COCOCure
POLICY WORDINGS

This is *Your* COCOCure Policy, which has been issued by *Us*, relying on the Information disclosed by *You* in *Your* Proposal for this *Policy* or its preceding *Policy/Policies* of which this is a *Renewal*. The terms set out in this *Policy* and its Schedule will be the basis for any claim or benefit under this *Policy*.

1. DEFINITIONS

The words defined in this document are assigned specified meanings and they are appearing in italics. Wherever the context permits, the singular will be deemed to include the plural, one gender shall be deemed to include the other genders and references to any statute shall be deemed to refer to any replacement or amendment of that statute.

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

1.2 **Admissible claim amount** - means the amount that is admissible as per policy terms and conditions before applying *deductible/co-payment*. Any *deductible/co-payment* will be applied on the admissible claim amount. The amount so arrived after application of *deductible/co-payment,* will be payable under the policy but not exceeding the *Sum Insured*.

1.3 **Adventure Sports** – means those sports / activities which involves speed, height, a high level of physical exertion and high degree of inherent danger. Such sports are racing on wheels or horseback, power boat racing, ski racing, hunting or equestrian activities, big game hunting, rock climbing/trekking/mountaineering, winter sports, Skydiving, Parachuting, paragliding/parapenting, Scuba Diving, ski doo riding, cavin/pot holing, bungee jumping, hell skiing, ski acrobatics, ski jumping, water ski jumping, ice hockey, ice speedway, ballooning, hand gliding, river rafting, black water rafting, yachting or boating outside coastal waters, canoeing involving rapid waters, micro-lighting, motor rallying, piloting aircraft, power lifting, quad biking, river boarding, river bugging, rodeo, roller hockey.

1.4 **Age** or **Aged –** means completed age in years as at the Policy Commencement Date.

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

1.6 **Authority** means the Insurance Regulatory and Development Authority of India established under the provisions of section 3 of the Insurance Regulatory and development authority Act, 1999 (41 of 1999).

1.7 **Bank Rate** means Bank Rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

1.8 **Base Sum Insured** means the amount stated in the Policy Schedule.

1.9 **Complaint or Grievance** means written expression (includes communication in the form of electronic mail or other electronic scripts), of dissatisfaction by a *Complainant* with *Insurer*, distribution channels, intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such *Insurer*, distribution channels, intermediaries, insurance intermediaries or other regulated entities.

1.10 **Complainant** means a *Policyholder* or prospect or any beneficiary of an insurance *Policy* who has filed a *Complaint* or *Grievance* against an *Insurer* or a distribution channel.

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

1.12 **Condition Precedent** - means a *Policy* term or condition upon which the *Insurer`s* liability under the *Policy* is conditional upon.

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

(a) **Internal Congenital Anomaly** – congenital anomaly which is not in the visible and accessible parts of the body.

(b) **External Congenital Anomaly** - congenital anomaly which is in the visible and accessible parts of the body.

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

1.15 **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*.

1.16 **Day Care Centre -** means any institution established for *Day Care Treatment* of *Illness* and / or *Injuries* or a medical setup with a *Hospital* and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified *Medical Practitioner* AND must comply with all minimum criterion 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.

1.17 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 *Hospitalisation* of more than 24 hours.

Note - **Treatment normally taken on an Out-patient basis is not included in the scope of this definition.**

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

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

1.20 Dependent Child – means biologically or legally adopted son or daughter of the Policyholder whose completed age is less than or equal to 30 years and who is financially dependent on the Policyholder with no source of income and have not established his/her own independent households.

1.21 Diagnosis - means conclusion drawn by a registered *Medical Practitioner*, supported by acceptable clinical, radiological, histological, histo-pathological, and laboratory evidence wherever applicable.

1.22 Disclosure of information norm - means the *Policy* shall be void and all premiums paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any *Material Fact.*

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

1.24 **Emergency -** means a severe *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 Person's* health.

1.25 **Emergency Care -** means management for 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 Person's* health.

1.26 **Family** - means the persons named in the *Policy Schedule* who are the *Policyholder's* legal spouse, dependent children, parents/ parents-in-Law.

1.27 **Family Floater -** means a *Policy* described as such in the *Policy Schedule* where *You* and *Your Family* named in the *Policy Schedule* are covered under this *Policy* as at the Commencement Date. The *Sum Insured* for a Family Floater is the amount shown in the *Policy Schedule* which represents *Our* maximum liability for any and all claims made by *You* and/or all of *Your Family* during each *Policy Year*.

1.28 **Non-Floater** – means a *Policy* where *You* and *Your Family* members named in the *Policy Schedule* are covered under this *Policy* as at the commencement date. The *Sum Insured* for Non-Floater is the amount shown in the *Policy Schedule* against each individual *Insured* Person which also represents *Our* maximum liability for that *Insured Person*.

1.29 **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**.**

1.30 **Harvesting** – means a *Surgical Procedure* to remove organs or tissues from a donor (Cadaveric or live), for the purpose of organ transplantation.

1.31 **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 Clinical Establishment (Registration and Regulation) Act,2010 or under enactments specified under the Schedule of Section 56 (1) of the said Act **Or** complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
iii. has qualified *Medical Practitioner(s)* in charge round the clock;
iv. has a fully equipped operation theatre of its own where *Surgical Procedures* are carried out;

v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

1.32 **Hospitalisation -** means admission in a *Hospital* for a minimum 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.

1.33 **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** 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** 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 or 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.

1.34 **Infertility** – means a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.

1.35 **Injury -** means *Accidental* physical bodily harm excluding *Illness* or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a *Medical Practitioner*.

1.36 **In-patient Care -** means treatment for which the *Insured Person* has to stay in a *Hospital* for more than 24 hours for a covered event.

1.37 **Insured Person (Insured)** – means persons named in the *Policy Schedule*.

1.38 **Intensive Care Unit (ICU) –** 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.

1.39 **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.

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

1.41 **Material Fact** - means a fact deemed so important that It would change the decision made by an *Insurer* if it were kept hidden.

1.42 **Maternity Expenses -** means:

i. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during *Hospitalisation*);
ii. expenses towards lawful medical termination of pregnancy during the *Policy Period*.

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

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

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

1.46 **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.

1.47 **Network Provider -** means *hospital* enlisted by an *Insurer*, *TPA* or jointly by an *Insurer* and *TPA* to provide medical services to an *Insured* by a *Cashless Facility*.

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

1.49 **Non-Allopathic Treatment -** means forms of treatments other than "Allopathy" or "modern medicine" and includes Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy in the Indian context.

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

1.51 **Nominee -** means the person named in the *Policy Schedule* who is nominated by the *Policyholder*/*Insured Person*, to receive the benefits under this *Policy* in accordance with the terms of the *Policy*, if the *Policyholder/Insured Person* is deceased.

1.52 **Notification of Claim -** means the process of intimating a claim to the *Insurer* or *TPA* through any of the recognized modes of communication.

1.53 **Outpatient (OPD) Treatment** - means the 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**.**

1.54 **Policy -** means *Your* Proposal Form, the *Policy Schedule*, annexures, insuring clauses that are appearing in each applicable coverage, definitions, exclusions, conditions and other terms contained herein and any endorsement attaching to or forming part hereof, either at inception or during the *Policy Period*.

1.55 **Policyholder** - means the person named in the *Policy Schedule* as the *Policyholder*.

1.56 **Policy Period** - means the period commencing from *Policy* start date and time as specified in the *Policy Schedule* and terminating at midnight on the *Policy* end date as specified in the *Policy Schedule*.

1.57 **Policy Schedule** – means schedule attached to and forming part of this *Policy* mentioning the details of the *Insured Persons*, the *Sum Insured*, the *Policy Period* and the limits, conditions to which the benefits under the *Policy* are subject to, including any annexures and/or endorsements.

1.58 **Policy Year** – means a period of 12 consecutive months commencing from the *Policy Period* Start Date and such 12 consecutive months thereafter but not beyond the *Policy Period*.

1.59 **Portability** – means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions from one insurer to another or from one plan to another plan of the same insurer.

1.60 **Pre-existing Disease -** means any condition, ailment or *Injury* or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which *Medical Advice*/ treatment was received within 48 months prior to the first *Policy* issued by the *Insurer* and renewed continuously thereafter.

1.61 **Pre-Hospitalisation Medical Expenses -** means *Medical Expenses* incurred during pre-defined number of days preceding the *Hospitalisation* of the *Insured Person*, provided that:

i. Such *Medical Expenses* are incurred for the same condition for which the *Insured Person's Hospitalisation* was required, and
ii. The In-patient *Hospitalisation* claim for such *Hospitalisation* is admissible by the Insurance Company.

1.62 **Post Hospitalisation Medical Expenses -** means *Medical Expenses* incurred during pre-defined number of days immediately after the *Insured Person* is discharged from the *Hospital* provided that:

i. Such *Medical Expenses* are for the same condition for which the *Insured Person's Hospitalisation* was required, and
ii. The inpatient *Hospitalisation* claim for such *Hospitalisation* is admissible by the insurance company.

1.63 **Pre-Natal Period** – means the period between conception and birth.

1.64 **Post-Natal Period** – means the period beginning immediately after the birth of a child and extending for 60 days.

1.65 **Proposal Form** - means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, benefits, terms and conditions of the cover to be granted.

1.66 **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.

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

1.68 **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.

1.69 **Relaxation Period -** means the specified period of time immediately following the premium instalment due date during which a payment can be made to continue a ***Policy*** in force without loss of continuity of waiting periods and coverage of ***Pre-existing diseases***.

1.70 **Road Ambulance** – means a motor vehicle operated by a licenced/authorised service provider and equipped for taking sick or injured people requiring medical attention to and from *Hospital* in emergencies.

1.71 **Room Rent -** means the amount charged by a *Hospital* towards Room and Boarding expenses and shall include the associated *Medical Expenses*.

1.72 **Sum Insured -** means the specified amount mentioned in the *Policy Schedule* which represents *Our* maximum liability for each *Insured Person* or *Family* in case of *Family floater* plan for any and all benefits claimed for during the *Policy Year*.

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

1.74 **TPA -** means any person who is registered under the *IRDAI* (Third Party Administrators - Health Services) Regulations, 2016 notified by the *Authority*, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

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

1.76 **We/Our/Us / Insurer -** means the DHFL General Insurance Limited.

1.77 **You/Your -** means the *Policyholder* named in the *Policy Schedule*.

2. SCOPE OF COVER

We will cover *Reasonable and Customary charges* for *Medically Necessary Treatment* taken by the *Insured Person* during the *Policy Year* under any of the benefits specified in the policy schedule subject to the terms, conditions and exclusions of this *Policy* up to the *Sum Insured* specified in the *Policy* or *Policy Schedule*.

2.1 In-patient Hospitalisation

We will cover the *Medical Expenses* incurred for *Medically Necessary Treatment* when the *Insured Person* is admitted as In-Patient in a *Hospital* for more than 24 consecutive hours.
Expenses shall include -

a) *Room Rent* and Nursing charges;
b) *Intensive Care Unit (ICU) charges*;
c) Operation Theatre charges;
d) Fees of *Medical Practitioner*/ *Surgeon* / Anaesthetist / Specialists;
e) Physiotherapy, Investigation & Diagnostic procedures;
f) Medicines, Drugs and Consumables;
g) Blood, Oxygen, Surgical appliances;
h) The cost of prosthetic and other devices or equipment recommended by the attending *Medical Practitioner* and if implanted internally during a *Surgical Procedure*.

If *You* are admitted in a room where the *Room Rent* is higher than the limit opted, then the *Insured Person* shall be considered as being his own insurer for the difference and shall accordingly bear a rateable proportion of the loss under (a), (b), (c), (d) & (e).

Mental Illness:
We will cover Mental Illness as per the provisions of Mental Healthcare Act, 2017. However, in case of following mental illnesses the Inpatient Hospitalization benefit will be restricted to Policy Sum Insured or 3 lacs, whichever is Lower;

1. Schizophrenia (ICD - F20 ; F21;F25)
2. Bipolar Affective Disorders (ICD - F31; F34)
3. Depression (ICD - F32; F33)
4. Obsessive Compulsive Disorders (ICD - F42 ; F60.5)
5. Psychosis (ICD - F 22 ; F23 ; F28 ; F29)

HIV & AIDS
We will cover upto the Sum Insured in case Inpatient hospitalization (including Day Care Treatment) for the treatment arising out of HIV or any condition caused by or associated with Acquired Immuno-Deficiency Syndrome (AIDS).

We will cover only the cost of Anti-Retro Viral Therapy (ART) in Pre-Hospitalization & Post Hospitalization period restricted to a maximum of Rs 20,000 in a Policy Year. This amount is in addition to the Inpatient hospitalisation benefit amount.

Extra Care Cover:

In case *Hospitalisation* is for following *Illnesses*, the *Sum Insured* will not be reduced if the admissible claim amount is up to ₹ 20,000 during the *Policy Year*.

1. Dengue
2. Chikungunya
3. Malaria
4. Leptospirosis
5. Japanese Encephalitis
6. Swine Flu

If admissible claim amount exceeds ₹ 20,000 then the amount in excess of ₹ 20,000 will be reduced from the *Sum Insured* during *Policy Year*.

We will not pay for any *Hospitalisation* for treatment arising out of the above specified *Illnesses* during the first 15 days from the inception date of the first *Policy* with Us.

2.2 Day Care Treatment

We will cover the *Day Care Treatment* undertaken in *Hospital / Day Care Centre.* List of such treatment is available in **Annexure I** of this document.

2.3 Pre-hospitalisation

We will cover the *Pre-hospitalisation Medical Expenses* incurred immediately before the *Insured Person's Hospitalisation* (including *Day Care Treatment*) for the number of days specified in the *Policy Schedule*.

Note –
The date of admission to the Hospital for this coverage shall be the date of the Insured Person's first admission to the Hospital in relation to Any One Illness.

2.4 Post-hospitalisation

We will cover the *Post-Hospitalisation Medical Expenses* incurred immediately after the *Insured Person's* discharge from the *Hospital* (including *Day Care Treatment*) for the number of days specified in the *Policy Schedule*.

Note –
In case of Any one illness where insured person undergoes more than one hospitalisation within 45 days, the cover for post hospitalisation expenses cumulatively shall not exceed 60 days.

2.5 Domiciliary Hospitalisation

We will cover *Domiciliary Hospitalisation* if medical treatment is continuously required for at least three (3) days, in which case the cost of medical treatment for the entire period shall be payable.
We will also cover the pre and post Hospitalisation medical expenses.

We will not pay for any *Medical Expenses* under this section for the treatment of the following diseases:

1. Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
2. Arthritis, gout and rheumatism;
3. Chronic nephritis and nephritic syndrome
4. Diarrhoea and all type of dysenteries including gastroenteritis
5. Diabetes Mellitus and Insipidus
6. Epilepsy
7. Hypertension
8. Psychiatric or psychosomatic disorders of all kinds;
9. Pyrexia of unknown origin

2.6 Organ Donor Expenses

We will reimburse the *Surgical* Expenses incurred towards donor in case of major organ transplant for *Harvesting* of the organ provided that:

a) The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994 and amendments thereof and other applicable laws & rules.
b) The organ donated is for the use of the *Insured Person*.
c) The *Insured Person* (recipient) has been medically advised to undergo an organ transplant.
d) *We* will cover the expenses incurred for transportation including preservation during transportation of the Organ subject to a maximum of Rs. 20,000/- per such event.
e) *We* have accepted claim under In-patient *Hospitalisation* - 2.1.

