be specified on the Policy Schedule.
Baby Care waiting period mentioned on the Policy Schedule will decrease by 1 year if long term Policy is opted and the entire premium is paid up front.
However, for Policies issued with 12 months waiting period for Baby Care, the waiting period will decrease by 3 months (i.e. 9 months waiting period will apply) if long term Policy is opted and the entire premium is paid up front.

II. General Exclusions

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

2. **Rest Cure, rehabilitation and respite care (Code-Excl05)**
   a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   ii. Any services for people who are terminally ill to address medical, physical, social, emotional and spiritual needs.

3. **Obesity/Weight Control (Code-Excl06)**
   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

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

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

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

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

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

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

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

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

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

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

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

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

15. **Maternity: (Code Excl18)**
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;
    ii. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the Cover Period.
    iii. This waiting period stands deleted if Maternity Package Expenses is covered under the respective plan of My Health Care Plan.

SECTION D) EXCLUSIONS - SPECIFIC EXCLUSIONS

1. Any dental treatment that comprises of cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, surgery of any kind unless as a result of Injury to natural teeth and also requiring Hospitalisation.

2. Medical Expenses where Inpatient care is not warranted and does not require supervision of qualified nursing staff and qualified medical practitioner round the clock

3. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority.

Any Medical Expenses incurred due to Act of Terrorism will be covered under the Policy Schedule.

4. The cost of spectacles, contact lenses, hearing aids, dentures, artificial teeth and similar expenses.

5. External medical equipment of any kind used at home as post Hospitalisation care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition.

6. Congenital external diseases or defects or anomalies, growth hormone therapy, stem cell implantation or surgery except for Hematopoietic stem cells for bone marrow transplant for haematological conditions.

7. Intentional self-Injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol).

8. Vaccination or inoculation unless forming a part of post bite treatment or if medically necessary and forming a part of treatment recommended by the treating Medical Practitioner.

9. All non-medical Items as per Annexure II.

10. Any medical treatment received outside India is not covered under this Policy except in case of optional cover - "International Cover-emergency care only" is opted.

11. Circumcision unless required for the treatment of Illness or Accidental bodily Injury.

Exclusions specific to OPD cover

Exclusions for Tele (Insta) Consultation Cover

1. Tele consultation outside the Digital platform of Insurer or service provider's application/website video/audio/chat consultation, in-clinic/physical consultation is not covered under this benefit of the product.
2. Teleconsultation benefit is not transferrable to any other beneficiary unless the beneficiary is covered under the Policy & has opted this coverage.
3. If the Tele Consultation is not availed in the Policy year during the Policy Period, the benefit cannot be carried forward to the subsequent policy year during the Policy Period.
4. Reimbursement of teleconsultation benefit is not permitted.
5. Only 1 (one) active Doctor consultation is allowed at any given time and the Insured member can book next consultation post completion of ongoing consultation.
6. Each Insured person is allowed to utilize a maximum of 5 consultations per day.
7. Insured member can book a maximum of 15 online consultations per month.
8. Initial 30 days waiting period is applicable on tele-consultation required for illness during the first year of Policy Period. This waiting period is not applicable for renewals.
9. Pre-Existing Diseases Waiting Period (Code-Excl01)
   a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of specified number of months of continuous coverage after the date of inception of the first My Heath Care Plan and the Policy Schedule with Us.
   b) The PED waiting period as opted would be specified on the Policy Schedule.
   c) If the Insured Beneficiary is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations then Waiting Period for the same would be reduced to the extent of prior coverage.
   d) Coverage under the Policy after the expiry of the waiting period as specified in Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

Exclusions for Doctor Consultation Cover (In clinic)

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

7. Each Insured member is allowed to utilize a maximum of 5 consultations per day, subject to the cover limit specified in the Policy Schedule.
8. Insured person can book a maximum of 15 consultations per month.
9. Pre-Existing Diseases Waiting Period (Code-Excl01)
   a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of specified number of months of continuous coverage after the date of inception of the first My Heath Care Plan and the Policy Schedule with Us.
   b) The PED waiting period as opted would be specified on the Policy Schedule.
   c) If the Insured Beneficiary is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations then Waiting Period for the same would be reduced to the extent of prior coverage.
   d) Coverage under the Policy after the expiry of the waiting period as specified in Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

Exclusions for Doctor Prescribed Lab and Radiology Cover
1. Any Lab or Radiology investigation which is not prescribed by a Medical Practitioner will not be covered.
2. Investigation cover is not transferrable to any other person unless the person is covered under the same Policy.
3. If the Investigation cover is not availed in the respective policy year the benefit cannot be carried forward to the subsequent policy year after renewal.
4. Initial 30 days waiting period is applicable for investigations Cover- Pathology & Radiology expenses related to illness during the first year of Policy. This waiting period is not applicable for renewals.
5. Pre-Existing Diseases Waiting Period (Code-Excl01)
   a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of specified number of months of continuous coverage after the date of inception of the first My Heath Care Plan and the Policy Schedule with Us.
   b) The PED waiting period as opted would be specified on the Policy Schedule.
   c) If the Insured Beneficiary is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations then Waiting Period for the same would be reduced to the extent of prior coverage.
   d) Coverage under the Policy after the expiry of the waiting period as specified in Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

Exclusions for Annual Preventive Health Check-up cover
1. Preventive health check-up cannot be availed outside the prescribed list of hospitals or diagnostic centers.
2. Home collection facility will available only at selected locations. For locations where home sample collection is not available, the customer will have to physically go and take the tests.
3. The complete list of tests as given above has to be completed in a single appointment.
4. If the health check-up is not availed in the Policy Year during the Policy Period the benefit cannot be carried forward to the subsequent Policy Year.
5. Reimbursement of preventive health check-up expenses is excluded from the scope of the Policy.
6. Initial 30 days waiting period is applicable for investigations related to Illness during the first year of Policy Period. This waiting period is not applicable for renewals.

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

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

2. **Condition Precedent to Admission of Liability**
   The terms and conditions of the Policy must be fulfilled by the Insured Beneficiary for the Company to make any payment for claim(s) arising under the Policy.

3. **Premium Payment in Installments**
   i. If the Insured Beneficiary has opted for Payment of Premium on an installment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy Schedule)
   ii. Grace Period of 15 days would be given to pay the installment premium due for the Policy Schedule.
   iii. During such grace period, Coverage will not be available from the installment premium payment due date till the date of receipt of premium by Company.
   iv. The Benefits provided under – “Waiting Periods”, “Specific Waiting Periods” Sections shall continue in the

event of payment of premium within the stipulated grace Period.

