



IFFCO-TOKIO GENERAL INSURANCE CO. LTD
Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

HEALTH PROTECTOR PLUS
UIN: IFFHLIP21328V022021

Policy Wording

This Policy is evidence of the contract between You and Us. The Proposal along with any written statement(s), declaration(s) of Yours for purpose of this Policy forms part of this contract.

This Policy witnesses that in consideration of Your having paid the premium for the period stated in the Schedule or for any further period for which We may accept the payment for renewal of this Policy, We will insure the Insured Person(s) and accordingly We will pay to You or to Insured Person(s) or their legal representatives as the case may be, in respect of events occurring during the Period of Insurance in the manner and to the extent set-forth in the Policy including endorsements, provided that all the terms, conditions, provisions, and exceptions of this Policy in so far as they relate to anything to be done or complied with by You and/or Insured Person(s) have been met.

The Schedule shall form part of this Policy and for purposes policy wording and schedule shall be read together.

Any word or expression to which a specific meaning has been attached in any part of this Policy or Schedule shall bear such meaning wherever it may appear.

The Policy is based on information which have been given to Us about Insured Person(s) pertaining to risk insured under the Policy and the truth of this information shall be condition precedent to Your or the Insured Person's right to recover under this Policy.

SECTION I **DEFINITION OF WORDS**

1. **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Age:** It means age of the Insured person on last birthday as on date of commencement of the Policy.
3. **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.
4. **AYUSH Treatment** refers to the hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems..
5. **AYUSH Hospital:**
An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
 - a. Central or State Government AYUSH Hospital or
 - b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or

- c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
- i. Having at least 5 in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iv. Maintaining daily records of the patients and making them accessible to Our authorized representative.
6. **AYUSH Day Care Centre**
AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
- i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
 - ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iii. Maintaining daily records of the patients and making them accessible to Our authorized representative.
7. **Break in Policy**
 It means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.
8. **Cashless facility** means a facility extended by Us 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.
9. **Condition Precedent** shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
10. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
- a. **Internal Congenital Anomaly:** Anomaly which is not in the visible and accessible parts of the body
 - b. **External Congenital Anomaly:** Anomaly which is in the visible and accessible parts of the body.
11. **Daycare centre**
 It 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 shall make these accessible to Our authorized personnel.
12. **Day Care Treatment** means medical treatment, and/or *surgical procedure* which:
- I. Is undertaken under General or Local Anesthesia in a *hospital/day care centre* in less than 24 (twenty-four) hrs. because of technological advancement, and
 - II. which would have otherwise required a hospitalization of more than 24 (twenty four) hours.

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

13. **Deductible**

It is 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.

The deductible shall be applicable on a per event basis in case of “Top Up” policy and on per year basis in case of “Super Top Up” policies.

14. **Dental Treatment** It means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

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

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

16. **Emergency Assistance Service Provider** means the licensed entity which will provide identified Emergency Medical Assistance and Personal Services to people travelling more than 150 kilometres from their declared place of residence in India

17. **Floater Benefit**

It means the amount of Sum Insured mentioned in the Policy Schedule which is common to the whole family covered under the policy which will be the maximum amount payable under this policy for all the covered family members put together, during the policy period if opted to be a Floater policy.

18. **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 the 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.

19. **Hospital/ Nursing Home**

It means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical

Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under 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 ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen 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 shall make these accessible to Our authorized personnel.

****Following are the enactments specified under the Schedule of section 56 of clinical Establishments (Registration and Regulation) Act, 2010 as of October 2013 or any amendments thereof.***

1. The Andhra Pradesh Private Medical Care Establishments (Registration and Regulation) Act, 2002.
2. The Bombay Nursing Homes Registration Act, 1949.
3. The Delhi Nursing Homes Registration Act, 1953.
4. The Madhya Pradesh Upcharya Griha Tatha Rujopchar Sanbabdu Sthapamaue (Ragistikaran Tatha Anugyapan) Adhiniyam, 1973.
5. The Manipur Homes and Clinics Registration Act, 1992.
6. The Nagaland Health Care Establishments Act, 1997.
7. The Orissa Clinical Establishments (Control and Regulation) Act, 1990.
8. The Punjab State Nursing Home Registration Act, 1991.
9. The West Bengal Clinical Establishments Act, 1950.

Note: Any make-shift or temporary hospital permitted temporarily by Central/ State Government and allowed by the IRDAI under specific situations shall also be regarded as a hospital.

20. **Hospitalization** means admission in a Hospital for a minimum period of 24 (Twenty-four) consecutive "In-patient Care" hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 (Twenty-four) consecutive hours.

21. **Illness**

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

- i. **Acute Condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
- ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
 - a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
 - b) it needs ongoing or long-term control or relief of symptoms
 - c) it requires rehabilitation for the patient or for the patient to be special trained to cope with it
 - d) it continues indefinitely
 - e) it recurs or is likely to recur

22. **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.

23. **Inpatient Care** means treatment for which the insured person has to stay in a *hospital* for more than 24 (twenty four) hours for a covered event.
24. **Insured Person** The Person(s) named as Insured Person(s) in the Schedule attached to the policy.
25. **Intensive Care Unit** means an identified section, ward or wing of a *hospital* which is under the constant supervision of a dedicated *medical practitioner(s)*, and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
26. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription
27. **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.
28. **Medically Necessary Treatment**—Medically necessary treatment is defined as any treatment, tests, medication, or stay in *hospital* or part of a stay in *hospital* which
- is required for the medical management of the illness or injury suffered by the insured;
 - must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - must have been prescribed by a *medical practitioner*,
 - Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
29. **Medical Practitioner** is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. The registered Medical Practitioner should not be the Insured or close family member
30. **Medical Services:** means the stipulated medical services offered by Emergency Assistance Service Provider during a medical emergency situation while You are away from home, consisting of medical consultation and evaluation, medical referrals, medically supervised repatriation.
31. **Migration**
It means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.
32. **Network Provider** means hospitals enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

The list of network hospitals is dynamic and hence may change from time to time. We suggest you to please check our website www.iffcotokio.co.in or contact our call centre/ nearest office for updated list of such hospitals before admission.