***We* will not pay for** –
i) Any expense other than specified above.
ii) Cost towards donor screening.
iii) *Pre / post hospitalisation Medical Expenses* of the organ donor.

iv) Cost directly or indirectly associated with acquisition of the organ.
v) Any other medical treatment for the donor consequent to the *Harvesting*.
vi) Expenses related to only organ preservation.
vii) Transplant of any organ/tissue where the transplant is experimental or investigational.
viii) Expenses incurred by an insured person while donating organ.

2.7 Emergency Road Ambulance / Repatriation of Mortal Remains (RMR) / Funeral expenses

i. *We* will cover the expenses up to the limits stated in the *Policy Schedule* for each *Policy Year*, incurred towards transportation of an *Insured Person* by a registered healthcare or ambulance service provider for treatment of a disease / *Illness* / *Injury* in case of an *Emergency*.

Expenses shall include:

(i) Transportation Costs towards transferring the *Insured Person* from the place of incident to *Hospital* or from one *Hospital* to another *Hospital* or to a diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing *Hospital* and advised by the treating *Medical Practitioner.*
(ii) When the *Insured Person* requires to be moved to a better *Hospital* facility due to lack of super speciality treatment in the existing *Hospital*.
(iii) When the *Insured Person* requires to be moved to home after discharge from the *Hospital*. The medical condition of *Insured Person* is such that it requires services of Ambulance and is certified by treating *Medical Practitioner*.

ii. *We* will also cover the following expenses if the *Insured Person* dies in the *Hospital* during the course of *Hospitalisation*.

(i) Transportation of Mortal remains from *Hospital* to home and/or to cremation ground for funeral purpose;
(ii) Cremation Expenses;
(iii) Coffin Charges.

Coverage shall be applicable only if *We* have accepted claim under In-patient *Hospitalisation* - 2.1 or under *Day Care Treatment* 2.2.

2.8 Emergency Air Ambulance

We will cover the expenses up to the limits stated in the *Policy Schedule* for each *Policy Year*, incurred towards necessary transportation of an *Insured Person* by an Air Ambulance offered by a *Hospital* or by an Ambulance Service Provider in India for treatment of a disease / *Illness* / *Injury* in case of an *Emergency*, provided that:

a) The severity of *Illness* of *Insured Person* is such that it requires services of an Air Ambulance and is certified by treating *Medical Practitioner*.
b) The transportation Costs is towards transferring the *Insured Person* from place of occurrence of Medical *Emergency* to the nearest *Hospital* or from one *Hospital* to another *Hospital* for providing better and adequate medical treatment, following a Medical *Emergency* where such facility is not available at the existing *Hospital*.
c) The Service Provider is able to provide the Air Ambulance service at the location of occurrence of Medical Emergency.
d) Ambulance Bill and payment receipt is submitted to us.
e) The Ambulance provider is registered in India.
f) Coverage shall be applicable only if *We* have accepted claim under In-patient *Hospitalisation* - 2.1.
g) The *Sum Insured* available under this benefit is in addition to the *Sum Insured* under the *Policy*.

***We* will not pay for** -

i) Return transportation to *Insured Person's* home by air ambulance.

2.9 Hospital Daily Cash

If *We* have accepted a claim under Inpatient *Hospitalisation* - 2.1, then *We* will pay a fixed amount stated in the *Policy Schedule*, for each day of *Hospitalisation*, during the *Policy Year* for treatment of an *Illness* /disease/ *Injury* provided that:

a) The *Insured Person* has been hospitalised for a minimum continuous period of 24 hours.
b) *We* will pay twice the daily cash amount for each day that the *Insured Person* spends in an *Intensive Care Unit*.
c) Our maximum liability is for 30 consecutive days of *Hospitalisation* during a *Policy Year*.
d) The *Sum Insured* available under this benefit will be in addition to the *Sum Insured* under the *Policy*.
e) In case, insured person spends a day partly in ICU and partly in Non-ICU then we will pay twice the daily cash amount for such day.
f) This coverage will not be applicable If the hospitalisation is under section 2.1 – Inpatient Hospitalization for Mental Illness

2.10 Bariatric Procedure

We will cover the *Medical Expenses* up to the limits stated in the *Policy Schedule* incurred for *Hospitalisation* for undergoing Bariatric *Surgery* on the advice of a *Medical Practitioner* subject to the *Insured Person* being aged 18 years or above and satisfies the following conditions;

1) BMI ≥ 40 or
2) BMI ≥ 35 with one of the following co-morbid conditions -

i) Coronary Artery Disease
ii) Type-2 Diabetes
iii) Obstructive Sleep Apnoea
iv) Hypertension

The benefit is subject to the following:

a) The *Insured Person* must have been covered in this *Policy* for a continuous period of 36 months before availing this benefit.
b) This cover is only available on cashless basis through *Our Network Providers* only.
c) Bariatric *Surgery* is not performed for Cosmetic reasons.
d) Clause 4.2.20 shall not apply to the extent of cover provided under this section.

2.11 AYUSH

We will cover the *Medical Expenses* incurred on In-patient *Hospitalisation* (2.1) up to the *Sum Insured* for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy treatment undergone in:

a) A government *Hospital* or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health.
b) Teaching *Hospitals* of AYUSH colleges recognised by Central Council of Indian Medicine (CCIM) and Central Council of Homoeopathy (CCH).
c) AYUSH *Hospitals* having a registration with a Government authority under the appropriate Act in the State/UT and complies with the following as minimum criteria:
    i) Has at least 15 in-patient beds
    ii) Has minimum five qualified and registered AYUSH doctors
    iii) Has qualified paramedical staff under its employment round the clock
    iv) Has dedicated AYUSH therapy sections
    v) Maintains daily records of patients and makes these accessible to the insurance company's authorised personnel

Clause 4.2.19 will not be applicable to the extent of cover provided under this section.

2.12 Reinstatement of In-patient Hospitalisation Sum Insured

If Base *Sum Insured* and accrued Cumulative Bonus and / or medical Inflation ,if any, is exhausted due to claims paid and payable (payable here means the claim where liability under the policy is admitted and amount of claim is established) during the *Policy Year*, then *We* will automatically reinstate 100% of the Base *Sum Insured* for the particular *Policy Year*. The benefit is subject to the following –

a) The reinstated Base *Sum Insured* will only be applicable for the benefits described under 2.1 – In-Patient Hospitalisation.

b) Reinstated amount shall not be available for the claim which has exhausted the base sum insured including accrued cumulative bonus &/ or medical inflation, if any. It will also not applicable to the claims related to relapse of same illness / injury within 45 days. The reinstated sum insured can be availed by the Insured person for any subsequent hospitalization(s).
c) This reinstatement of the Base *Sum Insured* will be done only once during the *Policy Year*.
d) For claims related to Cancer and Chronic Kidney Disease requiring regular dialysis, this benefit will be applicable only once during the lifetime of the *Insured Person*.
e) The reinstatement of Base *Sum Insured* will not be considered while calculating the Cumulative Bonus.
f) For *Family Floater* Policies, the reinstated Base *Sum Insured* will be available on a floater basis for all the *Insured Persons* in the *Family*.
g) The unutilised reinstated Base *Sum Insured* cannot be carried forward to any subsequent *Policy Year*.
h) During a *Policy Year*, the aggregate of all claims payable under the *Policy*, shall not exceed the sum of:
    i) Base *Sum Insured*
    ii) Cumulative Bonus
    iii) Reinstated Sum Insured
    iv) Medical Inflation

2.13 Maternity and New Born Baby

I. Maternity Expenses

We will cover *Maternity Expenses* up to the limits stated in the *Policy Schedule* for the delivery of a child and/or lawful termination of pregnancy up to a maximum of 2 deliveries or terminations during the lifetime of an *Insured Person*. The benefit is subject to the following –

a) The female *Insured Person* along with spouse must have been covered for a continuous period of 24 months before availing this benefit.
b) This benefit is only applicable for the female *Insured Person* of 18 years of *Age* or above.
c) *Pre/Post Hospitalisation Medical Expenses* will not be applicable to this benefit.
d) The *Sum Insured* available under this benefit is in addition to the *Sum Insured* of the *Policy*.
e) *Medical Expenses* for ectopic pregnancy are not covered under this benefit. However, these expenses are covered under 2.1 – In-patient Hospitalisation.
f) Clause 4.2.22 shall not apply to the extent of cover provided under this section.
g) Coverage of *Pre-Natal* and *Post-Natal Medical Expenses* – It includes expenses incurred on antenatal check-ups, doctor's consultations for monitoring of the pregnancy and any complications arising therefrom. Coverage of Pre-& Post-

natal *Medical Expenses* are valid for inpatient / *Outpatient Treatment*. *Medical Expenses* incurred towards pre/ post-natal treatment would be considered within the *Sum Insured* limit of this section.

II. New Born Baby

We will cover *Medical Expenses* towards treatment of a *New Born Baby* post birth up to 90 days from the date of delivery.

The benefit is subject to the following –

a) *We* have accepted claim under maternity expenses cover under 2.13 (I).
b) *Medical Expenses* will be within the limits of this Cover.
c) *We* will cover the expenses incurred for the vaccination of the *New Born Baby* as listed below, till the baby completes 1 year, within the *Sum Insured* limits of this Cover irrespective of expiry of the policy.
d) Clause 4.2.22 shall not apply to the extent of cover provided under this section.

Vaccines	Age (Completed weeks/months)	Frequency
BCG	At Birth	1
OPV	At Birth, 6 months, 9 months	3
Hepatitis B	At Birth, 6 weeks, 6 months	3
IPV	6, 10, 14 weeks	3
DPT	6, 10, 14 weeks	3
Hib	6, 10, 14 weeks	3
Rotavirus	6, 10, 14 weeks	3
PCV	6, 10, 14 weeks	3
MMR	9 months	1

2.14 Worldwide Emergency Hospitalisation

We will cover *Medical Expenses* for in-patient *Hospitalisation* (as described in 2.1 – In-patient Hospitalisation), incurred outside India, subject to the limit stated in the *Policy Schedule*, provided that:

a) The *Hospitalisation* is medically necessary, and the *Medical Practitioner* certifies that the *Insured* is suffering from a life-threatening *illness* which requires *Emergency Care* and such treatment cannot be postponed until the *Insured Person* returns to India.
b) The *Medical Expenses* payable shall be limited to In-patient Hospitalisation only.
c) This benefit will be extended through reimbursement facility only.
d) This cover can only be availed once in a *Policy Year*.
e) The claim documents as mentioned in clause 5.3.2.3 is submitted to us.
f) Clause 5.2.5 (Geography); Coverage 2.12 (Re-instatement of in-patient *Hospitalization Sum Insured*) and Coverage 2.1 – Inpatient Hospitalization (for Mental Illness) shall not apply to this section.

2.15 Cumulative Bonus

We will enhance the *Renewal Policy Sum Insured* by 10% of the Base *Sum Insured*, on cumulative basis for each claim free *Policy Year*.

The benefit is subject to the following:

a) The accumulated Cumulative Bonus shall not exceed 50% of the Base *Sum Insured* in any *Policy Year*.
b) The entire Cumulative Bonus will be lost if the *Policy* is not renewed on or before the end of the *Grace Period*.
c) If a claim is made in a policy year, then Cumulative Bonus will be reduced by 10% in the subsequent policy year but will not reduce the Base sum insured.
d) The Cumulative Bonus shall be applicable on annual basis subject to continuation of the *Policy*.
e) In a *Family Floater Policy*, the Cumulative Bonus shall be available on Floater basis. The Cumulative Bonus will only accumulate if no claim has been made in respect of any *Insured Person* during the expiring *Policy Year*.
f) The Cumulative Bonus which is accumulated during the claim free *Policy Year* will only be available to those *Insured Persons* who were insured in such claim free *Policy Year* and continue to be covered in the subsequent *Policy Year*.
g) This clause does not alter *Our* rights to decline *Renewal* or cancellation of the *Policy*.
h) If the Base *Sum Insured* under the *policy* is decreased at renewal, then the applicable *Cumulative Bonus* shall also be proportionally reduced to the *Sum Insured*.
i) If the Base *Sum Insured* under the *policy* is increased at renewal, then the *Cumulative Bonus* shall be applicable separately to the policy preceding Base Sum Insured and to the amount by which Sum Insured is enhanced.
j) In case the previous *policy* is a non-floater *policy*, then each insured member will have a separate cumulative bonus and when such *policy* is renewed on a floater basis, then the credit of cumulative bonus to the renewed *policy* will be the lowest cumulative bonus of all the individual insured members.
k) In case the previous policy is a floater *policy* and when such *policy* is renewed by splitting into 2 or more floater or non-floater *policies*, then the credit of cumulative bonus shall be apportioned to each of the renewed *policy* in the proportion of the Sum Insured.
l) The Cumulative Bonus shall be decreased by the same percentage (as was increased in the previous year subject to a minimum of '0') of the Base *Sum Insured* in the subsequent *Policy Year*, in case a claim is paid or payable under following sections in the previous *Policy Year*:
    (i) In Patient Hospitalisation
    (ii) Day Care Procedures
    (iii) Domiciliary Hospitalisation
    (iv) Organ Donor Expenses
    (v) AYUSH Cover
    (vi) Worldwide Emergency Hospitalisation

2.16 Medical Second Opinion

If the *Insured Person* is diagnosed with any Critical Illness as specified in section 2.26 or has been advised by the treating *Medical Practitioner* to undergo a *Surgery* during the *Policy Year* and opts to obtain medical second opinion with regards to the *Diagnosis* of the Critical Illness or before planning for any *Surgical Procedure / Surgery* / Course of treatment, *We* will organize the same by *Our* service provider provided:

a) *We* have received a request from *You* to exercise this option.
b) That the Second opinion will be based only on the information and documentation provided by the *Insured Person* that will be shared with the *Medical Practitioner.*
c) For a *Family Floater Policy* - This benefit can be availed once by any *Insured Person* during a *Policy Year* for a specified Critical Illness/before undergoing any *Surgery*.
d) For a *Non-Floater Policy* - This benefit can be availed once by each *Insured Person* during a *Policy Year* for a specified Critical Illness/before undergoing any *Surgery*.
e) This benefit is only a value-added service provided by *Us* and does not deem to substitute the *Insured Person's* visit or consultation to an independent *Medical Practitioner*.
f) The *Insured Person* is free to choose whether or not to obtain the Second opinion, and if obtained, then whether or not to act on it.
g) *We* shall not, in any event, be responsible for any actual or alleged errors or representations made by *Medical Practitioner* in any Medical Second opinion or for any consequence of actions taken or not taken in reliance thereon.
h) The Second opinion under this *Policy* shall not be valid for any medico legal purposes.
i) *We* do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the *Medical Practitioner*.

Service Provider - means any person, clinic, organization or institution that has been empanelled with Us to provide Second Opinion.