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

vi. In case of installment premium due is not received within the grace Period, the Policy will get cancelled automatically.

4. Multiple Policies

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

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

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

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

5. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

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

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest, to the Insured Beneficiary, at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(Explanation: “Bank rate” shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

6. Renewal of Policy

The Policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the Insured Beneficiary. The Company is not bound to give notice that it is due for Renewal.

i. Renewal of Policy shall not be denied on the ground that the Insured Beneficiary had made a claim or claims in the preceding policy years

ii. Request for Renewal along with requisite premium shall be received by the Company before the end of the Cover Period.

iii. At the end of the Policy Period, the Policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy Schedule. Coverage is not available during the grace period.

iv. If not renewed within Grace Period after due Renewal date, continuity benefits will be not be given or available to Insured.

7. Cancellation

a) The Insured Beneficiary may cancel the Policy Schedule by giving 15days’ written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Cover Period as per the rates detailed below.

Policy Period Term	1 Year	2 Year	3 Year
Within 30 Days as per free look clause			
Exceeding 30 days but less than 3 months	65%	80%	80%
Exceeding 3 months but less than 6 months	45%	65%	75%
Exceeding 6 months but less than 9 months	20%	55%	65%
Exceeding 9 months but less than 12 months	0%	45%	60%
Exceeding 12 months but less than 15 months	0%	35%	50%

Exceeding 15 months but less than 18 months	0%	20%	45%
Exceeding 18 months but less than 21 months	0%	10%	35%
Exceeding 21 months but less than 24 months	0%	0%	30%
Exceeding 24 months but less than 27 months	0%	0%	20%
Exceeding 27 months but less than 30 months	0%	0%	15%
Exceeding 30 months but less than 33 months	0%	0%	5%
Exceeding 33 months but less than 36 months	0%	0%	0%
Exceeding 36 months but less than 39 months	0%	0%	0%
Exceeding 39 months but less than 42 months	0%	0%	0%
Exceeding 42 months but less than 45 months	0%	0%	0%
Exceeding 45 months but less than 48 months	0%	0%	0%
Exceeding 48 months but less than 51 months	0%	0%	0%
Exceeding 51 months but less than 54 months	0%	0%	0%
Exceeding 54 months but less than 57 months	0%	0%	0%

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

b) The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Beneficiary, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

- **Cancellation grid for premium received on instalment basis-**

The premium will be refunded as per the below table:

Period in Risk (from latest instalment date)	% of Monthly Premium	% of Quarterly Premium	% of Half Yearly Premium
Upto 30 days from 1st Instalment Date	As per Free Look Period Condition		
Exceeding 30 days but less than or equal to 3 months	No refund		30%
Exceeding 3 months but less than or equal to 6 months			0%

Note:
In case of Renewal policies, period is risk "Exceeding 30 days but less than 3 months" should be read as "within 3 months".

8. Portability

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

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

9. Complete Discharge

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

10. Possibility of Revision of Terms:

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

11. Moratorium Period:

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

12. Norms on Migration

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

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

13. Withdrawal of Policy

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

14. Fraud

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

15. Nomination

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

16. Redressal Of Grievance

Grievance–In case of any grievance relating to servicing the Policy, the Insured Beneficiary may submit in writing to the Policy Schedule issuing office or regional office for redressal.
For updated details of grievance officer, https://www.bajajallianz.com/about-us/customer-service.html

IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

Insurance Ombudsman –The Insured Beneficiary may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have

been provided as Annexure-V.

17. Free Look Period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of Porting the Policy.
The Insured Beneficiary shall be allowed a period of thirty days from date of receipt of the Policy document to review the terms and conditions of the Policy, and to return the same if not acceptable.

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

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

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

18. Conditions Precedent

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

19. Insured Beneficiary

Only those persons named as the Insured Beneficiary(s) in the Policy Schedule shall be covered under the Policy. Cover under the Policy shall be withdrawn from any Insured Beneficiary upon such Insured Beneficiary giving 14 days written notice to be received by Us.

20. Additional Norms on Migration

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

21. Change of Sum Insured

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

22. Notice & Communication

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

23. Endorsements (Changes in Policy)

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

24. Terms and conditions of the Policy

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

25. Automatic change in Coverage under the Policy

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

i. In the case of his/ her (Insured Beneficiary) demise. However, the cover shall continue for the remaining Insured Beneficiaries till the end of Cover Period. The other Insured Beneficiaries may also apply to renew the Policy Schedule. In case, the other Insured Beneficiary is minor, the Policy Schedule shall be renewed only through any one of his/her natural guardian or guardians appointed by court. All relevant particulars in respect of such person

(including his/her relationship with the Insured Beneficiary) must be submitted to the Company along with the application. Provided no claim has been made, and termination takes place on account of death of the Insured Beneficiary, pro-rata refund of premium of the deceased Insured Beneficiary for the balance period of the Policy Schedule will be effective.

ii. Upon exhaustion of Sum Insured and cumulative bonus, for the Policy Year. However, the **Policy** is subject to Renewal on the due date as per the applicable terms and conditions.

26. Territorial Jurisdiction and Territorial Limit

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

27. Arbitration

Arbitration Clause shall not be applicable.

28. Discount

i. Zone Discount

Below discount will be applicable based on residential address of the proposer or insured person
- Residential address in Zone B: 15% on Zone A Premium
- Residential address in Zone C: 25% on Zone A Premium

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

ii. Family Discount

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

iii. Long Term Discount

a. 4% discount is applicable if Policy is opted for 2 years
b. 8% discount is applicable if Policy is opted for 3 years

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

iv. Employee Discount

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

v. Online/Direct Business Discount

Discount of 5% will be offered in this product for Policies underwritten through direct/online channel.
Note: this discount is not applicable for Policies where employee discount is given.

vi. **Loyalty Discount**
Discount of 5% shall be offered if the insured member is having any of the listed active Bajaj Allianz General Insurance Co. Ltd.'s retail policy of Motor, Health, Home, Cyber and Pet Insurance with a minimum premium of INR 2500.