33. **Non- Network Provider** means any *hospital/* day care centre that is not part of the *network*.
34. **Notification of Claim** is the process of intimating a claim to Us or our TPA through any of the recognized modes of communication
35. **Out-Patient (OPD) treatment** means treatment 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.
36. **Personal Services** means the other emergency services offered by Emergency Assistance Service Provider during a medical emergency situation while You are away from home, consisting of message transmission, care of minor children left unattended due to medical incident, return of mortal remains, prescription assistance, and legal and interpreter referrals.
37. **Policy**
It means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person.
38. **Policy Period/ Period of Insurance** - It means period of one policy year as mentioned in the schedule for which the Policy is issued.
39. **Policy Schedule** - It means the Policy Schedule attached to and forming part of Policy.
40. **Policy year** - It means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.
41. **Portability** means the right accorded to an individual health insurance policy holder (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another.
42. **Post Hospitalization Medical Expenses**
It means Medical Expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the hospital, provided that:
- a) Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and
 - b) The inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
43. **Pre-existing Disease**

It means any condition, ailment, injury or disease

- a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
- b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

44. Pre-Hospitalization Medical Expenses

It means Medical Expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

- a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
- b) The In-patient Hospitalization claim for such Hospitalization is admissible by Us.

45. Proposal means any signed proposal by filing up the questionnaires and declarations, written statements and any information in addition thereto supplied to Us by You.

46. 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

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

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

49. Room rent It means the amount charged by a hospital towards room and boarding expenses and shall include the associated medical expenses.

50. Sum Insured means the monetary amount mentioned in the schedule as Sum Insured which is the limit of indemnity available to any of the Insured Persons severally or jointly and represents Our maximum liability under a claim and all claims in the aggregate in the Period of Insurance.

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

52. Terrorism/Terrorist Incident means any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption, or the commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not. Robberies or other criminal acts, primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be

considered terrorist activity. Terrorism shall also include any act, which is verified or recognized by the relevant Government as an act of terrorism.

53. **Third Party Administrator (TPA)** means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.
54. **Unproven/Experimental treatment** is treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
55. **Waiting Period**
It means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.
56. **We/Our/Us/Insurer** means **IFFCO-TOKIO GENERAL INSURANCE COMPANY LIMITED**.
57. **You/Your** means the Person(s) named as Insured in the Schedule, including all Insured Persons

Definitions of Critical Illnesses –

1. Cancer of Specified Severity:

- I. It means 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;

2. Myocardial Infarction (First Heart Attack of specific 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.

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

4. Open Heart Replacement Or Repair Of Heart Valves

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an 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.

5. Coma Of Specified Severity

- I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
 - i. no response to external stimuli continuously for at least 96 hours;
 - ii. life support measures are necessary to sustain life; and
 - iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
- II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. Kidney Failure Requiring Regular Dialysis

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

7. 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.

8. 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

9. Permanent Paralysis Of Limbs

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

10. Motor Neuron Disease With Permanent Symptoms

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

11. Multiple Sclerosis With Persisting Symptoms

- 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 multiple sclerosis are excluded.

12. Benign Brain Tumor

- I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.
- II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
 - i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
 - ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded: Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

13. Blindness

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

II. The Blindness is evidenced by:

- i. corrected visual acuity being 3/60 or less in both eyes or ;
- ii. the field of vision being less than 10 degrees in both eyes.

III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

14. Deafness

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

15. End Stage Lung Failure

1. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

- i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
- ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
- iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55\text{mmHg}$); and
- iv. Dyspnea at rest

16. End Stage Liver Failure

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

- i. Permanent jaundice; and
- ii. Ascites; and
- iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

17. Loss Of Speech

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords.

The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

18. Loss Of Limbs

The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

Physical Separation - It shall mean separation at or above the wrist and/or of the foot at or above the ankle respectively.

19. Primary (Idiopathic) Pulmonary Hypertension

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Catheterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

20. Major Head Trauma

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

iv. Mobility: the ability to move indoors from room to room on level surfaces;

v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

vi. Feeding: the ability to feed oneself once food has been prepared and made available.

1. The following are excluded:

i. Spinal cord injury;

21. Third Degree Burns

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.

22. Angioplasty

I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

II. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

III. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

SECTION II

A. COVERAGE

WHAT IS COVERED	WHAT IS NOT COVERED
<p>If the Insured Person contracts any Disease or sustains any Injury due to any accident (including any act of terrorism) and he/she has to incur Medically Necessary Hospitalization expenses, then We will pay Reasonable and Customary Charges of the following Hospitalization expenses:</p> <ol style="list-style-type: none"> 1. Room Rent (including Boarding and Nursing expense etc.) 2. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees (including consultation through telemedicine as per prevailing Telemedicine Practice Guideline) whether paid directly to the treating doctor / surgeon or to the hospital. 3. Expenses on Anesthesia, Blood, Oxygen, Operation Theatre, Surgical Appliances, Medicines and Drugs, Diagnostic Materials, diagnostic imaging modalities, Dialysis, Chemotherapy, radiotherapy, Cost of Pacemaker, Artificial Limbs, Cost of transplantation of Organs and similar expenses. 4. AYUSH hospitalization expenses Incurred in AYUSH Hospitals or AYUSH Day Care Centres. Coverage also includes pre- hospitalization and post hospitalization expenses. 5. Ambulance Charges: As per actual or Rs.3000/- (Three Thousand) per claim; 	<ol style="list-style-type: none"> 1. Any payment unless the admissible Medical Expenses exceeding the Deductible. 2. Pre-Existing Diseases(Code- Excl01) <ol style="list-style-type: none"> a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with us. b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase. c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage. d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us. 3. First Thirty Days Waiting Period(Code- Excl03) <ol style="list-style-type: none"> i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered. ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months. iii. The within referred waiting period is made

whichever is less.