2.17 Counselling

We will cover cost incurred for counselling sessions, to help *you* deal with, anxiety, stress, depression, relational problems, substance related disorders, emotional and behavioural disorders during the policy year subject to the below conditions -

a) The requirement of such counselling session should be advised by the treating medical practitioner/psychiatrist. Such written referral/advise should be submitted to Us.
b) Counsellor Bill and payment receipt is submitted to *Us*.
c) A total of 5 sessions for each insured member (18 years of age and above) is allowed under the policy in a *Policy Year*.
d) *Our* liability is limited to ₹ 1500/- per session.

2.18 Health Care and Wellness

We will provide the following Healthcare and Wellness services during the *Policy Period*.

2.18.1 Health Check Up

Health check-up benefit will be available for each *Insured Person* (≥ 18 years of age) at the end of every claim free *Policy Year* as per the grid below.

Age / Sum Insured	Up to ₹ 10 lac	₹ 15-25 Lac	50-100 Lac
18 - 45 yrs.	Set-I	Set-II	Set-III
46-55 yrs.	Set-II	Set-III	Set-IV
Above 55 yrs.	Set-II	Set-III	Set-IV

Set	**List of Medical Tests**
Set-I	Complete Blood Count, ESR, Blood Group, Total Cholesterol, SGPT, Sr. Creatinine, FBSL, ECG, Urine Routine
Set-II	Complete Blood Count, ESR, Blood Group, Total Cholesterol, SGOT, SGPT, Bilirubin, Sr. Creatinine, FBSL, PPBSL, ECG, Urine Routine, Consultation on the reports
Set-III	Complete Blood Count, ESR, Blood Group, Lipid Profile, SGOT, SGPT, Bilirubin, Sr. Creatinine, BUN, HbA1c, ECG, Urine Routine, Consultation on the reports
Set-IV	Complete Blood Count, Blood Group, Lipid Profile, Bilirubin, Sr. Creatinine, HbA1c, 2D-Echo, Urine Routine, Consultation on the reports, PAP smear (Females)/PSA (Males)

A) Locations where *Our Empanelled Service Providers* are available

a) Health check Up benefit shall be available on cashless basis at *Our Empanelled Service Providers only*.

b) *We* will arrange for the *Insured Person's* Health Check-up at *Our Empanelled Service Providers* as per the above grid.

c) *We* will provide the Original Copies of all reports to *You,* while retaining a copy of the same with *Us*.

B) Locations where *Our Empanelled Service Providers* are not available

a) The benefit will be available on reimbursement basis only if, there is no *Empanelled Service Provider* within the municipal limits of the *Insured's* City of residence.

b) The *Insured Person* can opt for Health Check-up as per the above grid at any of the Diagnostic Centre of his choice near to his residence.

c) *We* will pay the amount towards the cost of health check-up up to the limit defined in the below grid or at actuals, whichever is lesser.

Age / Sum Insured	Up to ₹ 10 lac	₹ 15-25 Lac	₹ 50-100 Lac
18 - 45 yrs.	₹ 750	₹ 1000	₹ 1500
46-55 yrs.	₹ 1000	₹ 1500	₹ 2500
Above 55 yrs.	₹ 1000	₹ 1500	₹ 2500

Note:

i) If this benefit is not claimed within a year from the date it becomes applicable, then this benefit cannot be carried forwarded further.

ii) This benefit will not be available, if the *Policy* is not renewed further.

2.18.2 Wellness

You have option to enrol and participate in *Our* below mentioned wellness programs so as to lead a healthier lifestyle. On achieving the various wellness goals, *You* will not only lead a healthier lifestyle but avail a discount in premium as well.
Wellness for the purpose of this *Policy* is an active process of becoming aware and making choices towards a healthy and fulfilling life in order to subdue stress, reduce the risk of *Illness* and ensure positive interactions.

I. Health Risk Assessment (HRA) –

It is a screening tool based on questionnaire to assess *Your* lifestyle habits and health history to determine how healthy *You* are and whether *You* are at risk for certain chronic diseases or *Illness*.

You can complete the online HRA at the time of buying the *policy* and avail an individual discount equivalent to 0.5% of the *policy* premium, for participation. In case of family floater, discount shall be applied on the individual who has completed the HRA.

In case *You* have not completed the HRA at the time of buying the *policy*, then *You* can enrol and complete the same online anytime during the *Policy Period*. In such a case, the discount will be applicable at subsequent renewal only.

Once *You* complete the HRA, *you* will receive a report which contains a health score based on the assessment of *your* current health.

If *Your* health score is optimal (≥ 70), *you* will earn an additional discount in premium equivalent to 2%, which would be applied on the *Policy* Premium of the respective Individual.

We will allow above discount once either at the time of obtaining first policy from us or at any subsequent renewal depending upon when you have completed HRA.
In case *Your* score indicates risk of developing any lifestyle related diseases, then *We* will provide necessary counselling and guidance on healthy diet, nutrition and Stress management.

II. Self-Disease Management –

Self-disease management for the purpose of this *policy* means adopting healthy lifestyle practices such as healthy diet, regular physical activity, quitting smoking and good compliance to medication for preventing or controlling the onset of debilitating and expensive complications of chronic diseases.

You can earn discounts as mentioned under this section for controlling/managing your chronic disease (Hypertension/Diabetes/Hyperlipidaemia) by Yourself by adopting healthy lifestyle practices.

Normal level of the parameters pertaining to the chronic disease/s are as below.

Chronic Disease	Parameter	Normal Level
Hypertension	Blood Pressure	SBP - ≤ 119 mmHg DBP - ≤ 79 mmHg
Diabetes Mellitus	HbA1c	≤ 5.6
Hyperlipidaemia	Cholesterol	≤ 200 mg/dl

a) In case *you* are diagnosed, or you acquire the specified chronic disease during the *Policy Year*, then *you* have to undergo 1st health screening based on the screening test related to the specified chronic disease as provided below at the beginning of the next *Policy Year* in any one of *Our* Empanelled Network Provider only, at *your* own cost. *You* will also have to undergo the 2nd health screening test based on defined set of medical tests in *Our* network diagnostic centres only, at your own cost, 90 days before the expiry of the *Policy Period*.

b) If *you* are suffering from the chronic disease as mentioned above and have been covered under the *Policy* after undergoing pre-policy medical tests, then You have to undergo the 2nd health screening based on the screening test related to the specified chronic disease as provided below in *Our* Empanelled Service Provider only, at *your* own cost, 90 days before the expiry of the *Policy Period*.

Chronic Disease	**Health Screening Tests**
Hypertension	Blood pressure
Diabetes Mellitus	HbA1c (Glycated Haemoglobin)
Hyperlipidaemia	Total Lipids

Healthy Discount:

a. If *you* manage these disease/s successfully as per laid down parameter, *you* will be entitled to discount in renewal premium at the end of Policy Period, based on the range of the values obtained from the medical tests as per the below grid. In case of management of more than one specified chronic disease, the cumulative discounts shall be offered up to a maximum of 10% at the end of the Policy Period.

HYPERTENSION MANAGEMENT				
Category	**Blood Pressure at 1st test**	**Blood Pressure at 2nd test**	**Discount if Blood Pressure is controlled**	**Discount if all the health screening tests are controlled**
Pre-Hypertension	*SBP: 120-139 mmHg *DBP: 80-89 mmHg	SBP: ≤ 119 mmHg DBP: ≤ 79 mmHg	2%	3%
Hypertension	SBP: ≥ 140 mmHg DBP: ≥ 90 mmHg	SBP: 120-139 mmHg DBP: 80-89 mmHg	3%	5%
		SBP: ≤ 119 mmHg DBP: ≤ 79 mmHg	5%	8%
SBP- Systolic Blood Pressure; DBP – Diastolic Blood Pressure				

DIABETES MANAGEMENT				
Category	**HbA1C at 1st test**	**HbA1C at 2nd test**	**Discount if Blood Sugar is controlled**	**Discount if all the health screening tests are controlled**
Pre-Diabetes	5.7-6.4%	≤ 5.6	2%	3%
Diabetes	≥ 6.5	5.7-6.4%	3%	5%
		≤ 5.6	5%	8%

HYPERLIPIDEMIA MANAGEMENT				
Category	**Cholesterol at 1st test**	**Cholesterol at 2nd test**	**Discount if Total Cholesterol is controlled**	**Discount if all the health screening tests are controlled**
Borderline High	> 200 - 240 mg/dl	≤ 200 mg/dl	2%	3%
High	> 240 mg/dl	200 - 240 mg/dl	3%	5%
		≤ 200	5%	8%

Note – Above discounts shall be applied on the premium of the respective Insured Person based on their individual health score.

III. Stay Fit –

It is a pedometer based simple walking program designed for You to walk your way to a more active and healthier lifestyle. *Insured Persons* 18 years of *age* and above will only be eligible for this programme.

You may enrol in this programme at any time during the *policy period* by downloading *Our* mobile application. However, to avail maximum discount, *You* must enrol in this programme within 1 month of the *Policy* start date. The average step count walked by the *Insured Person* shall be recorded on the mobile application.

In case you are already using a health gadget (Fitbit, apple health and google fit) to calculate your steps, you may authenticate and synchronise the gadget with our application.

A discount as specified in the grid below can be availed at each *Renewal*, if the *Insured Person* achieves an average step count per day for specified number of days as per the table below.

In a *Non-Floater Policy*, the average step count shall be calculated per individual *Insured Person*. In a *Family Floater Policy*, average step count will be calculated by considering step counts of all adult members (18 years and above) covered.
In *Non-Floater Policies*, the discount percentage (%) would be applied on premium applicable per *Insured Person* and in a *Family Floater Policy*, it would be applied on premium applicable on the *Policy*.

1 Year Policy		
Average No. of Steps per day	Total No. of Days	
	≥ 200	≥ 250
≥ 6000	3%	5%
≥ 8000	5%	7%
≥ 10000	7%	10%

2 Year Policy		
Average No. of Steps per day	Total No. of Days	
	≥ 420	≥ 520
≥ 6000	3%	5%
≥ 8000	5%	7%
≥ 10000	7%	10%

3 Year Policy		
Average No. of Steps per day	Total No. of Days	
	≥ 700	≥ 800
≥ 6000	3%	5%
≥ 8000	5%	7%
≥ 10000	7%	10%

Note: Cumulative discounts under section 2.18.2 - Wellness for I. Health Risk Assessment II. Self Disease management and III. Stay fit shall not exceed 15% every policy year.

2.18.3 Health Helpline –

a. *This is an assistance service only and on your own discretion and choice, You* will have access to medical practitioner for any opinion on health related issue or queries from our empanelled service provider through our mobile application /website or telephonic mode for 24 by 7 hours during the *policy period*. *You* may contact *us* on our toll-free helpline number for availing this service.

b. The information services provided under this assistance does not substitute for any medical advice and You will be free to consider or not consider the opinion provided and We or our empanelled service provider will not be liable for any damages sustained due to reliance by the insured person on such information provided by medical Practitioner.

c. You may purchase medicines and diagnostic services from our empanelled service provider on your own discretion and choice provided that the cost for the purchase shall be borne by you.

Note:

1. *Empanelled Service Provider means any person, clinic, organisation, institution that has been empanelled with Us to provide the Healthcare & Wellness Services provided under this cover. (List provided on our website: www.dhflinsurance.com).*

2.19 Voluntary Co-Payment

a) *You* will bear a percentage share as specified in the *Policy Schedule*, of the admissible claim amount on each claim.

b) *Co-Payment* shall not apply to Out Patient Treatment, Hospital Daily Cash, Medical Second Opinion, Emergency Road Ambulance / Repatriation of Mortal Remains (RMR) / Funeral expenses, Emergency Air Ambulance, Infertility, Bariatric Procedure,, Maternity and *New Born Baby* and Health Check-up.

c) Voluntary *Co-Payment* will apply in conjunction with mandatory *Co-Payment* & *Co-Payment* due to treatment taken out of opted zone.

d) Voluntary *Co-Payment* will not be applicable in case of *Accidental Hospitalisation* claims.

2.20 Deductible

a) *You* will bear an amount equal to the *Deductible* as specified in the *Policy Schedule* and *We* shall be liable to make payment under the *Policy* for any claim over and above the *Deductible* amount.
b) The *Deductible* shall be applicable on each claim made by the *Insured Person* during the *Policy Year*.
c) The *Deductible* shall not apply to Out Patient Treatment, Hospital Daily Cash, Medical Second Opinion, Emergency Road Ambulance / Repatriation of Mortal Remains (RMR) / Funeral expenses, Emergency Air Ambulance, Infertility, Bariatric Procedure,,Maternity and *New Born Baby* and Health Check-up.
d) In case Mandatory *Co-Payment* is applicable to a Claim, then the same shall apply before the *Deductible* has been applied.

2.21 Waiver of Mandatory Co-Payment

We would not apply the Mandatory *Co-Payment* applicable to the *Insured Persons* whose *Age* at the time of first *Policy* inception is 61 years or above.

2.22 Out Patient Treatment

We will cover expenses incurred towards Outpatient consultations, Diagnostic Examinations and pharmacy up to the amount stated in the *Policy Schedule* at any of the Company's Empanelled Service Provider, during the *Policy* Year subject to the below conditions -

a) The Outpatient Consultations/Diagnostic Examinations/Medicines are prescribed by the treating registered *Medical Practitioner*.
b) Spectacles and Hearing Aids – The first claim for the cost of spectacles and hearing aids can be made in the third policy year provided that the policy is continuously in force during this period and prescribed by a Specialist *Medical Practitioner*. Thereafter, the subsequent claims can be made in every alternate year provided the *Policy* is continuously in force and prescribed by a *Specialist Medical Practitioner*.
c) Dental Care – *We* will cover expenses incurred for necessary *Dental Treatment*. However, any *Dental Treatment* for cosmetic purpose will not be covered under this *Policy*.
d) Treating doctor's prescription and bills are submitted to *us*.
e) Any balance amount under this section will not be carried forward to the subsequent *Policy* Year, if the benefit is not utilised.
f) The cover under this benefit is limited as defined in the below grid.
g) Clause 3, 4.2.7 and 4.2.12 will not be applicable to the extent of cover provided under this section.
h) The *Sum Insured* available under this benefit will be in addition to the *Sum Insured* under the *Policy*.

i) All waiting periods and exclusions shall not apply to this section.

Policy Sum Insured	**₹ 2 Lac - ₹ 100 Lac**	**₹ 6 Lac - ₹ 100 Lac**	**₹ 20 Lac - ₹ 100 Lac**	
Cover	**OPD Sum Insured Sublimit (in ₹)**			
Consultations	2000	4000	6000	8000
Diagnostic Tests	3000	6000	9000	12000
Medicines				
Dental Care				
Spectacles or contact lenses				
Hearing Aids				
Total Sum Insured	5000	10000	15000	20000

Note: *Empanelled Service Provider means any person, clinic, organisation, institution that has been empanelled with Us to provide the Healthcare & Wellness Services provided under this cover. (List provided on our website: www.dhflinsurance.com).*

2.23 Infertility

We will cover *Medical Expenses* for two In-Vitro Fertilisation Cycles in the lifetime of the female *Insured Person* for the treatment of infertility subject to the limit stated in the *Policy Schedule*.