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

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

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

Wellness Eligibility Criteria:

1. Wellness discount is applicable for members age 25 years and above
2. If the Insured person meets 4 or 5 out of 8 criteria, he/she is eligible for 5% discount, 6 or 7 out of 8 criteria he /she is eligible for 7.5% discount & meets with 8 criteria she / she is eligible for 10% discount.
3. If an Insured meets 8 out of 8 above mentioned parameters and in addition he/she walks for 10,000 steps for 20 days every month then they will be eligible for additional discount of 2.5%.
4. In Floater Policies, discount will be offered basis the average of number of Parameters Achieved by all Insured members age 25 years & above.
   Discount under Floater Policy = $\frac{\text{Total No. of Parameters achieved by eligible members}}{\text{Total No. of eligible members in the family}}$

viii. **Early Entry Discount**
5% discount shall be offered if, Insured Proposer is opting the My Health Care Plan long term policy prior to 35 years of age.

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

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

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

ix. **Fitness Discount**

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

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

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

x. **Voluntary co-payment Discount**

a. In the Voluntary co-payment option is opted, then a discount corresponding to the co-payment opted would be applicable.
b. If a claim has been admitted under In-patient Hospitalization Treatment then, the Insured shall bear a 5% or 10% or 15% or 20% (proportion to extent to discount availed) of the eligible claim amount payable under this Policy and Our liability, if any, shall only be in excess of that sum and would be subject to the Sum Insured.

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

Notwithstanding anything contained in any other clause in this Policy, where (i) the risk under the Policy has already commenced, or (ii) only a part of the insurance coverage has commenced, and the option of Policy return/cancellation is exercised by the Insured Beneficiary under clause 17, then in addition to deductions under Section 17 of this Policy, expenses incurred by the Company on medical examination of the Insured Beneficiary and the stamp duty charge will also be deducted before refund of premium to Insured.

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

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

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

Cashless Claims Procedure:

Cashless Facility is only available at Bajaj Allianz Network Providers. In order to avail of Cashless Facility, the following procedure must be followed by You:

i. For planned treatment or Hospitalisation, prior to taking treatment and/or incurring Medical Expenses at a Bajaj Allianz Network Providers, You or *Your* representative must intimate Us 48 hours before the planned Hospitalisation and request pre-authorisation by way of the written form.
ii. After considering Your request and after obtaining any further information or documentation We have sought, We may, if satisfied, send You or the Bajaj Allianz Network Providers, an authorisation letter. The authorisation letter, the ID card issued to You along with this Policy and any other information or documentation that We have specified must be produced to the Bajaj Allianz Network Providers identified in the pre-authorization letter at the time of Your admission to the same.
iii. If the procedure above is followed, You will not be required to directly pay for the bill amount in the Bajaj Allianz Network Providers that We are liable under In-Patient Hospitalisation Treatment and the original bills and evidence of treatment in respect of the same shall be left with the Bajaj Allianz Network Providers. Pre-authorisation does not guarantee that all costs and expenses will be covered. We reserve the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy.
iv. In case any treatment or procedure is to be taken on an Emergency basis, You or Your representative must intimate Us in writing immediately within 24 hours of Hospitalisation.

Reimbursement Claims Procedure:

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

i. You or someone claiming on *Your* behalf must inform Us in writing immediately within 48 hours of Hospitalisation in case of emergency Hospitalisation and 48 hours prior to Hospitalisation in case of planned Hospitalisation
ii. You must immediately consult a Medical Practitioner and follow the advice and treatment that he recommends.
iii. You must take reasonable steps or measures to minimize the quantum of any claim that may be made under this Policy.
iv. You must have Yourself examined by Our medical advisors if We ask for this, and as often as We consider this to be necessary at Our cost.

v. You or someone claiming on Your behalf must promptly and in any event within 30 days of discharge from a Hospital give Us the documentation as listed out in greater detail below and other information We ask for to investigate the claim or Our obligation to make payment for it.
vi. In the event of the death of the Insured Beneficiary, someone claiming on his behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if any) within 30 days
vii. If the original documents are submitted with the co-insurer, the Xerox copies attested by the co-insurer should be submitted.

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

List of Claim documents: -

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

Additional documents for claim under Renewal Premium Waiver Benefit
1. Death certificate stating the reason of death.

Additional documents for claim under International Cover – Emergency Care only
1. Passport and Visa copy with Entry Stamp Overseas and exit Stamp from India
2. Release of Medical Information Form (ROMIF) BAJAJ and Assistance Provider (to be filled and signed by Insured) to obtain the medical records from facility

Note- The list of documents given above is an indicative list and Insurer reserves rights for asking additional documents related to claim(s) in case required.
Please send the documents on below address
Bajaj Allianz General Insurance Company Ltd
2nd Floor, Bajaj Finserv Building,
Behind Weikfield IT park,
Off Nagar Road, Viman Nagar
Pune 411014| Toll free: 1800-103-2529, 1800-22-5858

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

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

- The doctor will join the call for instant consultation.

<u>Doctor consultation Service Delivery process</u>

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

<u>Doctor prescribed Investigations Cover – Pathology & Radiology Service Delivery Process</u>

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

<u>Reimbursement Process with Pre-approval for Doctor consultation and Doctor prescribed Investigations Cover</u>

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

- Confirm the Pre-Auth.
- Now visit the Lab at the informed date of visit.
- After the visit, come back within 30 days of visit date at Transaction History page and select the Authorized ticket for which pre-auth was taken
- In the reimbursement form page1:
    i. Enter the Invoice amount in the form
    ii. Enter the Date of visit in the form
- Click Next
- Fill the Form page2:
- Upload the Supporting Documents of the visit: Invoice and Reports/Prescription of the visit
- Submit the form.
- Visit the provider on the appointment date mentioned
- Post the visit, begin filing the claim for the completed appointment. Reimbursement journey can be started by Navigating to transaction history page of the respective plan and click on "Submit Claim" of respective authorized ticket Or navigate to the service page (Doctor/Labs/Hospital) where request for authorization was taken in the respective plan and click on "Submit Claim" of respective authorized ticket
- Verify previously filled details
- Edit actual date of appointment and actual claim amount
- Upload the invoice and the other supporting documents as required
- Enter the UPI ID or Bank Account details
- Review the details and documents properly before clicking on the final submit button
- Click on "Submit" to finally submit the claim
- Keep note of the Transaction ID for keeping a track of the claim in future
- Insured member/s can visit the Transaction History section in future to view the updates in the claim status
- The claim will be reimbursed within defined TAT as communicated during authorization