6. An additional Daily Allowance amount equivalent to 0.10% of the Sum Insured for the duration of Hospitalization towards defraying of miscellaneous expenses.
7. The above stated relevant expenses (except for clause 5 and 6), incurred for Domiciliary Hospitalisation, if Medically Necessary and at Reasonable and Customary Charges up to a maximum aggregate sub-limit of 20% (Twenty percent) of the Sum Insured.

Note:

- (a) Hospitalization expenses of person donating an organ during the course of organ transplant will also be payable subject to the limit of overall Sum Insured of the Insured Person or floater Sum Insured of family. For the Donor, no payment will be made towards Pre and Post Hospitalization expenses.
- (b) Pre-Hospitalization and Post Hospitalization expenses for 60(Sixty) and 90(Ninety) days respectively as defined under the Policy will also be reimbursed along with the aforesaid Hospitalization expenses subject to the overall Sum Insured limit of the Insured Person. Any Nursing expenses during Pre and Post Hospitalization will be considered only if Qualified Nurse is employed on the advice of the attending Medical Practitioner for the duration specified

Note 2: The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4. Specific Waiting Period: (Code- Excl02)

- a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage, as may be the case after the date of inception of the first policy with Us. This exclusion shall not be applicable for claims arising due to an accident.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
- d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
- f) List of specific diseases/procedures

24 Months waiting period

- i. Cataract
- ii. Benign Prostatic Hypertrophy,
- iii. Hysterectomy (for other than due to carcinoma),
Myomectomy, Endometriosis
- iv. Hernia, Hydrocele
- v. Fissures &/or Fistula in anus, Piles,
pilonidal sinus
- vi. Sinusitis & related disorders
- vii. Stones in the urinary and biliary systems
- viii. Gastric and Duodenal Ulcers
- ix. Dilatation and Curettage
- x. Joint Replacement (other than
caused by an accident)
- xi. Arthritis, Gout, Rheumatism and Spinal

Disorders

- xii. Chronic Renal failure or End Stage Renal Failure.
 - xiii. Any type of Cysts/Nodules/Polyps including breast lumps and any other benign growth
 - xiv. Varicose Veins / Varicose Ulcers
 - xv. Intervertebral disc diseases (other than caused by an accident)
5. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds
6. Circumcision, unless necessary for the treatment of a disease not otherwise excluded or required as a result of accidental bodily Injury, vaccination unless forming part of post-bite treatment, inoculation.
7. **Cosmetic or plastic Surgery: Code- Excl08**
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
8. Cost of spectacles and contact lens or hearing aids.
9. Dental treatment or surgery of any kind, unless requiring Hospitalization.
10. **Rest Cure, rehabilitation and respite care- Code- Excl05**
- a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
 - i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either

by skilled nurses or assistant or non-skilled persons.

- ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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

12. Breach of law: Code- Excl10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

13. Treatment of, external congenital Disease or defects or anomalies, venereal Disease or intentional self-Injury

14. Investigation & Evaluation (Code- Excl04)

- a) Expenses related to any admission primarily for diagnostics and evaluation purposes.
- b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.

15. Maternity Expenses (Code - Excl18):

- i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- ii. expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

16. Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility. This includes:

- i. Any type of contraception, sterilization
- ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- iii. Gestational Surrogacy
- iv. Reversal of sterilization

17. Nuclear attack or weapons, contributed to,

caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense.

For the purpose of this exclusion:

- a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.

18. Any Medical Expense on OPD Treatment.

19. Unproven Treatments: Code- Excl16

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

20. Any expense on procedure and treatment including acupressure, acupuncture and magnetic.

21. Hazardous or Adventure sports: Code- Excl09

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

22. Expenses related to any treatment necessitated due to participation as a non-professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving

23. External/Durable medical/non-medical equipment of any kind which can be used at home subsequently except the medicines or the solutions required for the treatment.

24. All non-medical expenses including personal comfort and convenience items or services and similar incidental expenses or servicing including ayah/ barber, cosmetics and napkins.

25. Obesity/ Weight Control: Code- Excl06

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

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

26. Change-of-Gender treatments: Code- Excl07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex

27. Pre-natal and post-natal expenses.

28. Any consequential or indirect loss or expenses arising out of or related to the Hospitalization.

29. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of license or registration granted to him by any medical Council.

30. Any kind of Service charges, Surcharges, levied by the hospital.

31. Any expense under Domiciliary Hospitalization for

Treatment of following Diseases:

- (i) Asthma
- (ii) Bronchitis
- (iii) Chronic Nephritis and Nephritic Syndrome
- (iv) Diarrhea and all type of Dysenteries including Gastro-enteritis
- (v) Diabetes Mellitus
- (vi) Epilepsy
- (vii) Hypertension
- (viii) Influenza, Cough and Cold
- (ix) Pyrexia of unknown origin for less than 15 days
- (x) Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis
- (xi) Arthritis, Gout and Rheumatism
- (xii) Dental Treatment or Surgery
- (xiii) Critical illness

32. Excluded Providers: Code- Excl11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

(Note: The list of such excluded provider(s) is dynamic and hence may change from time to time. Hence we suggest you to please check our website or contact our call centre/nearest office for updated list of such excluded hospitals before admission.)