The benefit is subject to the following:

a) The coverage is available for female *Insured* between the ages of 25 and 40 years.
b) The female *Insured Person* along with spouse must have been covered in this *Policy* for a continuous period of 36 months before availing this benefit.
c) If a claim is made under this section in any *Policy Period* and a pregnancy is successfully established, then the benefit under this section shall not be available for any subsequent *Renewal* (even if one In-Vitro Fertilisation cycle is remaining) for the particular *Insured Person (s)* irrespective of the amount claimed in the expiring *Policy*.
d) Clause 4.2.25 shall not apply to the extent of cover provided under this section.
e) The benefit under this section will only be applicable if infertility is diagnosed after the issuance of the first *Policy* with *Us*.
f) *Sum insured* of this cover cannot be enhanced during life time.

Special Condition –

i) This cover is not applicable for couples in which either of the partners had undergone a voluntary sterilization procedure, including tubal ligation or vasectomy, with or without *Surgical* reversal.

ii) This cover will cease once the pregnancy is established and a foetal heartbeat is detected.

2.24 Medical Inflation

We will enhance the Renewal *Policy Sum Insured* by 10% of the Base *Sum Insured*, on cumulative basis for each *Policy* Year irrespective of a claim in the expiring *policy* year.

The benefit is subject to the following:

a) The accumulated Medical Inflation shall not exceed 50% of the Base Sum Insured in any *Policy* Year.
b) The entire Medical Inflation will be lost if the *Policy* is not renewed on or before the end of the Grace Period.
c) The Medical Inflation shall be applicable on annual basis subject to continuation of the *Policy*.
d) In a Family Floater *Policy*, the Medical Inflation shall be available on Floater basis.
e) The Medical Inflation which is accumulated will be available to all the Insured Persons.
f) This clause does not alter *Our* rights to decline Renewal or cancellation of the *Policy*.
g) If the Base *Sum Insured* under the policy is decreased at renewal, then the applicable Medical Inflation shall also be proportionally reduced to the *Sum Insured*.
h) If the Base *Sum Insured* under the policy is increased at renewal, then the Medical Inflation shall be applicable separately to the preceding Base *Sum Insured* and to the enhanced *Sum Insured*.
i) In case the previous *policy* is non-floater *policy*, then each insured member will have a separate Medical Inflation and when such *policy* is renewed on a floater basis, then the credit of Medical Inflation to the renewed *policy* will be the lowest Medical Inflation of all the individual insured members.
j) In case the previous *policy* is floater *policy* and when such *policy* is renewed by splitting into 2 or more floater or non-floater *policies*, then the credit of Medical Inflation shall be apportioned to each of the renewed *policy* in the proportion of the Base *Sum Insured*.

2.25 Critical Illness Benefit

We will pay the Sum *Insured* as stated in the *Policy Schedule* if the *Insured Person* is of 18 years or above and is diagnosed to be suffering from a specified Critical Illness and provided the following conditions and other provisions, terms & conditions and limitations of the *Policy* are satisfied.

a) The *Insured Person* is diagnosed with a Critical Illness specifically defined in this *Policy*; and
b) Such Critical Illness occurs or manifests itself as a first incidence; and
c) Such Critical Illness commences after a waiting period of 90 days from the inception of the first *Policy* with *Us*; and

d) The *Insured Person* survives such Critical Illness for at least 30 days, from the date of *Diagnosis*/date of undergoing the *Surgical Procedure*.

e) If a claim is settled under this cover, this benefit shall automatically terminate for that insured person and this benefit shall not be available for further renewal.

2.25.1 Cancer of Specified Severity

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This *Diagnosis* must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

ix. All tumors in the presence of HIV infection.

2.25.2 Myocardial Infarction (First Heart Attack of Specified Severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The *Diagnosis* for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the *Diagnosis* of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

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

biochemical markers.

II. The following are excluded:
    i. Other acute Coronary Syndromes
    ii. Any type of angina pectoris
    iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

2.25.3 Open Chest CABG

I. The actual undergoing of heart *Surgery* to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The *Diagnosis* must be supported by a coronary angiography and the realization of *Surgery* has to be confirmed by a cardiologist.

II. The following are excluded:
    i. Angioplasty and/or any other intra-arterial procedures

2.25.4 Open Heart Replacement or Repair of Heart Valves

I. The actual undergoing of open-heart valve *Surgery* is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve(s). The *Diagnosis* of the valve abnormality must be supported by an echocardiography and the realization of *Surgery* has to be confirmed by a specialist *Medical Practitioner*. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

2.25.5 Kidney Failure Requiring Regular Dialysis

I. 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*.

2.25.6 Stroke Resulting in Permanent Symptoms

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

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

2.25.7 Major Organ / Bone Marrow Transplant

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

II. The following are excluded:
   i. Other stem-cell transplants
   ii. Where only islets of langerhans are transplanted

2.25.8 Permanent Paralysis of Limbs

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

2.25.9 Multiple Sclerosis with Persisting Symptoms

I. The unequivocal *Diagnosis* of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the *Diagnosis* to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

2.25.10 Third Degree Burns

I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The *Diagnosis* must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

3. WAITING PERIODS

3.1 **30 days Waiting Period** - *We* will not pay for any Hospitalisation unless the Hospitalisation is due to an Accident or for the treatment of three critical illnesses i.e. Cancer, Myocardial Infarction and Stroke, during the first 30 days from inception of first Policy with *Us*.

3.2 **Named Ailments Waiting Period -** *We* will not pay for any *Hospitalisation* for the treatment of disease/conditions mentioned below or any complication arising from the same except where underlying cause is cancer during the period specified in the *Policy Schedule* from inception of first *Policy* with *Us*.

S. No.	Organ / Organ Systems	Illness / Surgeries
1.	**Ear Nose Throat**	a. Sinusitis b. Chronic Suppurative Otitis Media (CSOM) c. Tonsillectomy d. Adenoidectomy e. Mastoidectomy f. Tympanoplasty g. *Surgery* for Deviated Nasal Septum h. *Surgery* for turbinate/Concha i. Any other benign ear, nose and throat disorder or *Surgery*
2.	**Eye**	a. Cataract b. *Surgical* Management of Glaucoma c. Retinopathy
3.	**Gastrointestinal**	a. Calculus Diseases of Gall Bladder including Cholecystectomy b. All types of *Surgery* of Hernia c. Fissure/Fistula in anus, Hemorrhoids, Pilonidal Sinus d. Ulcer of Stomach & Duodenum e. Gastroesophageal Reflux Disorder(GRD) f. Perianal / Perineal Abscess g. Rectal Prolapse
4.	**Gynaecological**	a. Cysts, polyps b. Any type of Breast lumps (unless malignant) c. Polycystic Ovarian Disease (PCOD) d. Fibroids (Fibromyoma) e. Myomectomy for fibroids

		f. Prolapse of Uterus unless necessitated by malignancy g. Adenomyosis h. Endometriosis i. Menorrhagia and Dysfunctional Uterine Bleeding (DUB) j. Dilatation & Curettage (D & C) k. Hysterectomy unless due to malignancy
5.	**Orthopaedic**	a. Non-Infectious Arthritis b. Gout and Rheumatism c. Osteoarthritis and Osteoporosis d. Ligament, Tendon & Meniscal Tear (other than caused by *Accident*) e. Spondylitis/Spondylosis/Spondylolisthesis f. *Surgery* for Prolapsed intervertebral disc (other than caused by *Accident*) g. Joint Replacement *Surgeries* (other than caused by *Accident*)
6.	**Urogenital**	a. Calculus of Urinary system (Kidney Stone/Urinary Bladder/Ureteric Stone) b. Any *Surgery* of the genitourinary system unless necessitated by malignancy. c. Benign Hyperplasia of Prostate d. *Surgery* for Hydrocele/Rectocele
7.	**Others**	a. Varicose veins and Varicose ulcers
8.	**General (Applicable to organ systems/organs/disciplines whether or not described above)**	a. Any type of cysts / Nodules / Polyps / Internal tumours / Skin tumours / Lump / growth

3.3 **Pre-existing Disease -** *We* will not pay for any treatment / *Hospitalisation* with respect to any *Pre-existing disease*/*Illness*/*Injury* or any complication arising from the same, during the period specified in the *Policy Schedule* from inception of first *Policy* with *Us*.

3.4 **Waiting Period for coverage of Internal Congenital Anomaly -** *We* will not pay in respect of *Internal Congenital Anomaly* within first 24 months from inception of first *Policy* with *Us*.

3.5 Waiting Period for coverage of HIV (Human Immunodeficiency Virus) & AIDS (Acquired Immuno Deficiency Syndrome) - *We* will not pay for any treatment / *Hospitalisation* with respect to HIV & or any complication arising from the same including AIDS, within first 48 months from inception of first *Policy* with *Us*.

3.6 Waiting Period for Named Mental Illness - We will not pay for any treatment / Hospitalisation mentioned below or any complication arising from the same, during first twenty four (24) months from the inception of first Policy with Us.

S. No.	Organ / Organ Systems	Illness
1.	**Mental Disorders**	a. Schizophrenia (ICD - F20 ; F21;F25) b. Bipolar Affective Disorders (ICD - F31; F34) c. Depression (ICD - F32; F33) d. Obsessive Compulsive Disorders (ICD - F42 ; F60.5) e. Psychosis (ICD - F 22 ; F23 ; F28 ; F29)

3.7 Portability –

You can opt to port your existing health insurance *Policy* to this product subject to the following:

a) *You* should submit application for portability with complete documentation at least 45 days prior to expiry of your existing health insurance *Policy*
b) *You* were covered under Retail Health Insurance *Policy* from a Non-Life Insurance Company/Health Insurance Company registered with the *Authority*.
c) If the previous *Policy Sum Insured* is lower than the *Sum Insured* opted under this *Policy*, waiting periods will apply to the amount of proposed increase in *Sum Insured* only.
d) If the previous *Policy Sum Insured* is higher than or equal to the *Sum Insured* opted under this *Policy*, then the waiting periods will be reduced by the number of months of continuous coverage under the previous policy.
e) Portability benefit will be credited up to the extent of the sum of previous Sum Insured and cumulative bonus (if any).
f) In case previous policy has permanent exclusions for Maternity, Bariatric procedure, infertility, Mental Illness and HIV/AIDS then waiting period for these conditions will be afresh.
g) In case previous policy has coverage for Maternity, Bariatric procedure, infertility, Mental Illness and HIV/AIDS then as per portability guidelines waiting period credit for these covers is permissible.
h) All waiting periods shall be applicable individually for each *Insured Person.*
i) Acceptance of the portability application will be based on the underwriting guidelines of the Company. *We* may at *Our* sole discretion restrict the terms on which *We* may offer the cover.

j) There is no obligation on *Us* to insure all *Insured Persons* on the proposed terms, even if *We* have received all the documentation from *you*.

k) In case *You* opt to port to any other Insurance Company for *Renewal*, under the portability provision and the outcome of such portability request is awaited from the new insurer on the date of *Renewal*:

   i) On *Your* request, *We* may extend this *Policy* for a period of not less than one month at an additional premium to be paid on a prorate basis.
   ii) If a claim is reported during this extension period, *You* shall be required to first pay the full annual *Policy* premium. *Our* liability for the payment of such claim shall commence only once such premium is received.

4. EXCLUSIONS

We will not make payment for a claim in respect of any *Insured Person* in any way resulting directly or indirectly from or attributable to any of the following unless specifically covered elsewhere in this *Policy*:

4.1 STANDARD EXCLUSIONS

4.1.1 **Breach of Law** - *We* will not pay any expense related to *Insured Person* committing or attempting to commit a breach of law with criminal intent.

4.1.2 **Chemical & Nuclear Exposure -** *We* will not pay for the treatment costs directly or indirectly caused by or contributed to or arising from nuclear weapons/materials, radioactive material, nuclear waste, nuclear fuel, chemical weapons/materials or biological weapons/materials.

4.1.3 **War -** *We* will not pay for the treatment related to any condition resulting directly or indirectly from, or as a consequence of War, invasion, act of foreign enemy, war like operations (whether war be declared or not), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts.

4.2 EXCLUSIONS SPECIFIC TO THE POLICY WHICH CANNOT BE WAIVED

4.2.1 **Alcohol and drug abuse & de – addiction programs** - *We* will not pay for the treatment (including cessation programs) resulting from dependency on or abuse of intoxicants or hallucinogenic substances , alcohol, drugs, nicotine and any *Illness* or *Injury* arising directly or indirectly from such dependency or abuse.

4.2.2 **Ancillary Hospital Charges -** *We* will not pay for the charges related to admission, discharge, administration, registration, documentation & filing, Home Visit Charges, service charge, surcharges and Luxury tax levied by the *Hospital*.

4.2.3 **Cosmetic surgery -** *We* will not pay for the plastic *Surgery* or cosmetic *Surgery* or any aesthetic treatment unless medically necessary as a part of treatment certified by the attending *Medical Practitioner* for reconstruction following an *Accident*, Cancer or Burns.

4.2.4 **Circumcision -** *We* will not pay for Circumcisions unless necessary for the treatment of a disease or necessitated by an *Injury*.

4.2.5 **General Debility -** *We* will not pay for any expense related to convalescence, supervision, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care, hospice care, custodial care, general debility or exhaustion (run-down condition).

4.2.6 **External Congenital Anomaly** - We will not cover for screening, counselling and treatment related to External congenital anomalies.

4.2.7 **Dental Care -** *We* will not pay for the *Dental Treatment* and *Surgery* of any kind, other than arising out of an *Accident* and subsequently requiring *Hospitalisation*.

4.2.8 **Developmental Disorders -** *We* will not pay for the treatment of developmental, behavioural or learning disorders, Attention deficit hyperactivity disorder (ADHD), speech disorders or dyslexia and physical developmental disorder.

4.2.9 **Dangerous Acts (Adventure/Professional Sports/Defence Operation) -** Any *Insured Person's* participation or involvement in naval, military or air force operation, or any adventure sports of a professional nature.

4.2.10 **Dietary supplements -** *We* will not pay for the substances that can be purchased without prescription, including vitamins, minerals, nutritional / electrolyte supplements and tonics unless certified to be required by the attending *Medical Practitioner* as a direct consequence of an otherwise covered claim.

4.2.11 **Experimental treatment -** *We* will not pay for the treatments which are experimental, investigational or unproven, which are not consistent with or incidental to the *Diagnosis* and treatment of the positive existence, pharmacological regimens, stem cell implantation/ therapy or *Surgery*.

4.2.12 **Eyesight, Hearing Aids & External prosthesis –**

(a) *We* will not pay for treatment related to correction of refractive errors of the eye, routine eyesight checking or hearing tests including optometric therapy.
(b) *We* will not pay for any cost of hearing aids / Cochlear Implants, Spectacles or Contact Lenses.
(c) *We* will not pay for any cost related to providing, maintaining and fitting of external and or durable medical/non-medical equipment (as listed in Annexure II – Non Medical Expenses) used for *Diagnosis* and or treatment, including Continuous Positive Airway Pressure (CPAP), Continuous Ambulatory Peritoneal Dialysis (CAPD) or Infusion Pump, ambulatory devices - walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, artificial limb and also medical equipment which is subsequently used at home (except when used intra-operatively).

4.2.13 **Gender identity disorders -** *We* will not pay for any treatment / *Surgery* for treatment for gender identity, change of sex or gender reassignments including any complication arising from these treatments.

4.2.14 **Sexually Transmitted Disease -** *We* will not pay for treatment related to any condition directly or indirectly caused by or associated with any sexually transmitted disease, Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind unless leading to AIDS.

