# Shri Health Suraksha Insurance Policy Wording
# UIN: SGLHLIP26035V032627

## 1. PREAMBLE

This Policy is a contract been is a contract of insurance issued by Shriram General Insurance Co. Ltd. (hereinafter called the 'Company') to the Proposer mentioned in the Schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The Policy is based on the statements and declaration provided in the Proposal Form by the Proposer and is subject to receipt of the requisite premium.

## 2. OPERATIVE CLAUSE

If during the Policy Period one or more Insured Person (s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital/ Day Care Center, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically Necessary, Reasonable and Customary Medical Expenses towards the Coverage mentioned the policy schedule.

Provided further that, any amount payable under the Policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) specified in the Schedule.

## 3. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

1. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Age** 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 forty-five days from the date of last consultation with the hospital where treatment has been taken.
4. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
5. **An AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment and procedure carried out by AYUSH Medical Practitioner(s) comprising of any of the following.
   a. Central and State Government AYUSH Hospital, or
   b. Teaching hospitals attached to AYUSH Colleges recognized by Central Government/Council of Indian Medicine/Central Council of Homeopathy, or
   c. AYUSH Hospitals standalone or co-locted with in-patient healthcare facility of recognized system of medicine, registered with local authority where applicable, and is under the supervision of qualified registered AYUSH Medical Practitioner and must comply with all the following creation:
      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 operation procedure are to be carried out.
      iv. Maintains daily records of patients and makes these accessible to the Company's authorized representative
6. **AYUSH Day Care Centre** means and include Community Health Center(CHC), Primary Health Center(PHC), Dispensary, Clinic, Policlinic or any such health center which is registered with local authorities where applicable and having facility for carrying out treatment procedure and medical or surgical/para- surgical interventions or both the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient service must comply with all the following criterion.
   i. Having qualified AYUSH Medical Practitioner in charge round the clock
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theater where operation procedure are to be carried out.
   iii. Maintains daily records of patients and makes these accessible to the Insurance Company's authorized representative.

7. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
8. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured person 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** means a Policy term or condition upon which the Company'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.
11. **Internal Congenital Anomaly**
    Congenital anomaly which is not in the visible and accessible parts of the body.
12. **External Congenital Anomaly**
    Congenital anomaly which is in the visible and accessible parts of the body.
13. **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
14. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
15. **Day Care Centre** means any institution established for day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:
    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 the Company's authorized personnel.
16. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
    i. undertaken under general or local anesthesia in a hospital/day care centre in less than twenty four hrs because of technological advancement, and
    ii. which would have otherwise required a hospitalisation of more than twenty-four hours.
    iii. Treatment normally taken on an out-patient basis is not included in the scope of this definition.
17. **Dental Treatment** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.
18. **Disclosure to information norm** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
19. **Emergency Care** Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.
20. **Family** means, the Family that consists of the proposer and any one or more of the family members as mentioned below:
    i. Legally wedded spouse.
    ii. Parents and Parents-in-law.
    iii. Dependent Children (i.e. natural or legally adopted) between the age 3months to 25 years. If the child above 18 years is financially independent, he or she shall be ineligible for coverage in the subsequent renewal

21. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

22. **Hospital:** means any institution established for in-patient care and day care treatment of disease/ 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 lacs 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 the Company's authorized personnel.

23. **Hospitalization:** means admission in a hospital for a minimum period of twenty-four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty-four (24) consecutive hours.

24. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

25. **Acute Condition** means a disease, illness or injury that is likely to response 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.

26. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
    i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
    ii. it needs ongoing or long-term control or relief of symptoms
    iii. it requires rehabilitation for the patient or for the patient to be special trained to cope with it
    iv. it continues indefinitely
    v. it recurs or is likely to recur

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

28. **In-Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

29. **Insured Person** means person(s) named in the schedule of the Policy.

30. **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.

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

32. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

33. **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.

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

    Note – The registered practitioner should not be the insured or close member of the family

35. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
    i. Is required for the medical management of illness or injury suffered by the insured ;
    ii. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii. Must have been prescribed by a medical practitioner;
    iv. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

36. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

37. **Network Provider** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

38. **Non- Network Provider** means any hospital that is not part of the network.

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

40. **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.