33. Refractive Error: Code- Excl15:

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries

34. Any other type of Laser treatments / surgeries for EYE which can be performed on OPD basis

35. Cytotron Therapy, Rotational Field Quantum Magnetic Resonance (RFQMR), EEC (Enhanced External Counter Pulsation) Therapy, Chelation Therapy, Hyperberic Oxygen Therapy

36. Interferon injections / Infliximab and like injections / Intra-articular injections. Intravenous Chemotherapy where no monitoring under Doctor Supervision is required in Hospital Setting. For example: Intravenous Cyclophosphamide, Intravenous Methotrexamate, etc.

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

38. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **Code- Excl14**

SECTION II

B. OPTIONAL COVERAGE

WAIVER OF DEDUCTIBLE:

The deductible is waived in case of loss or change of employment, if the policy is endorsed to waive the deductible at inception in consideration of additional premium. The proviso shall be subject to the following conditions:

- a) The cover is applicable only for insured persons who are in service (not for self employed) and are below 55 (Fifty Five) years of age and their dependents
- b) The cover shall be subject to a maximum period of Waiver of Deductible (WOD) period mentioned in the schedule.
- c) In case of multiple job changes during the same policy period, aggregate number of days of coverage during all such breaks shall be subject to maximum of WOD period mentioned in the schedule.
- d) Letter of intent for utilization of WOD period should be given at least 15 (Fifteen) days before the date of relieving from the existing job. Intent letter should be supported with relevant documents like resignation/termination/ relieving letter or any other similar document.
 - i. Advance Notice of 15 days for Letter of intent to cover may be waived on merits by the underwriting authority on case to case base, provided the notice is given on or before the date of relieving.

- ii. In case notice is given after date of relieving within a reasonable time, WOD may be granted from the date of notice, subject to confirmation of loss of job and of date of relieving, at the discretion of underwriter on case to case basis.
 - e) The waiver shall be effective from the next day of date of relieving from the existing job.
 - f) The cover will cease on the occurrence of any of the following events, whichever shall occur first:
 - i. expiry of Waiver of Deductible period
 - ii. Request for termination of cover for WOD by the insured.
- Request for termination of WOD cover should be given by the insured as soon as the cover under the Employee Health Benefit with the new employer or a new Health Insurance policy commences. In case of failure to give such notice to the company, the entire WOD period shall be deemed to have exhausted and no further waiver be allowed during the policy period.
- g) WOD cover for dependents will simultaneously cease along with the cover of proposer.
 - h) All other terms and conditions will be applicable as per the coverage.

SECTION III

1. Basis of Payment:

I. TOP-UP COVER:

- a) Basis of claim payment shall be Medical expenses incurred for each event (hospitalization) incepting during each policy year payable under 'What is covered' and which exceed the Deductible mentioned in the Schedule of the Policy
- b) Each event (hospitalization), if more than one, during the Policy period shall be separately subject to the specified Deductible mentioned in the Schedule of the Policy except in case of relapse within 45 (Forty Five) days, as defined under Any One Illness, this will be applicable for Individual Policy where each Insured Person has a separate Sum Insured as well as for Policy based on single floater Sum Insured for whole family
- c) In no case we shall be liable to pay any sum in excess of the Sum Insured during the period of the Policy
- d) All the Bills, Receipts, Reports and Discharge summary etc in respect of the claim should be submitted to us.

II. SUPER TOP-UP COVER:

- a) Basis of claim payment shall be aggregate of Medical expenses incurred for all hospitalization/s incepting during each policy year payable under 'What is covered' and which exceeds the Deductible mentioned in the Schedule of the Policy
- b) Deductible shall be separately applicable on per year basis on aggregate of Medical expenses incurred under 'What is covered' for each Insured person in case of Individual Policy or Deductible shall be applicable on per year basis on aggregate of Medical expenses payable in 'What is covered' for all Insured persons in case Single floater Sum Insured is opted for the whole Family.

- c) In no case we shall be liable to pay any sum in excess of the Sum Insured during the period of the Policy
- d) All the Bills, Receipts, Reports and Discharge summary etc in respect of all the claims adding up to the aggregate including claims falling within the deductible should be carefully preserved and submitted along with the claim to US whenever YOU are making a claim under Super Top Up Cover.

2. Option to buy Standard Health Policy with continuity of benefits:

We will offer the Insured with the option to buy the standard Health policy (Individual/floater Health product) without deductible with continuity of coverage in terms of waiver of waiting periods to the extent of deductible opted under this Policy provided

- o the Top Up/ Super Top up health product has been purchased for the first time before 50(Fifty) years of age and
- o Continuously renewed without break for a period of at least 4(Four) years.