4.2.15 **Incidental Services & Supplies -** *We* will not pay for the following Items of personal comfort and convenience – charges for television, telephone calls, internet, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products, toiletry items, barber or beauty service and guest service.

4.2.16 **Neurodevelopmental delays and other disorders -** *We* will not pay any expenses related to erectile dysfunction; treatment for neurodegenerative disorders , Dementia, Parkinson and Alzheimer's disease; Disorders of speech and language; stammering, dyslexia.

4.2.17 **Medically Necessary Expenses -** *We* will not pay for any treatment or part of a treatment that is not reasonable and medically necessary and drugs or treatments which are not supported by a prescription.

4.2.18 **Non-Medical Expenses -** *We* will not pay for any Non-medical expenses defined in Annexure-II.

4.2.19 **Non-Allopathic Treatment -** *We* will not pay any expenses related to Non-Allopathic treatment.

4.2.20 **Obesity -** *We* will not pay any expenses related to treatment of Obesity and any weight control program.

4.2.21 **Off Label Drug or Treatment** – Use of pharmaceutical drugs for an unapproved indication or in an unapproved age group, dosage, or route of administration as regulated and approved by Central Drugs Standard Control Organisation (CDSCO).

4.2.22 **Maternity Expenses -** *We* will not pay for *Maternity Expenses* except abdominal operation for extra uterine pregnancy (Ectopic Pregnancy), which is proved by submission of Ultra Sonographic Report and Certification by Gynaecologist that it is life threatening one if left untreated.

4.2.23 **Preventive Vaccinations -** *We* will not pay for the expenses towards any treatment related to preventive care, vaccination including inoculation and immunizations (except in case of post-bite vaccination treatment) unless certified and recommended by the attending

Medical Practitioner as part of in-patient treatment as a direct consequence of an otherwise covered claim.

4.2.24 **Birth control expenses and Reproductive treatment -** *We* will not pay for the expenses related to birth control and its procedures including complications arising out of the same, infertility services, artificial insemination and advanced reproductive technologies namely In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Intracytoplasmic sperm injection (ICSI), Gestational Surrogacy.

4.2.25 **Self-inflicted injuries or attempted suicide -** *We* will not pay any expenses for treatment resulting directly or indirectly from self-inflicted *Injury* or suicide, attempted suicide while sane or insane.

4.2.26 **Sleep disorders -** *We* will not pay for treatment related to sleep disorders.

4.2.27 **Treatment by a Medical Practitioner outside discipline -** *We* will not pay any expenses for treatment rendered by Persons not registered as *Medical Practitioner* or from a *Medical Practitioner* practising outside the discipline that he/she is licensed for.

4.2.28 **Time bound Exclusions -** *We* will not pay for any specific time bound exclusion(s) applied by *Us* and mentioned in the Schedule and accepted by the Insured Person.

4.2.29 **Unrelated diagnostic procedures -** *We* will not pay for diagnostic, X-ray or laboratory examinations or other diagnostic studies which are not consistent with or incidental to the *Diagnosis* and treatment of the positive existence or presence of any *Illness* for which confinement is required at a *Hospital*.

5. GENERAL TERMS AND CONDITIONS

5.1 CONDITIONS PRECEDENT

5.1.1 AGE

A person shall be eligible to become an *Insured Person* if he/she is not younger than 91 days. However, there is no maximum entry *Age* limit for *Sum Insured* of Rs. 2 Lac. For all other *Sum Insured's*, the maximum entry *Age* is restricted to 70 years. For a dependent child, the maximum entry *Age* limit is 30 years.

5.1.2 CONDITION PRECEDENT

This *Policy* requires fulfilment of the terms and conditions of this *Policy* at all times by You or any of the *Insured Persons,* payment of premium (including payment of premium by the due dates as mentioned in the *Policy Schedule*) and *Disclosure to Information Norm*. This is a precondition to any liability under the *Policy*.

5.1.3 DISCLOSURE TO INFORMATION NORM

The *Policy* shall be void and all premium paid shall be forfeited to *Us*, in the event of misrepresentation, mis-description or non-disclosure of any *Material Fact*.
In the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a Claim being fraudulent, or any fraudulent means or device being used by the *Policyholder*/ *Insured Person* or any one acting on his/ their behalf to obtain a benefit under this *Policy*, *We* may cancel this *Policy* at *Our* sole discretion. In such a case, the premium paid shall be forfeited and any benefit paid under the *Policy* shall also be forfeited and (if appropriate) shall be recoverable.

5.1.4 ELECTRONIC TRANSACTIONS

The *Policyholder* / *Insured Person* agrees to adhere to and comply with all such terms and conditions as may be imposed for electronic transactions that *We* may prescribe from time to time which shall be within the terms and conditions of the contract, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of *Us*, for and in respect of the *Policy* or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with *Our* terms and conditions for such

facilities, as may be prescribed from time to time which shall be within the terms and conditions of the contract. However, the terms of the condition shall not override provisions of any law(s) or statutory regulations including provisions of *IRDAI* regulations for protection of policyholder's interests.

5.1.5 NO CONSTRUCTIVE NOTICE

Any knowledge or information of any circumstance or condition in relation to the *Policyholder/ Insured Person* which is in *Our* possession and not specifically informed by the *Policyholder* / *Insured Person* shall not be held to bind or prejudicially affect *Us* notwithstanding subsequent acceptance of any premium.

5.1.6 MANDATORY CO PAYMENT

If the entry age of the *Insured Person* at the first inception of *policy* with us is 61 years or above, the *Co-Payment* will be applicable as per the below grid.

Age at Entry	***Co-Payment***
61-65 years	10%
66-70 years	20%
Above 70 years (Only for ₹ 2 Lac S.I)	30%

5.1.7 ZONE CLASSIFICATION

Zone – I: Delhi, NCR (Municipal limits of Faridabad, Gurgaon, Noida, Ghaziabad), Mumbai (All municipal regions under Mumbai Metropolitan Region), Bangalore (All municipal regions under Bangalore Metropolitan Region)

Zone – II: Hyderabad (All municipal regions under Hyderabad Metropolitan Region), Pune (All municipal regions under Pune metropolitan Region), Chennai (all municipal regions under Chennai Metropolitan Area), Kolkata (all municipal regions under Kolkata Metropolitan Area), Ahmedabad (All municipal regions under Ahmedabad municipal corporation)

Zone – III: All municipal regions of state capitals not included in Zone I and Zone II, Nagpur, Indore, Kochi, Coimbatore, Baroda, Surat, Ludhiana, Jallandhar.

Zone – IV: Rest of India excluding the cities included in Zone-I, Zone-II and Zone-III.

Policyholder's paying Zone-I premium can avail treatment all over India without any *Co-Payment*.

Policyholder's paying Zone-II premium can avail treatment in Zone-II, Zone-III and Zone-IV without any *Co-Payment* but shall have to bear a *Co-Payment* of <<12%>> of each and every claim if treatment in Zone-I is availed.

Policyholder's paying Zone-III premium can avail treatment in Zone-III and Zone-IV without any *Co-Payment* but shall have to bear a *Co-Payment* of

i) 25% of each and every claim if treatment in Zone-I is availed
ii) 15% of each and every claim if treatment in Zone-II is availed

Policyholder's paying Zone-IV premium can avail treatment in Zone-IV without any *Co-Payment* but shall have to bear a *Co-Payment* of

i) 35% of each and every claim if treatment in Zone-I is availed
ii) 25% of each and every claim if treatment in Zone-II is availed
iii) 10% of each and every claim if treatment in Zone-III is availed

Note:

a) *Policyholder's* residing in Zone-IV can select to pay premium for Zone-I / Zone-II/ Zone-III and avail treatment in the desired Zone with nil/less *Co-Payment*.
b) *Policyholder's* residing in Zone-III can select to pay premium for Zone-I / Zone-II and avail treatment in the desired Zone with nil/less *Co-payment*.
c) *Policyholder's* residing in Zone-II can select to pay premium for Zone-I and avail treatment in Zone-I with no *Co-payment*.
d) The *Co-Payments* for claims occurring outside of the Zone will not apply in case of *Hospitalisation* due to *Accident*.
e) In case of *Family Floater Policy*, a single zone shall be applicable to all the members covered under the *Policy*.
f) In case of *Non-Floater Policy*, there is option of selecting separate Zone for each *Insured Person*.

5.1.8 LOADINGS

We may apply risk loading on premium payable based on the information revealed in the Proposal Form and the current health status of the person.

The maximum risk loading for an individual shall not exceed 100%.

These loadings are applicable from commencement date of policy including subsequent renewal(s) with *Us*.

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

5.2 CONDITIONS APPLICABLE DURING THE CONTRACT

5.2.1 ALTERATIONS TO THE *POLICY*

The proposal form, declaration and *Policy* constitutes the complete contract of insurance. This *Policy* cannot be changed by any one (including an insurance agent or broker) except *Us*. Any change that *We* make will be communicated to *You* by a written endorsement signed and stamped by *Us*.

5.2.2 CANCELLATION OF *POLICY*

a) *We* may cancel this *Policy* on grounds of misrepresentation, fraud, non-disclosure of *Material Fact* and non-cooperation by *You* or anyone acting on *Your* behalf. When such cancellation of the *Policy* will be on the grounds of misrepresentation, fraud and non-disclosure of *Material Facts*, it will be from inception date or the *Renewal* date (as the case may be) upon 15 days' notice, delivered to or mailed to Your last address as shown in the records followed by an endorsement without refund of any premium. In case of cancellation of the *Policy* by *Us* on account of non-cooperation, *You* shall be entitled to refund of pro-rata premium for the unexpired portion of the *Policy* on the date of cancellation except for those *Insured Person(s)* for whom a claim (including utilisation of Second Medical Opinion) has been paid or is payable under the *Policy*.

b) *You* may cancel this *Policy* at any time by sending notice in writing to *Us* stating when cancellation is to take effect. In the event of such cancellation, *We* shall refund premium for the unexpired period of the *Policy* in accordance with the short period rate table below.
However, there will be no refund of premium in respect of the *Insured Person* for whom a claim (including utilisation of Second Medical Opinion) has been paid or is payable under the *Policy*.

Period on Risk (in Months)	1 Year Policy Term	2 Year Policy Term	3 Year Policy Term
	Premium to be refunded	Premium to be refunded	Premium to be refunded
1	79%	87%	90%
2	71%	83%	88%

3	63%	79%	85%
4	55%	75%	82%
5	47%	71%	80%
6	39%	67%	77%
7	31%	63%	74%
8	23%	59%	72%
9	9%	55%	69%
10	1%	51%	66%
11	0%	47%	64%
12	0%	43%	61%
13		39%	58%
14		35%	56%
15		31%	53%
16		27%	50%
17		23%	48%
18		19%	45%
19		15%	42%
20		11%	40%
21		5%	37%
22		1%	34%
23		0%	32%
24		0%	29%
25			26%
26			24%
27			21%
28			18%
29			16%
30			13%
31			10%
32			8%
33			3%
34			0%
35			0%
36			0%

5.2.3 COMMUNICATIONS & NOTICES

i) Any notice, direction or instruction under this *Policy* shall be in writing and if it is:
   - To any *Insured Person*, then it shall be sent to *You* at *Your* last updated address as shown in *Our* records and *You* shall act for all *Insured Persons* for these purposes.
   - To *Us*, it shall be delivered to *Our* address specified in the Schedule.

ii) No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on *Our* behalf unless *We* have expressly stated to the contrary in writing.

iii) Notice and instructions will be deemed served ten (10) days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail after posting.

iv) *You* must immediately bring to *Our* notice any change in the address or contact details. If *You* fail to inform *Us*, *We* shall send notice to the last known address and it would be considered that the notice has been sent to *You*.

Note: *Please include Your Policy number for any communication with Us.*

5.2.4 FREE LOOK PERIOD –

You have a period of 15 days from the date of receipt of the *Policy* Documents to review the terms and conditions of the *Policy*. If *You* have any objections to any of the terms and conditions, *You* have the option of cancelling the *Policy* stating the reasons for cancellation and *You* will be refunded the premium paid by *You* after adjusting the amounts spent on any medical check-up, stamp duty charges and proportionate risk premium. *You* can cancel *Your Policy* only if *You* have not made any claims under the *Policy*. All *Your* rights under this *Policy* will immediately stand extinguished on the free look cancellation of the *Policy*. Free look provision is not applicable for portability and at the time of *Renewal* of the *Policy*.

5.2.5 GEOGRAPHY

This *Policy* covers for events within the territorial limits of India except for cover under Worldwide Emergency Hospitalisation. However, all payments under this *Policy* will only be made in Indian Rupees.

5.2.6 INSTALMENT PREMIUM

In case premium is payable in instalments as specified in the *Policy Schedule*, instalments shall be payable on or before the due date for continuity of coverage under the *Policy*. *You* will have relaxation period of 15 days from the due date for payment of instalment. We will not charge interest on the instalment premium paid during the relaxation period

and there will be no impact on coverage of Pre-Existing Disease and continuity of waiting periods.

In case *We* do not receive the premium within the relaxation period, the *Policy* will be terminated.

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

We shall have the right to recover and deduct any or all the pending instalments from the claim amount due under the *Policy*.

IMPORTANT POINTS TO BE NOTED WHILE OPTING FOR INSTALMENT PREMIUM PAYMENT VIA ELECTRONIC CLEARING SERVICE

1. Completely filled & signed Electronic Clearing Service Mandate Form is mandatory.
2. Ensure that the Premium amount which would be auto debited & frequency of instalment is duly filled in the ECS Mandate form.
3. New ECS Mandate Form is required to be filled in case of any change in the Premium due to change of Sum Insured / age / plan /coverages/revision in premium.
4. You need to inform us atleast 15 days prior to the due date of instalment premium if you wish to discontinue with the ECS facility.
5. Non-payment of premium on due date as opted by You in the mandate form subject to an additional 15 days of relaxation period will lead to termination of the policy.

5.2.7 POLICY DISPUTES

Any and all disputes or differences concerning the interpretation of the coverage, terms, conditions, limitations and/ or exclusions under this *Policy* shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

5.2.8 PROTECTION OF POLICY HOLDERS INTEREST

This *Policy* is subject to IRDA (Protection of Policyholders' Interest) Regulation, 2017 or any amendment thereof from time to time.

5.2.9 RECORDS TO BE MAINTAINED

You or the *Insured Person*, as the case may be shall keep an accurate record containing all medical records pertaining to the treatment taken for any liability under the policy and shall allow *Us* or *Our* representative(s) to inspect such records. You or the *Insured Person* as the case may be, shall furnish such information as may be

required by *Us* under this *Policy* at any time during the *Policy Period* and up to three years after the *Policy* expiration, or until final adjustment (if any) and resolution of all claims under this *Policy*.

5.2.10 REVISION & MODIFICATION OF PRODUCT

Any revision or modification will be done with the approval of the *Authority*.
We shall notify You about revision / modification in the product including premium. Such information shall be given to You at least ninety (90) days prior to the effective date of modification or revision coming into effect.

5.2.11 INCLUSION OF COVER DURING POLICY PERIOD

Based on the plan opted during the proposal stage, You can include following covers in the Policy subject to our underwriting guidelines and payment of pro-rata premium for the unexpired policy period. In such a case, the following conditions will be applicable.

i. All the waiting periods as described in section3.1,3.2,3.3 & 3.4 for these cover will be applicable from the date of endorsement.
ii. Coverage will not be applicable for any claim prior to date of endorsement.