41. **Pre-Existing Disease (PED)** Pre-existing Disease means any condition, ailment, injury or disease:
    a. that is/are diagnosed by a physician not more than 36 months prior to the date of the policy commencement of the policy issued by the insurer or
    b. for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of the policy commencement of the policy.

42. **Pre-hospitalization Medical Expenses** means medical expenses incurred during of 30 days preceding the hospitalization of the Insured Person, provided that:
    Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

    The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

43. **Post-hospitalization Medical Expenses** means medical expenses incurred during 60 days immediately after the insured person is discharged from the hospital provided that:
    Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    The inpatient hospitalization claim for such hospitalization is admissible by the Insurance Company.

44. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person.

45. **Policy period** means period of one policy year as mentioned in the schedule for which the Policy is issued.

46. **Policy Schedule** means the Policy Schedule attached to and forming part of Policy.
47. **Policy year mea**ns 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
48. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.
49. **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.
50. **Renewal:** Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
51. **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.
52. **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit.
53. **Sum Insured** means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.
54. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.
55. **Specific waiting period** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.
56. **Waiting Period** 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.
57. **Unproven/ Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India. is treatment experimental or unproven.

## 4. COVERAGE

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

### 4.1. Hospitalization

The Company shall indemnify Medical Expense incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the Policy Schedule, for,

i. Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.
ii. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital / Nursing Home up to 5% of the sum insured subject to maximum of Rs.10,000/-, per day.
iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees provided they form part of and included in the Hospital Bill
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

#### 4.1.1. Other Expenses

i. Expenses incurred on treatment of cataract subject to the sub limits.
ii. Dental treatment, necessitated due to an injury.
iii. Plastic surgery necessitated due to injury.
iv. All day care treatment
v. Expenses incurred for road ambulance subject to a maximum of 2000/- per hospitalization

**Note:**

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment
2. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

### 4.2. AYUSH Treatment

The Company shall indemnify Medical Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems of medicines during the each policy year upto the limit of sum insured as specified in the policy schedule in any AYUSH hospital.

### 4.3. Cataract Treatment

The Company shall indemnify Medical Expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs.40,000/-, whichever is lower, per eye, under one policy year.

### 4.4. Pre-Hospitalization

The Company shall indemnify Pre-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 30 days prior to the date of admissible Hospitalization covered under the Policy.

### 4.5. Post Hospitalization

The Company shall indemnify Post Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 60 days from the date of discharge from the Hospital, towards Consultant fees, Diagnostic charges, Medicines and Drugs wherever required and recommended by the Hospital/ Medical Practitioner, where the treatment was taken, following an admissible Hospitalization covered under the Policy.

**4.6.** Following procedure will be covered (wherever medically indicate) either as in patient or as part of the day care treatment in a hospital up to 50% of sum insured, specified the schedule, 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. Intravitreal Injection
G. Robotic Surgeries
H. Stereotactic radio surgeries.
I. Bronchial thermoplasty
J. Vaporization of Prostate (Green laser treatment or holmium laser treatment)
K. IONM- (Intra Operative Neuro Monitoring)
L. Stem Cell Therapy: Hematopoietic stem cell for bone marrow transplant for hematological conditions to covered.

## 5. CUMULATIVE BONUS (CB)

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (no claims are reported), provided the policy is continuously renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

**Notes:**

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

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

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

iv. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is to the lowest among all the insured Persons.

v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed policy.

vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.

vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.

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

ix. If there has been no claim on your expiring policy, you have the option to choose between the Cumulative Bonus or a Renewal Discount at the time of renewal.

The renewal discount in lieu of the cumulative bonus.
The discount in premium is 2% for first 5 claim free renewal and 1% for next 5 claim free renewal.
This discount is offered against a choice of increase in Sum Insured of 5% per annum.
The maximum renewal discount is 15%. In case of a claim, the renewal discount reverts back to the same rate.

## 6. WAITING PERIOD

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

### 6.1. Pre-Existing Diseases (Code- Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 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 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

### 6.2. First Thirty Days Waiting Period (Code- Excl03)

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

### 6.3. Specific Waiting Period: (Code- Excl02)

**a)** Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage after the date of inception of the first policy with the Insurer. 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.