Preventive Health Check -up Service Delivery process

- Start by downloading the Caringly Yours app. / Service Providers digital application.
- Sign-up using the registered mobile number.
- Under my "Active Plans", select the purchased product/Plan.
- Select Lab benefit option.
- Select member and choose preventive health check-up.
- Select the hospital/lab from available network.
- Home collection facility is available only at selected locations. For locations where home sample collection is not available, the customer will have to physically go and take the tests.
- Enter the date of redemption and confirm.
- SMS with voucher link shared on the registered mobile number.
- Share the voucher code to avail cashless Preventive Health Check-up benefit

31. Paying a Claim

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

32. Basis of Claims Payment

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

33. Cost Sharing

Our obligation to make payment in respect of surgeries for cataracts (after the expiry of the waiting period as specified in the Policy Schedule) shall be as specified in the Policy Schedule

i. 20% of the Sum Insured for each eye, subject to maximum of INR 100,000 for each of You.
ii. The above mentioned limit for cataract can be waived, subject to payment of additional premium at the inception of the policy, provided this option is available under the plan.

34. Nationality:

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

35. Sum Insured Enhancement:

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

36. Inclusion of members under the Policy:

Where an Insured Beneficiary is added to the Policy, either by way of Endorsement or at the time of Renewal, the pre-existing disease clause, exclusions and Waiting Periods will be applicable considering such Policy Year as the first year of Policy with the Company for the newly added Insured Beneficiary.

Annexure I: List of Day Care Procedures:

ENT	General Surgery
1 Stapedotomy	204 Infected Keloid Excision
2 Myringoplasty (Type I Tympanoplasty)	205 Incision of a pilonidal sinus / abscess
3 Revision stapedectomy	206 Axillary lymphadenectomy
4 Labyrinthectomy for severe Vertigo	207 Wound debridement and Cover
5 Stapedectomy under GA	208 Abscess-Decompression
6 Ossiculoplasty	209 Cervical lymphadenectomy
7 Myringotomy with Grommet Insertion	210 infected sebaceous cyst
8 Tympanoplasty (Type III)	211 Inguinal lymphadenectomy
9 Stapedectomy under LA	212 Incision and drainage of Abscess
10 Revision of the fenestration of the inner ear.	213 Suturing of lacerations
11 Tympanoplasty (Type IV)	214 Scalp Suturing
12 Endolymphatic Sac Surgery for Meniere's Disease	215 Infected lipoma excision
13 Turbinectomy	216 Maximal anal dilatation
14 Removal of Tympanic Drain under LA	217 Piles
15 Endoscopic Stapedectomy	A)Injection Sclerotherapy
16 Fenestration of the inner ear	B)Piles banding
17 Incision and drainage of perichondritis	218 Liver Abscess- catheter drainage
18 Septoplasty	219 Fissure in Ano- fissurectomy
19 Vestibular Nerve section	220 Fibroadenoma breast excision
20 Thyroplasty Type I	221 Oesophageal varices Sclerotherapy
21 Pseudocyst of the Pinna - Excision	222 ERCP - pancreatic duct stone removal
22 Incision and drainage - Haematoma Auricle	223 Perianal abscess I&D

23 Tympanoplasty (Type II)	224 Perianal hematoma Evacuation
24 Keratosis removal under GA	225 Fissure in anosphincterotomy
25 Reduction of fracture of Nasal Bone	226 UGI scopy and Polypectomyoesophagus
26 Excision and destruction of lingual tonsils	227 Breast abscess I& D
27 Conchoplasty	228 Feeding Gastrostomy
28 Thyroplasty Type II	229 Oesophagoscopy and biopsy of growth oesophagus
29 Tracheostomy	230 UGI scopy and injection of adrenaline, sclerosants - bleeding ulcers
30 Excision of Angioma Septum	231 ERCP - Bile duct stone removal
31 Turbinoplasty	232 Ileostomy closure
32 Incision & Drainage of Retro Pharyngeal Abscess	233 Colonoscopy
33 UvuloPalatoPharyngoPlasty	234 Polypectomy colon
34 Palatoplasty	235 Splenic abscesses Laparoscopic Drainage
35 Tonsillectomy without adenoidectomy	236 UGI SCOPY and Polypectomy stomach
36 Adenoidectomy with Grommet insertion	237 Rigid Oesophagoscopy for FB removal
37 Adenoidectomy without Grommet insertion	238 Feeding Jejunostomy
38 Vocal Cord lateralisation Procedure	239 Colostomy
39 Incision & Drainage of Para Pharyngeal Abscess	240 Ileostomy
40 Transoral incision and drainage of a pharyngeal abscess	241 colostomy closure
41 Tonsillectomy with adenoidectomy	242 Submandibular salivary duct stone removal
42 Tracheoplasty Ophthalmology	243 Pneumatic reduction of intussusception
43 Incision of tear glands	244 Varicose veins legs - Injection sclerotherapy
44 Other operation on the tear ducts	245 Rigid Oesophagoscopy for Plummer vinson syndrome
45 Incision of diseased eyelids	246 Pancreatic Pseudocysts Endoscopic Drainage
46 Excision and destruction of the diseased tissue of the eyelid	247 ZADEK's Nail bed excision
47 Removal of foreign body from the lens of the eye.	248 Subcutaneous mastectomy
48 Corrective surgery of the entropion and ectropion	249 Excision of Ranula under GA
49 Operations for pterygium	250 Rigid Oesophagoscopy for dilation of benign Strictures
50 Corrective surgery of blepharoptosis	251 Eversion of Sac
51 Removal of foreign body from conjunctiva	a) Unilateral
52 Biopsy of tear gland	b)Bilateral
53 Removal of Foreign body from cornea	252 Lord's plication
54 Incision of the cornea	253 Jaboulay's Procedure
55 Other operations on the cornea	254 Scrotoplasty
56 Operation on the canthus and epicanthus	255 Surgical treatment of varicocele
57 Removal of foreign body from the orbit and the eye ball.	256 Epididymectomy
58 Surgery for cataract	257 Circumcision for Trauma
59 Treatment of retinal lesion	258 Meatoplasty
60 Removal of foreign body from the posterior chamber of the eye	259 Intersphincteric abscess incision and drainage
Oncology	260 Psoas Abscess Incision and Drainage
61 IV Push Chemotherapy	261 Thyroid abscess Incision and Drainage
62 HBI-Hemibody Radiotherapy	262 TIPS procedure for portal hypertension