Sr. No.	Cover	Sum Insured	30 days waiting period	Named Ailments Waiting Period	Pre-Existing Disease Waiting Period	Internal Congenital Anomaly Waiting Period	Waiting period for Coverage of mental Illness	Waiting Period for Coverage of HIV & AIDS
1	Emergency Road Ambulance/Repatriation of Mortal Remains/Funeral Expenses (per hospitalisation)	All Sum Insureds	Applicable from the date of Endorsement	Applicable from the date of Endorsement	Applicable from the date of Endorsement	Applicable from the date of Endorsement	Applicable from the date of Endorsement	Applicable from the date of Endorsement
2	Organ Donor Expenses							
3	AYUSH							
4	Hospital Daily Cash							
5	Maternity and New Born Baby							
6	Cumulative Bonus							
7	Medical Inflation							
8	Medical Second Opinion							
9	Outpatient Treatment							

10	Infertility	₹ 6 - 100 Lac						
11								
12	Worldwide Emergency Hospitalisation							Applicable from the date of Endorsement
13	Emergency Air Ambulance							
14	Bariatric Procedure							

5.2.12 TERMINATION OF *POLICY*

This *Policy* terminates on earliest of the following events-

a. Cancellation of *Policy* as per the cancellation provision.
b. On the *Policy* expiry date.

5.2.13 WITHDRAWAL OF THE PRODUCT

The product may be withdrawn after due approval from the *Authority*. In such case, *We* will provide one time option to all the *Policyholders* whose *Policy* is falling due for *Renewal* within 90 days of withdrawal of the product to renew the existing *Policy* or migrate to modified or other suitable Individual Health Policy with *Us* subject to Portability norms in vogue. All those *Policyholders* who choose to renew the existing *Policy* will be migrated to modified or other suitable Individual Health Insurance Policy at the time of next *Renewal*. However, if the *Policyholder* do not respond to *Our* intimation in case of such withdrawal, the *Policy* will be withdrawn on the *Renewal* date. All those *Policyholders* whose *Renewal* fall after 90 days of withdrawal of product will require to migrate to modified or other suitable Individual Health Insurance Policy.

5.3 CONDITIONS WHEN A CLAIM ARISES

5.3.1 ARBITRATION

If *We* admit liability for any claim but any difference or dispute arises as to the amount payable for any claim the same shall be decided by reference to Arbitration. The Arbitrator shall be appointed in accordance with the provisions of the Arbitration and Conciliation Act, 1996 or any amendment thereto. No reference to Arbitration shall be made unless *We* have admitted *Our* liability for a claim in writing.

5.3.2 CLAIMS

Claims Process & Management

Completed claim forms and processing documents must be furnished to *Us / TPA* within the stipulated timelines for reimbursement of all claims. Failure to furnish this documentation within the time required shall not invalidate nor reduce any claim if You can satisfy that it was not reasonably possible for You to submit / give proof within such time.

Cashless and Reimbursement Claim processing is through *Our* service partner *TPA*, details of the same will be available on the Health Card issued by *Us* on *Our /TPA* website. For the latest list of *Network Providers*, you can log on to *Our /TPA* website. *TPA* will facilitate health claims processing.

5.3.2.1 Claim Intimation:

If *You* meet with any *Accidental* Bodily *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 claims procedures:
You must notify *Your* claim to *Us / Our TPA* in writing or at call centre.

	Type of Hospitalisation	Notify *Us* or *Our* TPA
1)	Planned Hospitalisation	Immediately and in any event at least 48 hours prior to Your admission.
2)	Emergency Hospitalisation	Within 24 hours of Your admission to *Hospital* or before discharge whichever is earlier

The following details are to be provided to *Us* at the time of intimation of Claim:

- Policy Number
- Health Card ID No
- Name of *Policyholder*
- Name of the *Insured Person* in whose relation the Claim is being lodged
- Nature of *Illness* / *Injury*
- Name and address of the attending *Medical Practitioner* and *Hospital*
- Date of Admission
- Any other information as requested by Us

Failure to intimate a claim within the time required shall not invalidate nor reduce any claim if You can satisfy that it was not reasonably possible for You to intimate the claim within such time.

5.3.2.2 Cashless Facility:

Cashless Facility is available for *Hospitalisation* only at *Our Network Provider*. The *Insured Person* can avail *Cashless Facility* at *Network Provider*, by presenting the health card as provided by *Us* with this *Policy*, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / Aadhar Card, any other identity proof as approved by Us).

(a) For Planned Hospitalisation:

i) The *Insured Person* should at least 48 hrs prior to admission to the *Hospital* approach the *Network Provider* for *Hospitalisation* for medical treatment.
ii) The *Network Provider* will issue the request for authorization letter for *Hospitalisation* in the pre-authorization form prescribed by the *Authority*.
iii) The *Network Provider* shall electronically send the pre-authorization form along with all the relevant details to the 24 (twenty-four) hour authorization/cashless department of the TPA along with contact details of the treating *Medical Practitioner* and the *Insured Person*.
iv) Upon receiving the pre-authorization form and all related medical information from the *Network Provider*, the eligibility of cover under the *Policy* will be verified.
v) Wherever the information provided in the request is sufficient to ascertain the authorisation, the authorisation letter will be issued to the *Network Provider*. Wherever additional information or documents are required, the same will be called for from the *Network Provider* and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a period of 3 hours from the receipt of last complete documents.
vi) The Authorisation letter will include details of sanctioned amount, any specific limitation on the claim, any *Co-Payments* or *Deductibles* and non- payable items if applicable.
vii) The authorisation letter shall be valid only for a period of 15 days from the date of issuance of authorization.

In the event that the cost of *Hospitalisation* exceeds the authorized limit as mentioned in the authorization letter:

i) The *Network Provider* shall request for an enhancement of authorisation limit. Eligibility will be verified, and the enhancement will be evaluated on the availability of further limits.
ii) *We* shall accept or decline such additional expenses within 3 hours of receiving the request for enhancement.

At the time of discharge:

i) The *Network Provider* may forward a final request for authorization for any residual amount along with the discharge summary and the billing format in accordance with the process.
ii) Upon receipt of the final authorisation letter, *Insured* may be discharged by the *Network Provider*.
iii) Network provider to ensure that the final authorization letter is signed by *Insured.*
iv) *Insured* must ensure to take photocopies of relevant medical records for future reference.

(b) In case of Emergency Hospitalisation:

i) The *Insured Person* may approach the *Network Provider* for *Hospitalisation*.
ii) *Insured Person* will need to provide health Card / Health insurance *Policy* details at *Hospital* admission counter.
iii) The *Network Provider* shall forward the request for authorization within 24 hours of admission to the *Hospital* or before discharge whichever is earlier.
iv) In the interim, the *Network Provider* may either consider treating the *Insured Person* by taking a token deposit or treating as per their norms.
v) The *Network Provider* shall refund the deposit amount to you barring a token amount to take care of non-covered expenses once the authorization is issued.

The *Network Provider* will send the claim documents to *TPA* within 15 days from the date of discharge from *Hospital*

- Claim Form Duly Filled and Signed
- Original signed pre-authorisation request
- Copy of authorisation approval letter (s)
- Copy of Photo ID of Patient Verified by the *Hospital*
- Original Discharge/Death Summary
- Operation Theatre Notes (if any)
- Original *Hospital* Main Bill along with break up Bill and original receipts
- Original Investigation Reports, X Ray, MRI, CT Films, HPE
- Details of the implants including the sticker indicating the type as well as invoice towards the cost of implant
- Doctors Reference Slips for Investigations/Pharmacy
- Original Pharmacy Bills
- MLC/FIR Report/Post Mortem Report (if applicable and conducted).

Any additional documents may be called as required based on the circumstances of the claim.

There can be instances where *Cashless Facility* may be denied for *Hospitalisation* due to insufficient *Sum Insured* or insufficient information to determine admissibility in which case *You*/*Insured Person* may be required to pay for the treatment and submit the claim for reimbursement to *TPA* which will be considered subject to the *Policy* Terms &Conditions.

We in *Our* sole discretion, reserves the right to modify, add or restrict any *Network Provider* for Cashless services under the *Policy*. Before availing the Cashless service, the *Policyholder / Insured Person* is required to check the applicable/latest list of *Network Provider* on *TPA's* website or by calling call centre.

5.3.2.3 Claim Reimbursement Process

Wherever *You* have opted for a reimbursement of expenses, *You* may submit the documents for reimbursement of the claim to *Our / TPA* office not later than 15 days from the date of discharge from the *Hospital*. *You* can obtain a Claim Form from any of *Our / TPA* Offices or download a copy from *Our* website at www.dhflinsurance.com. The necessary claim documents to be submitted for reimbursement are as following:

- Claim Form Duly Filled and Signed
- Original Discharge/Death Summary
- Operation Theatre Notes (if any)
- Original *Hospital* Main Bill along with break up Bill and original receipts
- Original investigation reports, X Ray, MRI, CT films, HPE
- Doctors Reference Slips for Investigations/Pharmacy
- Original Pharmacy Bills
- MLC/FIR Report/Post Mortem Report (if applicable and conducted).
- Details of the implants including the sticker indicating the type as well as invoice towards the cost of implant
- KYC documents (Photo ID proof, Pan Card, Aadhar Card)
- Cancelled cheque for NEFT payment

We may call for any additional documents/information as required based on the circumstances of the claim.

5.3.2.4 Cashless Claim Process for Health Check Up

a) *You* can call our Network Provider on XXXX XXX XXX to make a request. Alternatively, *You* may call *Us* for any assistance you need to make such request.

b) The Network Provider will ask for your location of residence and will give options of Diagnostic Centers nearby your location.

c) *You* can select your preferential Diagnostic Centers and then the Network Provider will fix the appointment with the Diagnostic Centre.

d) After fixation of appointment, the Network Provider will generate an OTP (one-time password) and share the same with *You* and the Diagnostic Centre through SMS.

e) On the appointment date You need to visit the Diagnostic Centre and show the OTP for verification.

f) Once verified, the Diagnostic Centre will conduct the medical test as per the defined set.

g) Post completion of the medical tests, the Network Provider/ Diagnostic Centre will share the Original Copy medical reports to *You* and also share a soft copy of the medical reports with Us to enable *Us* to make payment to the Diagnostic Centre/Network Provider.

5.3.2.5 Scrutiny of Claim Documents:

We shall scrutinize the claim and accompanying documents. Any deficiency of documents, shall be intimated to *You* and the *Network Provider,* as the case may be and subsequent reminders will follow.
During claim processing if the claims are found deficient in documents, *TPA* shall intimate the same to DHFL GI customer within 3 working days of receiving claim documents. First reminder for deficient documents will be sent within 7 days of first deficiency letter and Second reminder - within 10 days of first reminder deficiency letter. Final reminder letter will be sent from 10 days from second reminder.

We will send a maximum of three (3) reminders following which, we will send a rejection letter after 15 days of the final reminder letter if the deficient documents are not received.

5.3.2.6 Claim Investigation:

We may investigate claims if reasonably required to determine the validity of claim. Verification carried out, if any, will be done by Individuals or *Medical Practitioners* or entities authorized by *Us* to carry out such verification / investigation(s) and the costs for such verification / investigation shall be borne by *Us*.
You additionally hereby consent to disclose *Us* of documentation and information that may be held with *your* medical professionals and other insurers.

5.3.2.7 Pre-& Post Hospitalisation Claims:

Claim documents for *Pre-& Post hospitalisation* should be sent to *TPA* within 15 days of completion of treatment.

5.3.2.8 Settlement & Repudiation of the Claim:

We shall be under no obligation to make any payment under this *Policy* unless *We* have been provided with the documentation and information to establish the validity of the claim.

i) *We* shall ordinary settle a Claim including its rejection within 30 days of submission of the last "necessary" document(s) as listed in the section 5.3.2.2 and 5.3.2.3.

ii) Where the circumstances of a claim warrant an investigation, *We* 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, *We* shall settle the claim within 45 days from the date of receipt of last necessary document.

iii) 'Repudiated' claims will be informed to *You* in writing with appropriate reasons of repudiation.

iv) "*We* will only make payment to *Policyholder* under this *Policy*. *Policy holder's* receipt shall be considered as a complete discharge of *Our* liability against any claim under this *Policy*. In the event of *Policyholder's* death, *We* will make payment to the *Nominee*/Assignee (as named in the Schedule)."

v) The payments under this *Policy* shall only be made in Indian Rupees within India.

vi) For all admissible claims where expenses are incurred in overseas country, the exchange rate on the date of payment shall be applied for reimbursement in Indian Rupees.

5.3.2.9 Payment of Interest:

All claims will be settled in accordance with the applicable regulatory guidelines, including *IRDAI* (Protection of Policyholders Regulation), 2017. In case of delay in payment of any claim that has been admitted as payable by *Us* under the *Policy* terms and condition, beyond the time period as prescribed under IRDA (Protection of Policyholders Regulation), 2017, *We* shall pay interest at a rate which is 2% above the *Bank Rate* or as per the applicable / extant IRDAI regulation. Such interest shall be paid from the date of receipt of the last relevant and necessary document from the insured /claimant by insurer till the date of actual payment.

5.3.2.10 Multiple Policies:

In case of multiple policies which provide fixed benefits, on the occurrence of the insured event, each insurer shall make the claim payments independently of payments received under other similar *polices* in accordance with the terms and conditions of its *policy*.

If two or more policies are taken by an *Insured* during a period from one or more insurers to indemnify treatment costs, the *Policyholder* shall have the right to require a settlement of his/her claim in terms of any of his/her *policies*.

1) In all such cases the insurer who has issued the chosen *Policy* 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*.
2) If the amount to be claimed exceeds the *Sum Insured* under a single *Policy* after considering the *Deductibles or Co-Payments*, the *Policyholder* shall have the right to choose other insurers from whom he/she wants to claim the balance amount.
3) Claims under other *policy/ies* may be made after exhaustion of *Sum Insured* in the earlier chosen *policy / policies*
4) Where an *Insured* has policies from more than one insurer to cover the same risk on indemnity basis, the *Insured* shall only be indemnified the *hospitalisation* costs in accordance with the terms and conditions of the chosen *Policy*.
5) The Insured shall have rights to prefer claims from other *Policy/ policies* for the amount disallowed under the earlier chosen *policy*/*policies*, even if the Sum Insured is not exhausted. Then the insurers shall settle the claim subject to the terms and conditions of the other *policy* / *policies* so chosen.

5.3.2.11 TPA Related Information

For intimation of claim, submission of claim related documents and any claim related query, *You* can contact *TPA* through:

TPA Name	:	<<Name of the TPA>>
Address	:	<<XXXX>>
Website	:	<<www.tpaname.com>>
E-mail Id	:	<<info@tpaname.com>>
Toll Free Number	:	<<XXX XXXXX XXX>>

5.3.3 COMPLETE DISCHARGE

Payment made by *Us* to *You* /Assignee/*Nominee*/legal representative, as the case may be, in respect of any benefit under the *Policy* shall in all cases be complete and construe as an effectual discharge in favour of *Us*.

5.3.4 DISCLAIMER OF CLAIM

If Company shall disclaim liability to the *Insured* for any claim and if the *Insured* shall not, within twelve (12) calendar months from the date or receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under the *Policy*.