**i. 24 Months Waiting Period:**

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age-related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident


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18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. Internal Congenital Anomalies
21. Derangement of Knee / Ligament or Tendon, unless due to an accident event within the Policy Period

**ii. 36 Months waiting period**

1. Treatment for joint replacement unless arising from accident.
2. Age-related Osteoarthritis & Osteoporosis

## 7. EXCLUSIONS

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

### 7.1 Investigation & Evaluation (Code- Excl04)

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

### 7.2 Rest Cure, rehabilitation and respite care (Code- Excl05)

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

### 7.3 Obesity/ Weight Control (Code- Excl06)

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

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

### 7.4 Change-of-Gender treatments: (Code- Excl07)

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

### 7.5 Cosmetic or plastic Surgery: (Code- Excl08)

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

### 7.6 Hazardous or Adventure sports: (Code- Excl09)


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

**7.7 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.

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

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

**7.10** Treatments received in heath 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)**

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

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

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

**7.14 Birth control, Sterility and Infertility: (Code- Excl17)**
Expenses related to Birth Control, 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

**7.15 Maternity Expenses (Code: Excl 18)**

(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.

**7.16 War** (whether declared or not) and war like occurrence or invasion, acts of forcing enemies hostilities, civil war, rebellion, revolutions, insurrection, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

**7.17 Nuclear,** chemical or biological 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.

b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any illness, incapacitating disablement or death

c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.

**7.18** Any expenses incurred on Outpatient treatment (OPD treatment) unless covered

**7.19** Treatment taken outside the geographical limits of India.

**7.20** In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent). Policy holder is not entitled to get the coverage for specified ICD codes.

**7.21** The expenses that are not covered in the policy are placed under the List -I,II,III and IV of Annexure I.

## 8. MORATORIUM PERIOD

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the company on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

## 9. CLAIM PROCEDURE

### 9.1. Procedure for Cashless claims:

i. Treatment may be taken in a network provider and is subject to pre-authorization by the Company or its authorized TPA.

ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.

iii. The Company TPA upon getting cashless request form and related medical information from the insured person network provider will issue pre-authorization letter to the hospital after verification.

iv. At the time of disclosure, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.

v. The Company TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.

vi. In case of denial of cashless access the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents lo the Company/TPA for reimbursement.

### 9.2. Procedure for reimbursement of claims

For reimbursement of claims the insured person may submit the necessary documents to TPA applicable)/Company within the prescribed time limit as specified hereunder.

| SL. No. | Type of Claims | Prescribed time Limit |
|---|---|---|
| 1. | Reimbursement of hospitalization, day care and pre-hospitalization expenses | Within 15 days of date of discharge from hospital |
| 2. | Reimbursement of post hospitalization expenses | Within the 15 days from of post hospitalization treatments |

### 9.3. Notification of Claim

Notice with full particulars shall be sent to the Company /TPA (if applicable) as under

i. Within 24hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.

ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

### 9.4. Documents to be submitted

The claim is to be supported with the following original documents and submitted within the prescribed time limit.

i. Duly completed claim form
ii. Photo Identity proof of the patient
iii. Medical practitioner's prescription advising admission
iv. Original bill with itemized break up
v. Payment receipt
vi. Discharge summery including complete medical history of the patient along with other details
vii. Investigation/Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases)
ix. Sticker/invoice of the implant, wherever applicable.
x. MLR (Medico Legal Report copy if carried out and FIR (First information report in registered, wherever applicable.
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii. KYC (Identity proof with Address of the prophet, where claim liability above Rs 1 Lakh as per AML Guidelines
xiii. Legal heir/succession certificate wherever applicable
xiv. Any other relevant document required by Company or TPA for assessment of the claim

**Note:**

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insure Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person.

### 9.5. Co-payment

Each and every claim under the Policy shall be subject to a Copayment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the copayment.

### 9.6. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as may be the case, within 15 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest in any case not later than 30 days from the dated of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days the Insurer shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

### 9.7. Services Offered by TPA

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;
ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

### 9.8. Payment of Claim

All claims under the policy shall be payable in Indian currency and through NEFT/ RTGS only.

## 10. GENERAL TERMS &CONDITIONS

### 10.1. Disclosure of Information

The Policy shall be void and all premium paid thereon shell be forfeited to the company in the event of misrepresentation, mis-description, non-disclosure of material facts.

### 10.2. Condition Precedent to Admission of Liability

The due observance and fulfillment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment under the policy.