63 Infusional Targeted therapy	263 Esophageal Growth stent
64 SRT-Stereotactic Arc Therapy	264 PAIR Procedure of Hydatid Cyst liver
65 SC administration of Growth Factors	265 Tru cut liver biopsy
66 Continuous Infusional Chemotherapy	266 Photodynamic therapy or esophageal tumour and Lung tumour
67 Infusional Chemotherapy	267 Excision of Cervical RIB
68 CCRT-Concurrent Chemo + RT	268 laparoscopic reduction of intussusception
69 2D Radiotherapy	269 Microdochectomy breast
70 3D Conformal Radiotherapy	270 Surgery for fracture Penis
71 IGRT- Image Guided Radiotherapy	271 Sentinel node biopsy
72 IMRT- Step & Shoot	272 Parastomal hernia
73 Infusional Bisphosphonates	273 Revision colostomy
74 IMRT- DMLC	274 Prolapsed colostomy- Correction
75 Rotational Arc Therapy	275 Testicular biopsy
76 Tele gamma therapy	276 laparoscopic cardiomyotomy(Hellers)
77 FSRT-Fractionated SRT	277 Sentinel node biopsy malignant melanoma
78 VMAT-Volumetric Modulated Arc Therapy	278 laparoscopic pyloromyotomy(Ramstedt)
79 SBRT-Stereotactic Body Radiotherapy	**Orthopedics**
80 Helical Tomotherapy	279 Arthroscopic Repair of ACL tear knee
81 SRS-Stereotactic Radiosurgery	280 Closed reduction of minor Fractures
82 X-Knife SRS	281 Arthroscopic repair of PCL tear knee
83 Gammaknife SRS	282 Tendon shortening
84 TBI- Total Body Radiotherapy	283 Arthroscopic Meniscectomy - Knee
85 intraluminal Brachytherapy	284 Treatment of clavicle dislocation
86 Electron Therapy	285 Arthroscopic meniscus repair
87 TSET-Total Electron Skin Therapy	286 Haemarthrosis knee- lavage
88 Extracorporeal Irradiation of Blood Products	287 Abscess knee joint drainage
89 Telecobalt Therapy	288 Carpal tunnel release
90 Telecesium Therapy	289 Closed reduction of minor dislocation
91 External mould Brachytherapy	290 Repair of knee cap tendon
92 Interstitial Brachytherapy	291 ORIF with K wire fixation- small bones
93 Intracavity Brachytherapy	292 Release of midfoot joint
94 3D Brachytherapy	293 ORIF with plating- Small long bones
95 Implant Brachytherapy	294 Implant removal minor
96 Intravesical Brachytherapy	295 K wire removal
97 Adjuvant Radiotherapy	296 POP application
98 Afterloading Catheter Brachytherapy	297 Closed reduction and external fixation
99 Conditioning Radiothearpy for BMT	298 Arthrotomy Hip joint
100 Extracorporeal Irradiation to the Homologous Bone grafts	299 Syme's amputation
101 Radical chemotherapy	300 Arthroplasty
102 Neoadjuvant radiotherapy	301 Partial removal of rib
103 LDR Brachytherapy	302 Treatment of sesamoid bone fracture
104 Palliative Radiotherapy	303 Shoulder arthroscopy / surgery
105 Radical Radiotherapy	304 Elbow arthroscopy
106 Palliative chemotherapy	305 Amputation of metacarpal bone

107 Template Brachytherapy	306 Release of thumb contracture
108 Neoadjuvant chemotherapy	307 Incision of foot fascia
109 Adjuvant chemotherapy	308 calcaneum spur hydrocort injection
110 Induction chemotherapy	309 Ganglion wrist hyalase injection
111 Consolidation chemotherapy	310 Partial removal of metatarsal
112 Maintenance chemotherapy	311 Repair / graft of foot tendon
113 HDR Brachytherapy	312 Revision/Removal of Knee cap
Plastic Surgery	313 Amputation follow-up surgery
114 Construction skin pedicle flap	314 Exploration of ankle joint
115 Gluteal pressure ulcer-Excision	315 Remove/graft leg bone lesion
116 Muscle-skin graft, leg	316 Repair/graft achilles tendon
117 Removal of bone for graft	317 Remove of tissue expander
118 Muscle-skin graft duct fistula	318 Biopsy elbow joint lining
119 Removal cartilage graft	319 Removal of wrist prosthesis
120 Myocutaneous flap	320 Biopsy finger joint lining
121 Fibro myocutaneous flap	321 Tendon lengthening
122 Breast reconstruction surgery after mastectomy	322 Treatment of shoulder dislocation
123 Sling operation for facial palsy	323 Lengthening of hand tendon
124 Split Skin Grafting under RA	324 Removal of elbow bursa
125 Wolfe skin graft	325 Fixation of knee joint
126 Plastic surgery to the floor of the mouth under GA	326 Treatment of foot dislocation
Urology	327 Surgery of bunion
127 AV fistula - wrist	328 intra articular steroid injection
128 URSL with stenting	329 Tendon transfer procedure
129 URSL with lithotripsy	330 Removal of knee cap bursa
130 CystoscopicLitholapaxy	331 Treatment of fracture of ulna
131 ESWL	332 Treatment of scapula fracture
132 Haemodialysis	333 Removal of tumor of arm/ elbow under RA/GA
133 Bladder Neck Incision	334 Repair of ruptured tendon
134 Cystoscopy & Biopsy	335 Decompress forearm space
135 Cystoscopy and removal of polyp	336 Revision of neck muscle (Torticollis release)
136 Suprapubiccystostomy	337 Lengthening of thigh tendons
137 percutaneous nephrostomy	338 Treatment fracture of radius & ulna
139 Cystoscopy and "SLING" procedure.	339 Repair of knee joint Paediatric surgery
140 TUNA- prostate	340 Excision Juvenile polyps rectum
141 Excision of urethral diverticulum	341 Vaginoplasty
142 Removal of urethral Stone	342 Dilatation of accidental caustic stricture oesophageal
143 Excision of urethral prolapse	343 PresacralTeratomas Excision
144 Mega-ureter reconstruction	344 Removal of vesical stone
145 Kidney renoscopy and biopsy	345 Excision Sigmoid Polyp
146 Ureter endoscopy and treatment	346 SternomastoidTenotomy
147 Vesico ureteric reflux correction	347 Infantile Hypertrophic Pyloric Stenosis pyloromyotomy
148 Surgery for pelvi ureteric junction obstruction	348 Excision of soft tissue rhabdomyosarcoma
149 Anderson hynes operation	349 Mediastinal lymph node biopsy