5.3.5 PHYSICAL EXAMINATION

Any *Medical Practitioner* authorized by *Us* shall be allowed to examine the *Insured Person* in case of any alleged disease/*Illness*/*Injury* requiring *Hospitalization*. Non-co-operation by the *Insured Person* will result into rejection of his/her claim. *We* will bear the cost towards performing such medical examination (at the specified location) of the *Insured Person*.

5.4 CONDITIONS FOR RENEWAL OF CONTRACT

5.4.1 RENEWAL TERMS

The *Policy* can be renewed on or before the end of the *Policy Period* subject to realization of *Renewal* premium. However, *We* shall not be bound to give notice that such *Renewal* premium is due. *We* may exercise option of not renewing the *Policy* on grounds of fraud, misrepresentation, non-cooperation, moral hazard or suppression of any *Material Fact* either at the time of taking the *Policy* or any time during the currency of the *Policy*.

A *Grace Period* of 30 days from the premium due date is allowed where you can still pay your premium and continue your *Policy*. Coverage would not be available for the period for which no premium has been received. Post 30 days from premium due date, if the premium is not paid, the *Policy* will lapse i.e. be terminated.

Your Renewal premium for this *Policy* will not change unless *We* have revised the premium and obtained due approval from *Authority*. Premium otherwise will only change on account of age or if you opt for a change in the *Sum Insured*/ tenure of the *Policy* or if you opt for a change in location (Zone).

We will not apply any additional loading on *your Policy* premium at *Renewal* based on your claim experience.

You may change the plan or add or delete *Insured Persons* (except due to child birth / marriage or death) only at the time of *Renewal* of the *Policy*. However, such changes shall be subject to underwriting guidelines of the company.

5.4.2 CHANGE OF POLICYHOLDER

The *Policyholder* may be changed only at the time of renewal. The new *Policyholder* must be a member of insured person's family (Spouse/ Son/ Daughter/ Parents).

The *Policyholder* may be changed during the *policy period* upon request in case of death of the *Policyholder*, emigration of *Policyholder* from India or in case of divorce of the *Policyholder*.

5.4.3 ADDITION OF INSURED PERSON

Addition of insured person can be made during the *Policy Period* for child between the age of 91 days and 180 days (both days inclusive) and for newly married spouse within 3 months of marriage.

Addition of insured person can also be done at renewal subject to underwriting.

For newly added insured person, all waiting periods will apply afresh.

5.4.4 CHANGE IN SUM INSURED

ENHANCEMENT -

Sum Insured can be enhanced at the time of renewal only. All waiting periods will apply afresh to the enhanced Sum Insured from the effective date of such enhancement.

You can submit a request for the enhancement in Sum Insured by filling the Change Request Form. For such requests, Underwriting will be done as per the Underwriting Guidelines of the Company.

REDUCTION –

Sum Insured can be reduced at the time of renewal only. *You* can submit a request for the reduction in Sum Insured by filling the Change Request Form.

6. GRIEVANCE REDRESSAL PROCEDURE

At DHFL General Insurance, *We* want your relationship with insurance to soar beyond what you've experienced yet. To understand, appreciate, and enjoy insurance—we're here for you. However, if *You* aren't satisfied—please feel free to connect with *Us* on the following channels.

a. Call *Us* on *Our* Toll Free 1800-123-0004 (From 8 am to 8 pm) for any queries that You may have!
b. Email *Your Policy* related queries to mycare@dhflinsurance.com
c. For Senior Citizens, *We* have a special cell and *Our* Senior Citizen customers can email *Us* at seniorcare@dhflinsurance.com for priority resolution
d. Visit *Our* website www.dhflinsurance.com to register & track *Your* queries
e. Please walk in to any of *Our* branches or partner locations
f. *You* can also dispatch *Your* letters to *Us* at:

DHFL General Insurance Limited
2nd Floor, DHFL House,
19, Sahar Road, Off Western Express Highway,
Vile Parle (East), Mumbai,
Maharashtra - 400099

We request *You* to please mention *Your* complete details: Full Name, *Policy* Number and Contact Details in all *Your* communications, to enable *Our* customer experience expert to connect with *You* and provide *You* with the quickest possible solution.

We'll make sure to acknowledge *Your* service request within 3 working days—and try and resolve it to *Your* satisfaction within 15 working days. That's a promise!

Escalation

Level – 1:

While *We* attempt to give *You* best-in-class and prompt resolution for any concerns—sometimes it may not be perfect. If *You* felt that *You* weren't offered a perfect resolution, please feel free to share *Your* feedback to *Our* Customer Experience team at Manager.CustomeExperience@dhflinsurance.com

Level – 2:

If *You* still are not happy about the resolution provided, then *You* may write to *Our* Head Customer Experience and Grievance Redressal Officer at Head.CustomerExperience@dhflinsurance.com
If *Your* concern remains unresolved after having followed the above escalation procedure then *You* may please approach the Insurance Ombudsman for Redressal. To know who *Your* Insurance Ombudsman is – simply refer to the list below/overleaf.

S. No.	CONTACT DETAILS	JURISDICTION OF OFFICE
1	**AHMEDABAD** Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in	State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu
2	**BENGALURU** 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@gbic.co.in	Karnataka
3	**BHOPAL** Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@gbic.co.in	States of Madhya Pradesh and Chattisgarh.
4	**BHUBANESHWAR** Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in	State of Orissa

5	**CHANDIGARH** Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in	States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh.
6	**CHENNAI** Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in	State of Tamil Nadu and Union Territories - Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
7	**DELHI** Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in	State of Delhi
8	**GUWAHATI** Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

9	**HYDERABAD** Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in	States of Andhra Pradesh, Telangana and Union Territory of Yanam - a part of the Union Territory of Pondicherry
10	**JAIPUR** Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.co.in	State of Rajasthan
11	**ERNAKULAM** Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@gbic.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry
12	**KOLKATA** Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@gbic.co.in	States of West Bengal, Bihar, Sikkim and Union Territories of Andaman and Nicobar Islands

13	**LUCKNOW** Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in	District of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varansi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sulanpur, Maharajganj, Santkabirnagar, Azamgarh, Kaushinagar, Gorkhpur, Deoria, Mau, Chandauli, Ballia, Sidharathnagar.
14	**MUMBAI** Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in	States of Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
15	**NOIDA** Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@gbic.co.in	States of Uttaranchal and the following Districts of Uttar Pradesh:. Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozabad, Gautam Budh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
16	**PATNA** Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@gbic.co.in	States of Bihar and Jharkhand

17	**PUNE** Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@gbic.co.in	States of Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

IRDAI Regulation No 17: This **Policy** is subject to regulation 17 of **IRDAI** (Protection of Policyholder's Interests) Regulation 2017or any amendment thereof from time to time.

ANNEXURE-I - Day Care Procedures

Sr. No	System	Procedure
1	ENT	Adenoidectomy with Grommet insertion
2		Adenoidectomy without Grommet insertion
3		Conchoplasty
4		Endolymphatic Sac Surgery for Meniere's Disease
5		Excision and destruction of lingual tonsils
6		Excision of Angioma Septum
7		Fenestration of the inner ear
8		Incision & Drainage of Pharyngeal Abscess
9		Incision and drainage – Hematoma Auricle
10		Incision and drainage of perichondritis
11		Labyrinthectomy for severe Vertigo
12		Myringoplasty
13		Myringotomy with Grommet Insertion
14		Ossiculoplasty
15		Palatoplasty
16		Pseudocyst of the Pinna - Excision
17		Reduction of fracture of Nasal Bone
18		Removal of Tympanic Drain under LA
19		Septoplasty
20		Stapedectomy under GA
21		Stapedectomy under LA
22		Stapedotomy
23		Thyroplasty Type I
24		Tonsillectomy with adenoidectomy
25		Tonsillectomy without adenoidectomy
26		Tracheoplasty
27		Tracheostomy
28		Transoral incision and drainage of a pharyngeal abscess
29		Turbinectomy
30		Turbinoplasty
31		Tympanoplasty
32		Uvulo Palato Pharyngo Plasty
33		Vestibular Nerve section
34		Vocal Cord lateralisation Procedure
35		Mastoidectomy

36	Ophthalmology	Biopsy of tear gland
37		Corrective surgery of blepharoptosis
38		Corrective surgery of the entropion and ectropion
39		Excision and destruction of the diseased tissue of the eyelid
40		Incision of diseased eyelids
41		Incision of tear glands
42		Incision of the cornea
43		Operation on the canthus and epicanthus
44		Operations for pterygium
45		Removal of foreign body from eye
46		Surgery for cataract
47		Treatment of retinal lesion
48		Other operation on the tear ducts
49		Other operations on the cornea
50		Enucleation of Eye Without Implant
51		Dacryocystorhinostomy for Various Lesions of Lacrimal Gland
52	Oncology	2D Radiotherapy
53		3D Brachytherapy
54		3D Conformal Radiotherapy
55		Adjuvant chemotherapy
56		Adjuvant Radiotherapy
57		Afterloading Catheter Brachytherapy
58		CCRT-Concurrent Chemo + RT
59		Conditioning Radiothearpy for BMT
60		Consolidation chemotherapy
61		Continuous Infusional Chemotherapy
62		Electron Therapy
63		External mould Brachytherapy
64		Extracorporeal Irradiation of Blood Products
65		Extracorporeal Irradiation to the Homologous Bone grafts
66		FSRT-Fractionated SRT
67		Gamma knife SRS
68		HBI-Hemibody Radiotherapy
69		HDR Brachytherapy
70		Helical Tomotherapy
71		IGRT- Image Guided Radiotherapy
72		Implant Brachytherapy
73		IMRT- DMLC

74		IMRT- Step & Shoot
75		Induction chemotherapy
76		Infusional Bisphosphonates
77		Infusional Chemotherapy
78		Infusional Targeted therapy
79		Interstitial Brachytherapy
80		Intracavity Brachytherapy
81		intraluminal Brachytherapy
82		Intravesical Brachytherapy
83		IV Push Chemotherapy
84		LDR Brachytherapy
85		Maintenance chemotherapy
86		Neoadjuvant chemotherapy
87		Neoadjuvant radiotherapy
88		Palliative chemotherapy
89		Palliative Radiotherapy
90		Radical chemotherapy
91		Radical Radiotherapy
92		Rotational Arc Therapy
93		SBRT-Stereotactic Body Radiotherapy
94		SC administration of Growth Factors
95		SRS-Stereotactic Radiosurgery
96		SRT-Stereotactic Arc Therapy
97		TBI- Total Body Radiotherapy
98		Tele gamma therapy
99		Telecesium Therapy
100		Telecobalt Therapy
101		Template Brachytherapy
102		TSET-Total Electron Skin Therapy
103		VMAT-Volumetric Modulated Arc Therapy
104		X-Knife SRS
105	Plastic Surgery	Breast reconstruction surgery after mastectomy
106		Construction skin pedicle flap
107		Fibro myocutaneous flap
108		Gluteal pressure ulcer-Excision
109		Muscle-skin graft duct fistula
110		Muscle-skin graft, leg
111		Myocutaneous flap

112		Plastic surgery to the floor of the mouth under GA
113		Removal cartilage graft
114		Removal of bone for graft
115		Sling operation for facial palsy
116		Split Skin Grafting under RA
117		Wolfe skin graft
118	Urology	Anderson hynes operation
119		AV fistula - wrist
120		Bladder Neck Incision
121		Cystoscopic Litholapaxy
122		Cystoscopy & Biopsy
123		Cystoscopy and "SLING" procedure.
124		Cystoscopy and removal of FB
125		Cystoscopy and removal of polyp
126		Drainage of prostate abscess
127		ESWL
128		Excision of urethral diverticulum
129		Excision of urethral prolapse
130		Frenular tear repair
131		Haemodialysis
132		injury prepuce- circumcision
133		Kidney endoscopy and biopsy
134		Meatotomy for meatal stenosis
135		Mega-ureter reconstruction
136		Orchiectomy
137		Paraphimosis surgery
138		Percutaneous nephrostomy
139		Removal of urethral Stone
140		Repair of penile torsion
141		Suprapubic cystostomy
142		Surgery filarial scrotum
143		Surgery for fournier's gangrene scrotum
144		Surgery for pelvi ureteric junction obstruction
145		Surgery for watering can perineum
146		TUNA- prostate
147		Ureter endoscopy and treatment
148		URSL with lithotripsy
149		URSL with stenting

150		Vesico ureteric reflux correction
151	Neurology	Diagnostic cerebral angiography
152		Entrapment neuropathy Release
153		Epidural steroid injection
154		Facial nerve physiotherapy
155		Glycerol rhizotomy
156		Intrathecal Baclofen therapy
157		Motor cortex stimulation
158		Muscle biopsy
159		Nerve biopsy
160		Percutaneous Cordotomy
161		Spinal cord stimulation
162		Stereotactic Radiosurgery
163		Ventriculoatrial shunt
164		VP shunt
165	Thoracic Surgery	Brochoscopic treatment of bleeding lesion
166		Brochoscopic treatment of fistula / stenting
167		Bronchoalveolar lavage & biopsy
168		Coronary Angiography
169		Direct Laryngoscopy with biopsy
170		EBUS + Biopsy
171		Endoscopic thoracic sympathectomy
172		Laser Ablation of Barrett's oesophagus
173		Pleurodesis
174		Thoracoscopy and Lung Biopsy
175		Thoracoscopy and pleural biopsy
176		Thoracoscopy assisted empyema drainage
177		Thoracoscopy ligation thoracic duct
178	Gastroenterology	Colonoscopy ,lesion removal
179		Colonoscopy stenting of stricture
180		Construction of gastrostomy tube
181		ERCP
182		ERCP + placement of biliary stents
183		ERCP and choledochoscopy
184		ERCP and papillotomy
185		ERCP and sphincterotomy
186		Esophageal stent placement
187		Esophagoscope and sclerosant injection

188		EUS + aspiration pancreatic cyst
189		EUS + coeliac node biopsy
190		EUS + submucosal resection
191		EUS and pancreatic pseudo cyst drainage
192		Pancreatic pseudocyst EUS & drainage
193		Percutaneous Endoscopic Gastrostomy
194		Proctosigmoidoscopy volvulus detorsion
195		RF ablation for barrett's Esophagus
196		Sigmoidoscopy
197		Small bowel endoscopy (therapeutic)
198	General Surgery	Abscess-Decompression
199		Axillary lymphadenectomy
200		Breast abscess I& D
201		Cervical lymphadenectomy
202		Circumcision for Trauma
203		Colonoscopy
204		Colostomy
205		colostomy closure
206		Drainage of pyelonephrosis / perinephric abscess
207		Epididymectomy
208		ERCP - Bile duct stone removal
209		ERCP - pancreatic duct stone removal
210		Esophageal Growth stent
211		Eversion of Sac
212		Excision of Cervical RIB
213		Excision of Ranula under GA
214		Feeding Gastrostomy
215		Feeding Jejunostomy
216		Fibroadenoma breast excision
217		Fissure in Ano- fissurectomy
218		Fissure in ano sphincterotomy
219		Glossectomy
220		Surgical treatment of Hydrocele
221		Ileostomy
222		Ileostomy closure
223		Incision and drainage of Abscess
224		Incision of a pilonidal sinus / abscess
225		Infected keloid excision