### 10.3. Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

### 10.4. Records to be Maintained

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

### 10.5. Complete Discharge

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

### 10.6. Notice & Communication

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

### 10.7. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

### 10.8. Multiple Policies

1. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer if chosen by the policy holder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. Policyholder 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(s) shall settle the claim subject to the terms and conditions of this policy.
3. If the amount to be claimed exceeds the sum insured under a single policy after considering the co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

### 10.9. Fraud


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If any claim made by the insured person, is in any respect fraudulent, or if any false statement of 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 shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy-

a. The suggestion as a fact of that which is not true and which the Insured Person does not believe to be true
b. The active concealment of a fact by the Insured Person having knowledge or belief or the fact,
c. Any other act fitted to deceive; and
d. Any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy 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 mis-statement of or suppression of material fact are within the knowledge of the insurer Onus of disproving is upon the policyholder, if alive, or beneficiaries.

## 10.10. Cancellation

### A. Cancellation by Insured/Policy Holder

The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Company shall

a. refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period
b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

### B. Cancellation by Insurer

The Company may cancel the policy at any time on the grounds of mis-representation, non-disclosure of material facts, fraud by the insured person, by giving 7 days notice in writing . There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of Material facts or fraud

## 10.11. Automatic change in Coverage under the policy

The coverage for the Insured Person shall automatically terminate:

1. 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 Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardians appointed by Court. All relevant particulars in respect of such person (including his/her relationship with the Insured person) must be submitted to the Company along with the application. Provided no Claim has been made, and termination takes place on account of death of the Insured Person, pro-rata refund of premium of the deceased Insured Person for the balance period of the Policy will be effective.
2. 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.

## 10.12. 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.

## 10.13. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered


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without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

### 10.14. Portability

- 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 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.
- The existing insurer shall provide the information sought by the Acquiring insurer immediately but not more than 72 hours of receipt of request through Insurance Information Bureau of India (IIB) https://iib.gov.in/ portal.
- The Acquiring insurer shall decide and communicate on the proposal immediately but not more than 5 days of receipt of information from Existing insurer.
- The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy.
- Portability is not available under the benefit-based health insurance policy.

### 10.15. Renewal of Policy

i. The health insurance policy shall be renewable except on grounds of established fraud, or non-disclosure misrepresentation by the insured, provided the policy is not withdrawn and also subject to Moratorium clause.
ii. A Company shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policy
iii. The Company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy
iv. For individual products, the loadings on renewal premium shall be at portfolio and not based upon any individual policy claim experience. However, discount in premium may be provided by Company to individual policyholders for good claims experience
v. Company shall not resort to fresh underwriting by calling for medical examination, fresh proposal form etc. at renewal stage where there is no change in sum insured offered. Provided that where there is an improvement in the risk profile, the company may endeavour to recognize that for removal of loadings at the point of renewal.
vi. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
vii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
viii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
ix. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 15/30 days as per the due date of premium payment to maintain continuity of benefits without break in policy also.
x. If the premium is paid in instalments during the policy period, policy coverage will be available for the grace period.
xi. No loading shall apply on renewals based on individual claims experience

### 10.16. Premium Payment in Installments

If the insured person has opted for Payment of Premium on an instalments basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy

a. Instalments shall be payable on or before the due date for continuity of coverage under the Policy.
b. You will have Grace Period of 15 days from the due date for payment of instalment for monthly mode and for other modes it is 30 days.
c. We will not charge interest on the instalment premium paid during the Grace Period
d. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.
e. In case We do not receive the premium within the Grace Period, the Policy will be terminated
f. In the event of a claim during the Grace Period, all the subsequent premium instalments shall immediately become due and payable.
g. We shall have the right to recover and deduct any or all the pending instalments from the claim amount due under the Policy.

If You are opting for Electronic Clearing Service for Instalment premium payment, then kindly ensure that:

a. Electronic Clearing Service (ECS) Mandate form is completely filled & signed by You.
b. The Premium amount which would be auto debited & frequency of instalment is duly filled in the ECS Mandate form.
c. New ECS Mandate Form is required to be filled in case of any change in the Premium due to change of Sum Insured / age / plan /coverages/revision in premium.
d. You need to inform us at least 15 days prior to the due date of instalment premium if You wish to discontinue with the ECS facility.