In such case you will be offered continuity of coverage in terms of waiver of waiting periods to the extent of deductible opted under this Policy. In all other cases, no benefits shall accrue to any Insured Person by virtue of continuity of coverage in the event of discontinuation of this Policy at any point of time or shifting to any other health insurance Policy with Us

SECTION IV: ADDITIONAL BENEFITS

1. MODERN TREATMENT METHODS AND ADVANCEMENT IN TECHNOLOGIES:

The following procedures will be covered (wherever medically indicated) either as in patient or as part of Domiciliary Hospitalization or as part of day care treatment in a hospital upto 50% of Sum Insured, during the policy period:

- A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
- B. Balloon Sinuplasty
- C. Deep Brain stimulation
- D. Oral chemotherapy
- E. Immunotherapy- Monoclonal Antibody to be given as injection
- F. Intra vitreal injections
- G. Robotic surgeries
- H. Stereotactic radio surgeries
- I. Bronchial Thermoplasty
- J. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
- K. IONM - (Intra Operative Neuro Monitoring)
- L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

- 2. DAY CARE TREATMENT:** Day care medical treatments listed in Annexure – “List of Day Care Procedures” of the policy document, will be payable even if the duration of hospitalization is less than 24 (Twenty-four) hours. (Note: The list of such treatments is dynamic and hence may change from time to time. Hence we suggest you to please check our website/ contact our nearest office for updated list of such treatments.)

3. EMERGENCY ASSISTANCE SERVICES

1. This policy provides, at no additional cost, whatsoever, a host of value added emergency medical assistance and emergency personal services as described below. The services are provided when insured person(s) is/are traveling within India 150(one hundred and fifty) kilometers or more away from the residential address as mentioned in the policy schedule for less than 90(ninety) days. No claims for reimbursement of expenses incurred for services arranged by insured/insured person(s) will be entertained unless agreed by us or our authorized representative. Wherever, it is not reasonably possible to ascertain if the reported situation was an emergency or not, the benefit of doubt shall be available to you in respect of the insured person.
 - a) Medical consultation, evaluation and referral: Insured person(s) has/have access to an operations center with multilingual medical staff on duty 24(twenty four) hours a day, throughout the policy period year. Medical personnel are available for medical consultation, evaluation and referrals to qualified physicians.
 - b) Emergency medical evacuation: If insured person(s) has/have a medical emergency and an adequate medical facility is not available (as determined by physician and the consultant physician) proximate to where insured person(s) is/are located, we/our representative will arrange an emergency evacuation, with medical supervision, by an appropriate means to the nearest medical facility capable of providing the required care.
 - c) Medical repatriation: When medically necessary, as determined by us / our physician and the consulting physician, repatriation under medical supervision to insured person(s)/your address as mentioned in the policy schedule at such time as insured person(s) is/ are medically cleared for travel via commercial carrier, provided the repatriation can be accomplished without compromising insured person(s) medical condition. If the time period to receive medical clearance to travel by common carrier exceeds 14(fourteen) days from the date of discharge from the hospital, an appropriate mode of transportation may be arranged by us/our representative, such as an air ambulance. Medical or non-medical escorts may also be provided, if necessary.
 - d) Transportation to join patient: We will provide a designated family member or personal friend with an economy, round-trip, common carrier transportation to the major airport closest to the place of hospitalisation, provided insured person (s) has/ have travelled alone and insured person(s) is/ are required to be hospitalized for more than seven consecutive days. At insured person (s) request, we/our representative will also provide assistance with regards to arrangements for the accommodation of family member or the friend. It is the responsibility of the family member or the friend to meet all documentary requirements for the travel and accommodation costs.
 - e) Care and/or transportation of minor children: When insured person(s)'s minor child(ren) is/are left unattended as a result of insured person (s) medical situation, we/our representative will provide the child with transportation to home or to the home of a person designated by insured person (s) living in the same city as insured person (s) address. If appropriate, an attendant will escort the child.
 - f) Emergency message transmission: we/our representative will receive and transmit emergency messages to/from home.
 - g) Return of mortal remains: In the event of death of insured person, we/our representative will arrange and pay for the return of mortal remains. we/our representative will render any assistance necessary in the transport including locating a local, emergency assistance funeral home, mortuary or direct disposition facility to prepare the body for transport, completing all documentation, obtaining all legal

clearances, providing death certificates, purchasing the minimally necessary casket or air transport container, as well as transporting the remains, including retrieval from site of death and delivery to receiving funeral home.

- h) Emergency cash coordination: We/our representative will assist in coordinating the transfer of emergency cash. Source of funds is solely your responsibility

Conditions:

1. The Emergency Assistance Services-Medical and Personal are not available on reimbursement basis.
2. The provision of the Emergency Medical or Personal Assistance Services to You during the Period of Insurance does not necessarily mean that the hospitalization claim is admissible under the Policy.

Exclusions: The emergency assistance services are available subject to certain limited exclusions as set forth below:

Emergency assistance service will not be provided in the following instances:

- a) Travel undertaken specifically for securing medical treatment
- b) Services sought outside India.
- c) Injuries resulting from participation in acts of war or insurrection
- d) Commission of unlawful act(s) with malafide intent.
- e) Attempt at suicide /self inflicted injuries
- f) Incidents involving the use of drugs, unless prescribed by a physician
- g) Transfer of the insured person from one medical facility to another medical facility of similar capabilities and providing a similar level of care

We/our representative will not evacuate or repatriate an insured person in the following instances:

- a) Without medical authorization
- b) With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness which can be treated by local doctors and do not prevent insured person (s) from continuing your trip or returning home
- c) With a pregnancy term of over six (6) months
- d) With mental or nervous disorders unless hospitalized.

Specific exclusions:

- a) Trips exceeding 90(ninety) days from declared residence without prior notification to emergency assistance service provider.
- b) Students at home/school campus address (as they are not considered to be in travel status).

Legal actions arising hereunder shall be barred unless written notice thereof is received by us, within one (1) year from the date of event giving rise to such legal action.