226		Infected lipoma excision
227		Infected sebaceous cyst
228		Inguinal lymphadenectomy
229		Intersphincteric abscess incision and drainage
230		Jaboulay's Procedure
231		Laparoscopic cardiomyotomy(Hellers)
232		Laparoscopic pyloromyotomy(Ramstedt)
233		Laparoscopicreduction of intussusception
234		Liver Abscess- catheter drainage
235		Lord's plication
236		Maximal anal dilatation
237		Meatoplasty
238		Microdochectomy breast
239		Oesophageal varices Sclerotherapy
240		Oesophagoscopy and biopsy of growth oesophagus
241		PAIR Procedure of Hydatid Cyst liver
242		Pancreatic Pseudocysts Endoscopic Drainage
243		Parastomal hernia
244		Perianal abscess I&D
245		Perianal hematoma Evacuation
246		Photodynamic therapy or esophageal tumour and Lung tumour
247		Piles
248		Pneumatic reduction of intussusception
249		Polypectomy colon
250		Prolapsed colostomy- Correction
251		Psoas Abscess Incision and Drainage
252		Resection of Salivary Gland
253		Rigid Oesophagoscopy for dilation of benign Strictures
254		Rigid Oesophagoscopy for FB removal
255		Rigid Oesophagoscopy for Plummer vinson syndrome
256		Scalp Suturing
257		Scrotoplasty
258		Sentinel node biopsy
259		Sentinel node biopsy malignant melanoma
260		Splenic abscesses Laparoscopic Drainage
261		Subcutaneous mastectomy
262		Submandibular salivary duct stone removal
263		Surgery for fracture Penis

264		Surgical treatment of varicocele
265		Suturing of lacerations
266		Testicular biopsy
267		Thyroid abscess Incision and Drainage
268		TIPS procedure for portal hypertension
269		Tru cut liver biopsy
270		UGI scopy and injection of adrenaline, sclerosants - bleeding ulcers
271		UGI scopy and Polypectomy oesophagus
272		UGI Scopy and Polypectomy stomach
273		Varicose veins legs - Injection sclerotherapy
274		Wound debridement and Cover
275		ZADEK's Nail bed excision
276	Orthopedic	Abscess knee joint drainage
277		Amputation follow-up surgery
278		Amputation of metacarpal bone
279		Arthroplasty
280		Arthroscopic Meniscle repiar
281		Arthroscopic Repair of ACL tear knee
282		Arthroscopic repair of PCL tear knee
283		Arthroscopic Shoulder surgery
284		Arthrotomy Hip joint
285		Aspiration of Hematoma
286		Biopsy elbow joint lining
287		Biopsy finger joint lining
288		Calcaneum spur hydrocort injection
289		Carpal tunnel release
290		Closed reduction and external fixation
291		Closed reduction of dislocation / Fracture
292		Decompress forearm space
293		Elbow arthroscopy
294		Excision of dupuytren's contracture
295		Excision of various lesions in Coccyx
296		Exploration of ankle joint
297		Fixation of knee joint
298		Ganglion wrist hyalase injection
299		Haemarthrosis knee- lavage
300		Implant removal minor
301		Incision of foot fascia

302		Intra articular steroid injection
303		Joint Aspiration - Daignostic / Theraputic
304		K wire removal
305		Lengthening of hand tendon
306		Lengthening of thigh tendons
307		ORIF with K wire fixation- small bones
308		ORIF with plating- Small long bones
309		Partial removal of metatarsal
310		Partial removal of rib
311		POP application under GA
312		Release of midfoot joint
313		Release of thumb contracture
314		Removal of elbow bursa
315		Removal of fracture pins/ nails
316		Removal of knee cap bursa
317		Removal of tumor of arm/ elbow under RA/GA
318		Removal of wrist prosthesis
319		Remove/graft bone lesion
320		Repair of knee joint
321		Repair of ruptured tendon
322		Revision of neck muscle (Torticollis release)
323		Revision/Removal of Knee cap
324		Surgery of bunion
325		Syme's amputation
326		Tendon lengthening
327		Tendon shortening
328		Tendon transfer procedure
329		Tennis elbow release
330		Treatment fracture of radius & ulna
331		Treatment of clavicle dislocation
332		Treatment of foot dislocation
333		Treatment of fracture of ulna
334		Treatment of scapula fracture
335		Treatment of sesamoid bone fracture
336		Treatment of shoulder dislocation
337		Excision of any other bursitis
338	Paediatric surgery	Cystic hygroma - Injection treatment
339		Detorsion of torsion Testis

340		Dilatation of accidental caustic stricture oesophageal
341		EUA + biopsy multiple fistula in ano
342		Excision Juvenile polyps rectum
343		Excision of cervical teratoma
344		Excision of fistula-in-ano
345		Excision of soft tissue rhabdomyosarcoma
346		Excision Sigmoid Polyp
347		High Orchidectomy for testis tumours
348		Infantile Hypertrophic Pyloric Stenosis pyloromyotomy
349		lap.Abdominal exploration in cryptorchidism
350		Mediastinal lymph node biopsy
351		Orchidopexy for undescended testis
352		Presacral Teratomas Excision
353		Rectal prolapse (Delorme's procedure)
354		Rectal-Myomectomy
355		Removal of vesical stone
356		Sternomastoid Tenotomy
357		Vaginoplasty
358	Gynaecology	Bartholin Cyst excision
359		Conization
360		Cryocauterisation of Cervix
361		D&C
362		Endometrial ablation
363		Hymenectomy(imperforate Hymen)
364		Hysteroscopic adhesiolysis
365		Hysteroscopic removal of myoma
366		Hysteroscopic resection of endometrial polyp
367		Hysteroscopic resection of fibroid
368		Hysteroscopic resection of septum
369		Laparoscopic cystectomy
370		Laparoscopic Myomectomy
371		Laparoscopic oophorectomy
372		Laparoscopic cyst excision
373		Large loop excision of the transformation zone
374		Loop Electrosurgical excision procedure
375		MIRENA insertion for therapeutic use
376		Pelvic floor repair(excluding Fistula repair)
377		Polypectomy

378		Repair of vagina (vaginal atresia)
379		Repair recto- vagina fistula
380		Surgery for Stress Urinary Incontienance
381		Thermal Cauterisation of Cervix
382		Transurethral Resection of Bladder Tumor
383		Ureterocoele repair - congenital internal
384		Uterine artery embolization
385		Vaginal mesh For POP
386		Vaginal wall cyst excision
387		Vulval cyst Excision
388		Vulval wart excision
389	Dental	FNAC
390		Oral biopsy in case of abnormal tissue presentation
391		Splinting of avulsed teeth
392		Suturing lacerated lip
393		Suturing oral mucosa

Note:

a) The above list is exhaustive. Any addition / deletion in this list shall be subject to IRDAI's approval.

b) The standard exclusions and waiting periods are applicable to all of the above Day Care Procedures.

ANNEXURE-II - Non-Medical Expenses

SR NO	ITEMS	Payable /Non-Payable
I	**TOILETRIES/COSMETICS/PERSONAL COMFORT OR CONVENIENCE ITEMS/SIMILAR EXPENSES**	
1	HAIR REMOVAL CREAM	Payable - for site preparation
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	MOISTURISER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Payable for 1 (Qty) only in surgical cases of Thoracic or Lumbar Spine
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Payable
26	EYE SHEILD	Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Only sterile gown is payable in surgical cases, otherwise not payable
31	LEGGINGS	Payable in cases of Varicose Veins and DVT if the claim is payable as per the Policy

32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Payable for 1 (Qty) only for Fracture of upper arm cases
59	WEIGHT CONTROL PROGRAMS / SUPPLIES / SERVICES	Not payable, unless specified in policy
60	COST OF SPECTACLES / CONTACT LENSES / HEARING AIDS ETC	Not payable, unless specified in policy
61	HOME VISIT CHARGES	Not payable, unless specified in policy
62	DONOR SCREENING CHARGES	Not Payable
63	ADMISSION / REGISTRATION CHARGES	Not Payable
64	HOSPITALISATION FOR EVALUATION / DIAGNOSTIC PURPOSE	Not Payable
65	EXPENSES FOR INVESTIGATION / TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable
66	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges
67	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS	Payable under OT Charges

68	MICROSCOPE COVER	Payable under OT Charges
69	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER	Payable under OT Charges
70	SURGICAL DRILL	Payable under OT Charges
71	EYE KIT	Payable under OT Charges
72	EYE DRAPE	Payable
73	X-RAY FILM	Payable under Radiology Charges
74	SPUTUM CUP	Payable under Investigation Charges, not as consumable
75	BOYLES APPARATUS CHARGES	Payable under OT Charges
76	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
77	ANTISEPTIC OR DISINFECTANT LOTIONS	Not Payable - Part of Dressing charges
78	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
79	COTTON	Not Payable - Part of Dressing charges
80	COTTON BANDAGE	Not Payable - Part of Dressing charges
81	MICROPORE / SURGICAL TAPE	Not Payable - Part of Dressing charges
82	BLADE	Not Payable
83	APRON	Not Payable - Part of Hospital Services/ Disposable linen to be part of OT/ICU charges
84	TORNIQUET	Not Payable (service Is Charged by Hospitals Consumables Cannot Be Separately Charged)
85	ORTHOBUNDLE, GYNAEC BUNDLE	Not Payable - Part of Dressing charges
86	URINE CONTAINER	Not Payable
II	**ELEMENTS OF ROOM CHARGE**	
87	LUXURY TAX	Part of Room charge not payable separately
88	HVAC	Part of Room charge not payable separately
89	HOUSE KEEPING CHARGES	Part of Room charge not payable separately
90	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of Room charge not payable separately
91	TELEVISION AND AIR CONDITIONER CHARGES	Payable under Room charges

92	SURCHARGES	Part of Room charge not payable separately
93	ATTENDANT CHARGES	Not Payable - Part of Room charges
94	IM IV INJECTION CHARGES	Part of Nursing charges, not payable seperately
95	CLEAN SHEET	Part of Laundry/ Housekeeping not payable separately
96	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
97	BLANKET / WARMER BLANKET	Not Payable - Part of Room charges
III	**ADMINISTRATIVE OR NON-MEDICAL CHARGES**	
98	ADMISSION KIT	Not Payable
99	BIRTH CERTIFICATE	Not Payable
100	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
101	CERTIFICATE CHARGES	Not Payable
102	COURIER CHARGES	Not Payable
103	CONVENYANCE CHARGES	Not Payable
104	DIABETIC CHART CHARGES	Not Payable
105	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
106	DISCHARGE PROCEDURE CHARGES	Not Payable
107	DAILY CHART CHARGES	Not Payable
108	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
109	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
110	FILE OPENING CHARGES	Not Payable
111	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
112	MEDICAL CERTIFICATE	Not Payable
113	MAINTAINANCE CHARGES	Not Payable
114	MEDICAL RECORDS	Not Payable
115	PREPARATION CHARGES	Not Payable
116	PHOTOCOPIES CHARGES	Not Payable
117	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
118	WASHING CHARGES	Not Payable
119	MEDICINE BOX	Not Payable
120	MORTUARY CHARGES	Not payable, unless specified in policy
121	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
IV	**EXTERNAL DURABLE DEVICES**	
122	WALKING AIDS CHARGES	Not Payable
123	BIPAP MACHINE	Device Not Payable. Rental charges for use during hospital are payable

124	COMMODE	Not Payable
125	CPAP / CAPD EQUIPMENTS	Device Not Payable. Rental charges for use during hospital are payable
126	INFUSION PUMP – COST	Device Not Payable. Rental charges for use during hospital are payable
127	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
128	PULSEOXYMETER CHARGES	Device Not Payable. Rental charges for use during hospital are payable
129	SPACER	Not Payable
130	SPIROMETRE	Payable
131	SPO2 PROBE	Not Payable
132	NEBULIZER KIT	Device Not Payable. Rental charges for use during hospital are payable
133	STEAM INHALER	Not Payable
134	ARMSLING	Payable for 1 (Qty) only for Fracture of upper arm cases
135	THERMOMETER	Not Payable
136	CERVICAL COLLAR	Not Payable
137	SPLINT	Not Payable
138	DIABETIC FOOT WEAR	Not Payable
139	KNEE BRACES (LONG / SHORT / HINGED)	Not Payable
140	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER	Not Payable
141	LUMBO SACRAL BELT	Payable for 1 (Qty) only for Fracture/Surgery Of Lumbar Spine.
142	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, All patients with Paraplegia/Quadriplegia for any reason is payable within Room Limit.
143	AMBULANCE COLLAR	Not Payable
144	AMBULANCE EQUIPMENT	Not Payable
145	MICROSHEILD	Not Payable
146	ABDOMINAL BINDER	Payable for 1 (Qty) only for Post Surgery Patients of Major Abdominal Surgery Including TAH, LSCS, Incisional Hernia Repair, Exploratory Laparotomy for intestinal Obstruction, Liver Transplant Etc.

V	ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
147	BETADINE \ HYDROGEN PEROXIDE \ SPIRIT \ DISINFECTANTS ETC	Payable under Hospital services
148	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES	Not Payable
149	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES	Patient Diet provided by hospital is payable
150	SUGAR FREE TABLETS	Payable - Sugar free variants of admissable medicines are not excluded
151	CREAMS POWDERS LOTIONS (Toileteries are not payable,only prescribed medical pharmaceuticals payable)	Payable when prescribed
152	DIGESTION GELS	Payable when prescribed
153	ECG ELECTRODES	Payable
154	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
155	HIV KIT	Payable - payable Pre operative screening
156	LISTERINE / ANTISEPTIC MOUTHWASH	Payable when prescribed
157	LOZENGES	Payable when prescribed
158	MOUTH PAINT	Payable when prescribed
159	NEBULISATION KIT	Payable for IPD patients
160	NOVARAPID	Payable when prescribed
161	VOLINI GEL / ANALGESIC GEL	Payable when prescribed
162	ZYTEE GEL	Payable when prescribed
163	VACCINATION CHARGES	Not payable, unless specified in policy
VI	**PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE**	
164	AHD	Not Payable - Part of Hospital's internal Cost
165	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
166	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
VII	**OTHERS**	
167	VACCINE CHARGES FOR BABY	Not payable, unless specified in policy
168	TPA CHARGES	Not Payable
169	VISCO BELT CHARGES	Payable for surgical cases like thoracic and lumbar spine
170	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
171	EXAMINATION GLOVES	Not Payable

172	KIDNEY TRAY	Not Payable
173	MASK	Not Payable
174	OUNCE GLASS	Not Payable
175	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not Payable
176	OXYGEN MASK	Not Payable
177	PAPER GLOVES	Not Payable
178	PELVIC TRACTION BELT	Payable for 1 (Qty) only for Of PIVD Requiring Traction.
179	REFERAL DOCTOR'S FEES	Not Payable
180	ACCU CHECK (Glucometery / Strips)	Not Payable
181	PAN CAN	Not Payable
182	SOFNET	Not Payable
183	TROLLY COVER	Not Payable
184	UROMETER, URINE JUG	Not Payable
185	AMBULANCE	Not payable, unless specified in policy
186	TEGADERM / VASOFIX SAFETY	Payable
187	URINE BAG	Payable
188	SOFTOVAC	Not Payable
189	STOCKINGS	Payable in cases of Varicose Veins and DVT if the claim is payable as per the Policy