Non-payment of premium on due date as opted by You in the mandate form subject to an additional 15 days of Relaxation Period will lead to termination of the policy.

### 10.17. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of competent authority, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

### 10.18. Free look period

At the time of inception of the policy, the Insured will be allowed a period of 30 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the policy if not acceptable. In such a case, the premium refund shall be as follows:

If the Insured has not made any claim during the free look period, the Insured shall be entitled to –

a. A refund of the premium paid less any expenses incurred by the Insurer on medical examination of the insured persons and the stamp duty charges and any policy administrative charges or
b. Where the risk has already commenced and the option of return of the policy is exercised by the policy holder, a deduction towards the proportionate risk premium for period on cover or
c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.
d. Free look period shall not be applicable at the time of renewal.
e. This option is available if policy period is one year or more.
f. Refund of free look cancellation will be provided within 7 days

### 10.19. Endorsement (Change 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 the company. Any change made by the company 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 the company 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 him/her moving out of India.

### 10.20. Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh for the incremental portion of the sum insured.

**10.21. Terms and condition 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.

**10.22. 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 the company in writing and such change shall be effective only when an endorsement on the policy is made For Claim settlement under reimbursement, the Company will pay the policyholder, In the event of death of the policyholder, the Company will pay the nominee (as named in the Policy Schedule/Policy Certificate/Endorsement of any) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated full and final as of discharge its liability under Policy.

Nomination can be changed any time during the term of the policy.


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## 11. OPTIONAL COVERS – VALUE PACK ADD-ON

The Covers listed below shall be available to the Insured Person only if the additional premium has been received by Us. The optional cover is applicable to an Insured Person only if it is specified in the Policy.

Covers under this Section are subject to the terms, conditions, waiting periods and exclusions of this Policy.

**1. Pre and Post Hospitalization Medical Expenses.**

**Pre-Hospitalization**

The Company shall indemnify Pre-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 60 days prior to the date of admissible Hospitalization covered under the Policy.

**Post Hospitalization**

The Company shall indemnify Post Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 90 days from the date of discharge from the Hospital, towards Consultant fees, Diagnostic charges, Medicines and Drugs wherever required and recommended by the Hospital/ Medical Practitioner, where the treatment was taken, following an admissible Hospitalization covered under the Policy.

In case the insured or proposer has taken these coverages then the terms and conditions stated above shall be read as revised with respect to scope of cover/terms and conditions contains in part 4.4 and 4.5 respectively of the policy coverages and shall deem to be modified accordingly or superseded.

**2. Room Capping**

The Company shall indemnify Medical Expense incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the Policy Schedule, for,

i. Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.10000/-, per day.
ii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees provided they form part of and included in the Hospital Bill
iii. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Note –

- In case the insured or proposer has taken these coverages then the terms and conditions stated above shall be read as revised with respect to scope of cover/terms and conditions contains in part 4.1 of the policy coverages and shall deem to be modified accordingly or superseded.
- This cover is applicable above 2.5 lakhs of sum insured

**3. ICU Capping**

The Company shall indemnify Medical Expense incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the Policy Schedule, for,

i. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital / Nursing Home up to 5% of the sum insured subject to maximum of Rs.20,000/-, per day.
ii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees provided they form part of and included in the Hospital Bill
iii. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Note –

- In case the insured or proposer has taken these coverages then the terms and conditions stated above shall be read as revised with respect to scope of cover/terms and conditions contains in part 4.1 of the policy coverages and shall deem to be modified accordingly or superseded.
- This cover is applicable above 2.5 lakhs of sum insured.

**4. Co-Pay Waiver**

If this Add on is opted, then mandatory Copayment section 9.5 shall not be applicable on admissible claim under the base Policy other terms and conditions of the Add on are to be read in conjunction with the terms and conditions of the base Policy.

**5. Single AC Room**

If insured opt this cover, Section 4.1 (i) of Hospitalization shall be modified as below.
The Company shall indemnify Medical Expense incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the Policy Schedule, for

i. Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital / Nursing Home up to Single Private AC Room available in hospital.