150 Kidney endoscopy and biopsy	350 High Orchidectomy for testis tumours
151 Paraphimosis surgery	351 Excision of cervical teratoma
152 injury prepuce- circumcision	352 Rectal-Myomectomy
153 Frenular tear repair	353 Rectal prolapse (Delorme's procedure)
154 Meatotomy for meatal stenosis	354 Orchidopexy for undescended testis
155 surgery for fournier's gangrene scrotum	355 Detorsion of torsion Testis
156 surgery filarial scrotum	356 lap.Abdominal exploration in cryptorchidism
157 surgery for watering can perineum	357 EUA + biopsy multiple fistula in ano
158 Repair of penile torsion	358 Cystic hygroma - Injection treatment
159 Drainage of prostate abscess	359 Excision of fistula-in-ano
160 Orchiectomy	**Gynaecology**
161 Cystoscopy and removal of FB	360 Hysteroscopic removal of myoma
Neurology	361 D&C
162 Facial nerve physiotherapy	362 Hysteroscopic resection of septum
163 Nerve biopsy	363 thermal Cauterisation of Cervix
164 Muscle biopsy	364 MIRENA insertion
165 Epidural steroid injection	365 Hysteroscopicadhesiolysis
166 Glycerol rhizotomy	366 LEEP
167 Spinal cord stimulation	367 Cryocauterisation of Cervix
168 Motor cortex stimulation	368 Polypectomy Endometrium
169 Stereotactic Radiosurgery	369 Hysteroscopic resection of fibroid
170 Percutaneous Cordotomy	370 LLETZ
171 Intrathecal Baclofen therapy	371 Conization
172 Entrapment neuropathy Release	372 polypectomy cervix
173 Diagnostic cerebral angiography	373 Hysteroscopic resection of endometrial polyp
174 VP shunt	374 Vulval wart excision
175 Ventriculoatrial shunt	375 Laparoscopic paraovarian cyst excision
Thoracic surgery	376 uterine artery embolization
176 Thoracoscopy and Lung Biopsy	377 Bartholin Cyst excision
177 Excision of cervical sympathetic Chain Thoracoscopic	378 Laparoscopic cystectomy
178 Laser Ablation of Barrett's oesophagus	379 Hymenectomy(imperforate Hymen)
179 Pleurodesis	380 Endometrial ablation
180 Thoracoscopy and pleural biopsy	381 vaginal wall cyst excision
181 EBUS + Biopsy	382 Vulval cyst Excision
182 Thoracoscopy ligation thoracic duct	383 Laparoscopic paratubal cyst excision
183 Thoracoscopy assisted empyaema drainage	384 Repair of vagina (vaginal atresia)
Gastroenterology	385 Hysteroscopy, removal of myoma
184 Pancreatic pseudocyst EUS & drainage	386 TURBT
185 RF ablation for barrett'sOesophagus	387 Ureterocoele repair - congenital internal
186 ERCP and papillotomy	388 Vaginal mesh For POP
187 Esophagoscope and sclerosant injection	389 Laparoscopic Myomectomy
188 EUS + submucosal resection	390 Surgery for SUI
189 Construction of gastrostomy tube	391 Repair recto- vagina fistula
190 EUS + aspiration pancreatic cyst	392 Pelvic floor repair(excluding Fistula repair)
191 Small bowel endoscopy (therapeutic)	393 URS + LL

192 Colonoscopy ,lesion removal	394 Laparoscopic oophorectomy
193 ERCP	**Critical care**
194 Colonscopy stenting of stricture	395 Insert non- tunnel CV cath
195 Percutaneous Endoscopic Gastrostomy	396 Insert PICC cath (peripherally inserted central catheter)
196 EUS and pancreatic pseudo cyst drainage	397 Replace PICC cath (peripherally inserted central catheter)
197 ERCP and choledochoscopy	398 Insertion catheter, intra anterior
198 Proctosigmoidoscopy volvulus detorsion	399 Insertion of Portacath
199 ERCP and sphincterotomy	
200 Esophageal stent placement	
201 ERCP + placement of biliary stents	
202 Sigmoidoscopy w / stent	
203 EUS + coeliac node biopsy	

NOTE:

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

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

Annexure II:-

List 1: List of Non-Medical Items

S No	Item
1	Baby Food
2	Baby Utilities Charges
3	Beauty Services
4	Buds
5	Carry Bags
6	Email / Internet Charges
7	Food Charges (Other Than Patient's Diet Provided By Hospital)
8	Laundry Charges
9	Mineral Water
10	Sanitary Pad
11	Telephone Charges
12	Guest Services
13	Diaper Of Any Type
14	Television Charges
15	Attendant Charges
16	Extra Diet Of Patient (Other Than That Which Forms Part Of Bed Charge)
17	Birth Certificate
18	Certificate Charges
19	Courier Charges
20	Conveyance Charges
21	Medical Certificate
22	Medical Records

23	Photocopies Charges
24	Diabetic Foot Wear
25	Private Nurses Charges - Special Nursing Charges
26	Sugar Free Tablets
27	Creams Powders Lotions (Toiletries Are Not Payable, Only Prescribed Medical

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

S. No.	Item
1	Baby Charges (Unless Specified /Indicated)
2	Hand Wash
3	Shoe Cover
4	Caps
5	Cradle Charges
6	Comb
7	Eau-De-Cologne/Room Fresheners
8	Foot Cover
9	Gown
10	Slippers
11	Tissue Paper
12	Tooth Paste
13	Tooth Brush
14	Bed Pan
15	Face Mask
16	Flexi Mask
17	Hand Holder
18	Sputum Cup
19	Disinfectant Lotions
20	Luxury Tax
21	HVAC
22	House Keeping Charges
23	Air Conditioner Charges
24	IM IV Injection Charges
25	Clean Sheet
26	Blanket/Warmer Blanket
27	Admission Kit
28	Diabetic Chart Charges
29	Documentation Charges/Administrative Expenses
30	Discharge Procedure Charges
31	Daily Chart Charges
32	Entrance Pass / Visitors Pass Charges
33	Expenses Related To Prescription On Discharge
34	File Opening Charges
35	Incidental Expenses / Misc. Charges (Not Explained)
36	Patient Identification Band / Name Tag
37	Pulse oximeter Charges