While assistance services are available all over India, transportation response time is directly related to the location/jurisdiction where an event occurs. We shall not be responsible for failing to provide services or for delays in the delivery of services caused by strikes or conditions beyond our control, including by way of example and not by limitation, weather conditions, availability of airports, flight

conditions, availability of hyperbaric chambers, communications systems or where rendering of service is limited or prohibited by local law or edict.

All consulting physicians and attorneys are independent contractors and not under our control. We/our representative are not responsible or liable for any malpractice committed by professionals rendering services to you.

CLAIM PROCEDURE AND REQUIREMENTS:

- a. Notification of Claim: An event which might become a claim under the Policy must be reported to Us as soon as possible, but not later than 7(Seven) days from the date of Hospitalization. Such notification of claim is mandatory, even for claims falling within the deductible.

A written statement of the claim will be required and the claim must be filed as under except in extreme cases of hardship where it is proved to Our satisfaction that under the circumstances in which You / Insured Person or his/her personal representative were placed, it was not possible for any one of You to give notice or file claim within the prescribed time limit.

- i. Hospitalization and Pre Hospitalization claim should be filed within 30(thirty) days from the date of discharge from the Hospital
- ii. Post Hospitalization claim should be filed within 90(ninety) days from the date of discharge from the hospital. Hospitalization and Post Hospitalization claims may be submitted together within 90(ninety) days from the date of discharge at the option of the insured.
- b. If IFFCO-TOKIO seeks any further clarification or documents in support of the claim, the same should be provided along with all supporting documents within 15(Fifteen) days from the date of such requirement from IFFCO-TOKIO.
- c. In case of covered Hospitalization, the costs of which were not initially estimated to exceed the Deductible but were subsequently found likely to exceed the Deductible, the intimation should be submitted along with details of intimation made to the other insurer/reimbursement provider immediately on knowing that the Deductible is likely to be exceeded
- d. For cashless Hospitalization, the insured must contact the Third Party Administrator/Company at least 48(Forty eight) hours before a planned Hospitalization. In an emergency situation the Third Party Administrator/Company should be contacted within 24(twenty four) hours of Hospitalization.
- e. Necessary documents: The Insured Person must give all original bills, receipts, certificates, information and evidences from the attending Medical Practitioner/Hospital/Chemist/Laboratory as required by Us in the manner and form as We may prescribe. In such claims, Our representative shall be allowed to carry out examination and obtain information on any alleged Injury or Disease requiring Hospitalization if and when We may reasonably require.

The claim should be filed along with duly filled in claim form and all other documents supporting your claim as required by the company. Following is an indicative list of "Necessary documents" to be submitted along with the claim.

- i. Claim Form duly filled in and signed – As per prescribed format (Form B to be filled in and signed by the Hospital authorities under seal)

- ii. Copy of Photo ID / Proof
- iii. Discharge Summary (Photo Copy in case of claim for Pre/Post Hospitalization only)
- iv. Hospital Bill (Original Only)
- v. Hospital Receipt (Original Only)
- vi. Investigation Reports with supporting prescriptions
- vii. Investigation Bills (Original Only)
- viii. Pharmacy Bills (Original Only)with supporting prescriptions
- ix. Bills including the relevant stickers for Implants
- x. All previous treatment papers related to Ailment.
- xi. All the above in respect of the previous hospitalizations adding up to the aggregate including claims falling within the deductible should be carefully preserved and submitted along with the claim to US whenever YOU are making a claim under Super Top Up Cover.
- xii. Copy/Copies of previous insurance policies if not provided already
- xiii. Registration Certificate of the Hospital under Clinical Establishment Act or similar state act for medical establishments. Please note registration under Shops and Establishment Act, Registration with CMO etc. are not sufficient to meet the requirements of policy.
- xiv. KYC (know your customer) form, if claim is more than 1(One) lakh
- xv. Any other documents in support of the claim (Pl Specify)

Note:

- 1) When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organization/provider have to be submitted.
- 2) If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming from other organization/provider, then on request from the Insured Person We will provide attested copies of the bills and other documents submitted by the Insured Person.

(a) Notification of Claim: An event which might become a claim under the Policy must be reported to Us as soon as possible, but not later than 7 days from the date of Hospitalization. A written statement of the claim will be required and a Claim Form will be completed and the claim must be filed within 30 days from the date of discharge from the Hospital or completion of treatment, except in extreme cases of hardship where it is proved to Our satisfaction that under the circumstances in which You / Insured Person or his/her personal representative were placed, it was not possible for any one of You to give notice or file claim within the prescribed time limit.

For all claims (cashless/reimbursement) the following documents are required:

- i. Claim Form duly filled in and signed – As per prescribed format (Form B to be filled in and signed by the Hospital authorities under seal)
- ii. Copy of Photo ID / Proof
- iii. Discharge Summary (Photo Copy in case of claim for Pre/Post Hospitalization only)
- iv. Hospital Bill (Original Only)
- v. Hospital Receipt (Original Only)
- vi. Investigation Reports with supporting prescriptions
- vii. Investigation Bills (Original Only)
- viii. Pharmacy Bills (Original Only)with supporting prescriptions
- ix. Bills including the relevant stickers for Implants
- x. All previous treatment papers related to Ailment of last 4 years. (In some cases, we may ask for more than 4 years record if required)

- xi. Copy/Copies of previous insurance policies if required (in case not provided earlier)
- xii. Registration Certificate of the Hospital under Clinical Establishment Act or similar state act for medical establishments. Please note registration under Shops and Establishment Act, Registration with CMO etc. are not sufficient to meet the requirements of policy.
- xiii. KYC (know your customer) form, if claim is more than 1(One) lakh
- xiv. Any other document if insured wants to furnish in support of the claim (PI Specify)

Our representative shall be allowed to carry out examination and obtain information on any alleged Injury or Disease requiring Hospitalization if and when We may reasonably require at Our cost.