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

S. No.	Item
1	Hair Removal Cream
2	Disposables Razors Charges (For Site Preparations)
3	Eye Pad
4	Eye Shield
5	Camera Cover
6	DVD/CD Charges
7	Gauze Soft
8	Gauze
9	Ward And Theatre Booking Charges
10	Arthroscopy And Endoscopy Instruments
11	Microscope Cover
12	Surgical Blades, Harmonic scalpel, Shaver
13	Surgical Drill
14	Eye Kit
15	Eye Drape
16	X-Ray Film
17	Boyles Apparatus Charges
18	Cotton
19	Cotton Bandage
20	Surgical Tape
21	Apron
22	Torniquet
23	Ortho bundle, Gynaec Bundle

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

S. No.	Item
1	Admission/Registration Charges
2	Hospitalization For Evaluation/Diagnostic Purpose
3	Urine Container
4	Blood Reservation Charges And Ante Natal Booking Charges
5	Bi-pap Machine
6	CPAP/CPAD Equipment
7	Infusion Pump-Cost
8	Hydrogen Peroxide\Spirit\Disinfection Etc.
9	Nutrition Planning Charges - Dietician Charges - Diet Charges
10	HIV Kit
11	Antiseptic Mouthwash
12	Lozenges
13	Mouth Paint
14	Vaccination Charges
15	Alcohol Swabs

16	Scrub Solution / Sterillium
17	Glucometer & Strips
18	Urine Bag

Annexure III:- ICD specific for Mental Illness

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

Annexure IV:-

List Of Non-Medical Items Payable Under Consumable Expenses Cover	
1	Belts/ Braces
2	Cold Pack/Hot Pack
3	Leggings
4	Crepe Bandage
5	Eyelet Collar
6	Slings
7	Blood Grouping And Cross Matching Of Donors Samples
8	Service Charges Where Nursing Charges Also Charged
9	Surcharges
10	Mortuary Charges
11	Walking Aids Charges
12	Oxygen Cylinder (For Usage Outside The Hospital)
13	Spacer
14	Spirometre
15	Nebulizer Kit
16	Steam Inhaler
17	Arm sling
18	Thermometer
19	Cervical Collar
20	Splint
21	Knee Braces (Long/ Short/ Hinged)
22	Knee Immobilizer/Shoulder Immobilizer
23	Lumbosacral Belt
24	Nimbus Bed Or Water Or Air Bed Charges

25	Ambulance Collar
26	Ambulance Equipment
27	Abdominal Binder
28	Ecg Electrodes
29	Gloves
30	Any Kit With No Details Mentioned [Delivery Kit, Orthokit, Recovery Kit, Etc]
31	Kidney Tray
32	Mask
33	Ounce Glass
34	Oxygen Mask
35	Pelvic Traction Belt
36	Pan Can
37	Trolly Cover
38	Urometer, Urine Jug
39	Vasofix Safety

Annexure V:- List of Office of the Insurance Ombudsman

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 – 25501201 /02 /05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL - Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor, “Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR – Insurance Ombudsman	Orissa.

Office Details	Jurisdiction of Office Union Territory, District)
Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 – 2596461 / 2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	
CHANDIGARH - Insurance Ombudsman Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 – 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
CHENNAI - Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)
DELHI – Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR - Insurance Ombudsman Office of the Insurance Ombudsman,	Rajasthan.

Office Details	Jurisdiction of Office Union Territory, District)
Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 –2740363 / 2740798 Email: bimalokpal.jaipur@cioins.co.in	
KOCHI – Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA – Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW – Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, 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 - Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/ 27/ 29/ 31/ 32/ 33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
NOIDA - Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA – Insurance Ombudsman Office of the Insurance Ombudsman,	Bihar, Jharkhand.

Office Details	Jurisdiction of Office Union Territory, District)
2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	
PUNE - Insurance Ombudsman 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- 24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

Note: Address and contact number of Governing Body of Insurance Council:
Council for Insurance Ombudsmen,3rd Floor, Jeevan Seva Annexe,S. V. Road, Santacruz (W), Mumbai - 400 054.
E-mail: inscoun@cioins.co.in, **Tel**: 022 -69038800/69038812, **Website**: https://www.cioins.co.in

Table of Benefits

My Health Care Plan				
Cover	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 4 (Super Top –up)**
In-Patient Hospitalization Expenses	3/4/5/7.5/10/15/20/25/30/35/40/45/50/75 lacs and 1/2/3/4/5 Crore	1/2/3/4 Lacs	5 lacs to 5 Crore	2,3,5,7.5,10,15,20, 25,50,75,90 lacs,1 /1.5/2/3/4/5 Crores
Aggregate Deductible	NA	NA	NA	50K/1/2/3/4/5/7.5/10/15/20 /30/40/50/75 Lacs/ 1Cr
Room rent for 3 Lac to 10 Lac SI	Single Pvt AC Room	1% of Sum Insured	Actuals	Single Private Room