(b) Claim Settlement (provision for Penal Interest)

- i. We shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- ii. In the case of delay in the payment of a claim, We shall be liable to pay interest to You/the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate**
- iii. However, where the circumstances of a claim warrant an investigation in Our opinion, 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 or reject the claim within 45 days from the date of receipt of last necessary document.
- iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate** from the date of receipt of last necessary document to the date of payment of claim.

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

Note : This Clause shall always correspond with the amendment(s), if any, to the relevant provisions of Protection of Policyholder's Interests Regulations, 2017.

General Conditions

1. Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to us, in the event of misrepresentation, mis-description or non-disclosure of any material fact* by you/policyholder.

*Material facts for the purpose of this policy shall mean all relevant information sought by Us in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

(Note: We, at our discretion, might choose to continue the policy by imposing a waiting period or by taking any other measures in such an event of non-declaration/ mis-representation of material facts that surface during the course of the policy contract.)

2. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by You /the insured person for Us to make any payment for claim(s) arising under the policy.

3. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow Us or Our representatives to inspect such records. You/ Insured Person shall furnish such information as We may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

4. **Complete Discharge**

Any payment to You/the policyholder/insured person or your/his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by Us to the extent of that amount for the particular claim.

5. **Multiple Policies**

- i. In case of multiple policies taken by You/ insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
- ii. You/Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
- iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
- iv. Where You/Insured person has policies from more than one insurer to cover the same risk on indemnity basis, You/the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

6. **Fraud**

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to Us.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by You/the insured person or by your/his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive Us or to induce Us to issue an insurance policy:

- a) the suggestion, as a fact of that which is not true and which You/the insured person do/does not believe to be true;
- b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
- c) any other act fitted to deceive; and
- d) any such act or omission as the law specially declares to be fraudulent

We shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

7. **Cancellation**

- a) You/the Policy holder may cancel this Policy by giving 15 days’ written notice, and in such an event, We shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Period of cover upto	Refund of Annual Premium Rate (%)
1 month	75.00%
3 months	50.00%
6 months	25.00%
6 to 12 months	0.00%

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

- b) We may cancel the Policy at any time on grounds of mis-representation, non-disclosure of material facts, fraud by the Insured Person, by giving 15 days’ written notice. There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of material facts or fraud.

8. **Migration**

You/the Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by Us by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration.

If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by Us, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

9. **Portability**

You/the Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability.

If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_Layout.aspx?page=PageNo2908&flag=1

https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

10. **Renewal of Policy**

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by You/the insured person.

- i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years
- iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period
- iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- v. No loading shall apply on renewals based on individual claims experience.
- vi. The Premium applicable for renewal shall be based on the rating factors like Age, Sum Insured etc. However no loading shall be applied on individual claims experience.
- vii. Sum Insured can be enhanced at the time of renewal for which fresh proposal form and medical reports will be required to be submitted. However the waiting periods will apply afresh for the enhanced sum insured

11. Withdrawal of Policy

- i. In the likelihood of this product being withdrawn in future, We will intimate You/the insured person about the same 90 days prior to expiry of the policy.
- ii. You/ Insured Person will have the option to migrate to similar health insurance product available with Us at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

12. Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period, no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

13. Possibility of Revision of Terms of the Policy Including the Premium Rates

We, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. You shall be notified three months before the changes are affected.

14. Free look period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting/ migrating the policy.

You/the insured shall be allowed a period of fifteen days from date of receipt of the Policy document to review the terms and conditions of the Policy, and to return the same if not acceptable.

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

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

15. Nomination

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

16. Notice & Communication

- i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
- ii. Such communication shall be sent to Our address or through any other electronic modes specified in the Policy Schedule.
- iii. We shall communicate with You/ Insured person at the address or through any other electronic mode mentioned in the schedule.

17. No Constructive Notice

Any knowledge or information of any circumstance(s) or condition in connection with you / insured person(s), in possession of any of our official shall not be the notice to or be held to bind or prejudicially affect us notwithstanding subsequent acceptance of the premium.

18. Notice of Charge

We will not be bound to take cognizance or be affected by any notice of trust, charge, lien, assignment or other dealings with or relating to this policy. Your receipt or receipt of insured person shall in all cases be an effective discharge to us.

19. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only and all claims shall be payable in Indian currency.

20. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

21. Automatic change in Coverage under the policy

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

- a) In the case of his/ her (Insured Person) demise. However the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to Us along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

- b) Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

22. Endorsements (Changes in Policy)

- i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except Us. Any change made by Us shall be evidenced by a written endorsement signed and stamped.
- ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by Us and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

23. Changes in Circumstances

You must inform us, as soon as reasonably possible of any change in information you have provided to us about insured person(s) which may affect the insurance cover provided.

24. Increase in Sum Insured or Reduction in Deductible

If You renew with Us or transfer from any other Insurer and increase the Sum Insured or reduce Your deductible, then the waiting periods mentioned under Exclusion numbers 2, 3 and 4 shall apply fresh in relation to the amount by which the Sum Insured has been increased or Deductible has been reduced.

25. Terms and conditions of the Policy

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

26. Payment of Premium:

The premium payable shall be paid in advance before commencement of risk.

27. Electronic Transaction

You /insured person(s) agree(s) to adhere to and comply with all such terms and conditions as we may prescribe from time to time and hereby agree(s) and confirm(s) that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centers, teleservice 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 or our other products and services, 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. However, the terms of the condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDA regulations for protection of policy holder's interests.