Room rent for Above 10 Lacs SI	Actuals	NA	Actual	Actuals
Pre-hospitalization Medical Expenses	60 days	30 days	90 days	90 days
Post-hospitalization Medical Expenses	90 days	60 days	180 days	180 days
Organ Donor	Up to Sum Insured	Up to Sum Insured	Up to Sum Insured	Up to Sum Insured
Ayurvedic and Homeopathic Hospitalization Cover	Up to Sum Insured	Up to Sum Insured	Up to Sum Insured	Up to Sum Insured
Road Ambulance	Up to Sum Insured	Up to Sum Insured	Up to Sum Insured	Up to Sum Insured
Maternity Package expenses **A. Maternity expenses** **B. Maternity expenses for Surrogacy** **C. Complications of Assisted reproductive technique**	For SI 3 and 4 Lac – Not covered	NA	NA	For SI 3 and 4 Lac - Not covered
	For SI 5 Lac to 10 Lac – INR 50,000		For SI 5 Lac to 10 Lac – INR 50,000	For SI 5 Lac to 10 Lac – INR 50,000
	For SI 15 Lac to 20 Lac- INR 75,000		For SI 15 Lac to 20 Lac- INR 75,000	For SI 15 Lac to 20 Lac- INR 75,000
	For SI above 20 Lacs – INR 1,00,000		For SI above 20 Lacs – INR 1,00,000	For SI above 20 Lacs – INR 1,00,000
Baby care	For SI up to 4 Lac- 1 lac	NA	NA	NA
	For SI 5 Lac to 10 Lac- 5 Lac		For SI 5 Lac to 10 Lac- 5 Lac	
	For SI 15 Lac to 50 Lac- 10 Lac		For SI 15 Lac to 50 Lac- 10 Lac	
	For SI above 50 Lac- 15 Lac		For SI above 50 Lac- 15 Lac	
Out-Patient Treatment (OPD) Expenses	a) Insta-Consultation (Instant Teleconsultation) Cover	NA	a) Insta-Consultation (Instant Teleconsultation) Cover	a) Insta-Consultation (Instant Teleconsultation) Cover
	b) Doctor Consultation Cover (in clinic)- Limit-50% of OPD SI		b) Doctor Consultation Cover (in clinic)- Limit-50% of OPD SI	b) Doctor Consultation Cover (in clinic)- Limit-50% of OPD SI
	c) Doctor Prescribed investigation/ pathology and Radiology Cover-Limit 50% of OPD SI		c) Doctor Prescribed investigation/ pathology and Radiology Cover-Limit 50% of OPD SI	c) Doctor Prescribed investigation/ pathology and Radiology Cover-Limit 50% of OPD SI
	d) Annual Preventive Health check-up cover - (1 voucher)		d) Annual Preventive Health check-up cover - (1 voucher)	d) Annual Preventive Health check-up cover - (1 voucher)
Home Nursing Benefit (max 10 weeks)	For SI up to 50 Lac- 5,000/week	NA	For SI up to 50 Lac- 10,000/week	For SI up to 50 Lac- 5,000/week
	For SI above 50 Lac- 10,000/week		For SI above 50 Lac- 20,000/week	For SI above 50 Lac- 10,000/week

Cover	Plan 1	Plan 2	Plan 3	Plan 4 (Super Top –up)
Cost of Prescribed External Medical Aid	For SI up to 10 Lac-10,000	Up to INR 10,000	For SI up to 10 Lac-15,000	For SI up to 10 Lac-10,000
	For SI 15 Lac to 50 Lac-25,000	NA	For SI 15 Lac to 50 Lac-40,000	For SI 15 Lac to 50 Lac-25,000
	For SI above 50 Lac-50,000		For SI above 50 Lac-75,000	For SI above 50 Lac-50,000
Sum Insured Reinstatement (Available for same illness)	For SI less than 5 lacs - Once	Once	Unlimited	NA
	For SI 5 lacs and above - Unlimited	NA		
Recharge	NA	NA	20% of the Sum Insured maximum up to INR 25 Lacs	NA
Airlift Cover	For SI above 50 Lac to 1 Crore - Limit for Air Lift up to INR 10 Lac	NA	For SI above 50 Lac to 1 Crore - Limit for Air Lift up to INR 10 Lac	For SI above 50 Lac to 1 Crore - Limit for Air Lift up to INR 10 Lac
	For SI Above 1Crore - Limit for Air Lift up to 20 Lac		For SI Above 1Crore - Limit for Air Lift up to 20 Lac	For SI Above 1Crore - Limit for Air Lift up to 20 Lac
Cumulative bonus (reduces in case of claim)	For SI 3 & 4 lacs - 25% Per Annum max 100%	25% per annum max up to 100%	For SI up to 5 Lac- 25% Per Annum max 100%	NA
	For SI 5 Lac and above- 50% Per Annum max 100%		For SI 5 Lac and above- 50% Per Annum max 100%	NA
Family Visit	For SI upto 10 lacs- upto INR 25,000	For SI upto 10 lacs- upto INR 25,000	For SI upto 10 lacs- upto INR 25,000	For SI upto 10 lacs- upto INR 25,000
	For SI More than 10 lacs – Upto INR 50,000	NA	For SI More than 10 lacs – Upto INR 50,000	For SI More than 10 lacs – Upto INR 50,000
Renewal premium waiver benefit in case of death of proposer	Applicable			
Consumables cover	Up to In-patient SI	NA	Up to In-patient SI	Up to In-patient SI

Waiting Period				
Waiting Periods	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 4**
Pre-Existing Diseases Waiting Period	36 months	48 months	24 months	36 months
Specified disease/procedure Waiting Period	24 months	36 months	24 months (Option to change to 12 Months)	24 months
Initial Waiting period	30 days	30 days	30 days	30 days
Maternity Expenses waiting period	36 months(will decrease by 1 year if premium for long term policy is paid upfront)	NA	36 months(will decrease by 1 year if premium for long term policy is paid upfront)	36 months(will decrease by 1 year if premium for long term policy is paid upfront)
Baby Care waiting period	36 months(will decrease by 1 year if premium for long term policy is paid upfront)	NA	36 months(will decrease by 1 year if premium for long term policy is paid upfront)	36 months(will decrease by 1 year if premium for long term policy is paid upfront)

The above given plans are indicative. Please refer your Policy Schedule for Coverage details and corresponding limits in your plan.

OPTIONAL COVERS AVAILABLE IN MY HEALTH CARE PLAN
1. Loss of Income Cover (Applicable to Part I and Part II)
2. Procedure wise sub limit (Applicable to Part I only)
3. Surgery Only cover (Applicable to Part I and Part II)
4. Air Ambulance (Applicable to Part I and Part II)
5. Major Illness and Accident Multiplier (Indemnity) (Applicable to Part I only)
6. International Cover – Emergency Care only (Applicable to Part I only)
7. Hospital Daily Cash Benefit (Applicable to Part I and Part II)
8. Fracture Care (Applicable to Part I and Part II)
9. Super Cumulative Bonus (Applicable to Part I only)
10. Double Sum Insured Benefit (Applicable to Part I only) (Applicable only if Sum Insured Opted is 5 Lac and above)

Options Available for Room Rent	General Ward
	Twin Sharing
	Single Pvt Ac
	Actual (this option will be available for SI 5 Lac and above only)
	1% of SI max up to 5000
	1.5% of SI max 7500
	2% of SI max up to 7500

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

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

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

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

Options Available for Super Cumulative Bonus	50% per annum max up to 100%
	50% per annum max up to 200%
	50% per annum max up to 500%
	100% per annum max up to 200%
	100% per annum max up to 500%
	100% per annum max up to 600%