28. Reasonable Precaution

You/insured person(s) shall take all reasonable precaution to prevent injury, illness, and disease in order to minimize claims.

29. Disclaimer Clause

If we shall disclaim our liability for any claim and such claim shall not have been made subject matter of suit in a court of law within 12(twelve) months from date of disclaimer, then the claim shall for all purpose be deemed to have been abandoned and shall not thereafter be recoverable under this policy.

30. Arbitration

- i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
- ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.
- iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

31. Provision for Senior Citizens

Separate channel to address the related claims and grievances of senior citizen are mentioned below:

Claims/ Grievance: seniorcitizengrievance@iffcotokio.co.in

Courier: Chief Grievance Officer
IFFCO-Tokio General Insurance Co Ltd
IFFCO Tower, Plot no. 3
Sector -29, Gurgaon - 122001

32. Redressal Of Grievance

In case of any grievance, the insured person may contact Us through:

Website: <https://www.iffcotokio.co.in/customer-services/grievance-redressal>

Toll free: 1800-103-5499

E-mail: support@iffcotokio.co.in

Courier : Chief Grievance Officer
IFFCO-Tokio General Insurance Co Ltd
IFFCO Tower, Plot no. 3
Sector -29, Gurgaon - 122001

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. The list of branches with addresses are available at <https://www.iffcotokio.co.in/contact-us>

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at chiefgrievanceofficer@iffcotokio.co.in

For updated details of grievance officer, kindly refer the link

<https://www.iffcotokio.co.in/customer-services/grievance-redressal>

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal

of grievance as per Insurance Ombudsman Rules 2017. The contact details of the Insurance Ombudsman offices have been provided as below

Grievance may also be lodged at IRDAI Integrated Grievance Management System

- <https://igms.irda.gov.in/>

Office Details	Jurisdiction of Office (Union Territory, District)
<p>AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in</p> <p>BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in</p>	<p>Gujarat, Dadra & Nagar Haveli, Daman and Diu.</p> <p>Karnataka.</p>
<p>BHOPAL - Shri Guru Saran Shrivastava 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@ecoi.co.in</p> <p>BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in</p> <p>CHANDIGARH - Dr. Dinesh Kumar Verma 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</p>	<p>Madhya Pradesh Chattisgarh.</p> <p>Orissa.</p> <p>Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.</p>

Office Details	Jurisdiction of Office Union Territory, District)
<p>Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in</p> <p>CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in</p>	<p>Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).</p>
<p>DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in</p>	<p>Delhi.</p>
<p>GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in</p> <p>HYDERABAD - Shri I. Suresh Babu 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 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in</p> <p>JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in</p> <p>ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman,</p>	<p>Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.</p> <p>Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.</p> <p>Rajasthan.</p> <p>Kerala, Lakshadweep,</p>

Office Details	Jurisdiction of Office Union Territory, District)
<p>2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in</p> <p>KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in</p>	<p>Mahe-a part of Pondicherry.</p> <p>West Bengal, Sikkim, Andaman & Nicobar Islands.</p>
<p>LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in</p>	<p>Districts of Uttar Pradesh :</p> <p>Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.</p>
<p>MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in</p> <p>NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301.</p>	<p>Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.</p> <p>State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad,</p>

Office Details	Jurisdiction of Office Union Territory, District)
Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Insurance is the subject matter of solicitation

SECTION VI LOADINGS

1. Loading for Predisposing Factors (PDF)

The loading structure for different PDFs is as follows:

Predisposing Factor	Loading on Base premium for each member
(A) Diabetes : Range of HbA1C Level	
> 6 and < 7	10% (Ten percent)
>= 7 and <= 8	15% (Fifteen percent)
More than 8	25% (Twenty Five percent)
(B) Hypertension	
	10% (Ten percent)
(C) Obesity : Range of Body Mass Index (BMI)	
> 28 and < 32	5% (Five percent)
>= 32 and <= 35	10% (Ten percent)
More than 35	25% (Twenty Five percent)

2. In case of Adverse Medical History / Pre-existing Diseases other than Pre-disposing factors (PDF) mentioned above- up to 20% loading will be applicable on base premium separately for each member.

Note:

If there is more than one member having PDF or Adverse Medical history/Pre-existing diseases, the loading will apply on base premium separately for each member.

- Loadings as mentioned in (1) and (2) above will be applicable only if any of the above mentioned conditions are pre-existing at the time of inception of the first policy with the Company and will continue to be charged at every renewal.
However, No loading will be charged, if these conditions manifest after the inception of the first policy with the Company.
- Loadings for (1) and (2) for all factors put together will not exceed:
 - a) 50% of the basic premium per person for an Individual Sum Insured policy and
 - b) 35% of the basic premium per person for a Floater Sum Insured policy.
- Range of HbA1C Level and BMI will be reviewed after every three renewals, wherever loading is already applied for these factors at the time of inception of policy for the first time with the Company.

In case there is an improvement in HbA1C level and BMI, then the loading may be withdrawn or reduced according to the value of parameters. However no further loading shall be done for worsening of the situation.

DISCOUNTS

1. In case of Individual basis, a Family discount on total premium, depending upon the total number of insured persons covered under the policy at the inception of the cover is permissible as below:
 - For 2 (Two) Family Members- 5% discount on total premium.
 - For 3 and more Family Members- 10% discount on total premium.

This family discount is offered on account of savings in management expenses and reduced probability of anti- selection.

2. For online purchase, a discount of 15% will be given on the total premium computed. This discount is in lieu of agency commission.

Annexure - A

List I – List of non-payable Items

Sl. No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES

3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT

48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

Sl No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS

20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

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

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

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