**Specific Definitions -** Single AC room (Excluding Suite) means an air-conditioned room in a Hospital where a single patient along with the attendant is accommodated and which has an attached toilet (lavatory & bath). Such room type shall be the most basic and the most economical of all accommodations available as a single room in that Hospital .
Note - You can opt either coverage 2 or 5

**6. ICU No Limit**

If insured opt this cover, Section 4.1 (ii) of Hospitalization shall be modified as below.
The Company shall indemnify Medical Expense incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the Policy Schedule, for Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital / Nursing Home up to actual expenses subject to maximum of policy sum insured.

**Specific Definitions –** ICU (Intensive Care Unit) means the most economical of all ICU accommodations available in that Hospital (Excluding Suite).
Note - You can opt either coverage 3 or 6

**7. Restoration Benefit**

In consideration of the payment of additional premium, the policy is extended to cover Restoration Benefit add-on.
Restoration benefit is an Add-on which can be endorsed along with the Base Plan only and cannot be bought in isolation or as a separate product. The Add-on shall be available only if it is specifically mentioned in Your Base Plan's policy schedule.

1. **What is cover**

Upon complete exhaustion of the Sum Insured and Cumulative Bonus during the Policy Year, The Company will restore Sum Insured unlimited times subject to maximum 100% of Sum Insured each time.

1.1. **Conditions**

i. Restoration Benefit is available immediately upon exhaustion of the Sum Insured and Cumulative Bonus, during the policy period.
ii. The Restoration Benefit is applicable for hospitalization due to illness or accident for Inpatient Treatment or Day Care procedure including AYUSH Hospitalization.

iii. The Restoration Benefit can be utilized for subsequent Hospitalization only for an illness or disease unrelated to the illness / disease for which claim/s was /were not made.

iv. If policy is on individual basis than it will be available for individual whereas in family floater it will be available for all covered members on floater basis.

v. Any unutilized Restoration Benefit will not be carried forward to any subsequent Policy Years.

1.2. **Illustration for Restoration Benefit**

The order of utilization of Sum Insured will as follow

- Base policy Sum Insured
- Cumulative Bonus (CB)
- Restoration Sum Insured

| Particulars | New Policy | Renewal Policy With CB |
|---|---|---|
| Base Sum insured (₹) | 10 lakhs | 10 lakhs |
| Cumulative Bonus (CB) (₹) | 0 lakhs | 2.5 lakhs |
| Total Sum insured (SI) available (₹) | 10 lakhs | 12.5 lakhs |
| **Claim 1st** | | |
| Medical/ Hospitalization Expenses (₹) | 5 lakhs | 10 lakhs |
| Claim Paid (₹) | 5 lakhs (5 lakh from SI) | 10 lakhs (10 lakh from SI) |
| Sum Insured Restoration | No | No |
| SI available (₹) for next claim | 5 lakhs (Available SI amount :5 lakhs) | 2.5 lakhs (Available CB amount :2.5 lakhs) |
| **Claim 2nd for different disease** | | |
| Medical/ Hospitalization Expenses (₹) | 10 lakhs | 5 lakhs |
| Claim Paid (₹) | 5 lakhs (5 lakhs from SI) | 2.5 lakhs (2.5 lakh from CB) |
| Sum Insured Restoration | 10 lakhs | 10 lakhs |
| SI available (₹) for next claim | 10 lakhs | 10 lakhs |
| **Claim 3rd for same disease** | | |
| Medical/ Hospitalization Expenses (₹) | 12 lakhs | 15 lakhs |
| Claim Paid (₹) | No claim as same disease | No claim as same disease |
| **Claim 4th for different disease** | | |
| Medical/ Hospitalization Expenses (₹) | 10 lakhs | 10 lakhs |
| Claim Paid (₹) | 10 lakhs (10 lakhs from restored SI) | 10 lakhs (10 lakhs from restored SI) |
| Sum Insured Restoration | 10 lakhs | 10 lakhs |

## 8. Bonus Boost (BB)

In consideration of the payment of additional premium, the policy is extended to cover Bonus Boost (BB) Benefit add-on. Section 5- Cumulative Bonus will replace with below wording

Bonus Boost will be increased sum insured by 25% in respect of each claim free policy year (when no claims are reported), provided the policy is continuously renewed with the company without a break subject to maximum of 250% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

**1. Conditions**

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

ii. In case where the policy is on floater basis, the Bonus Boost benefit shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family.

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

iv. If the Sum Insured has been reduced at the time of Renewal, the applicable Bonus Boost benefit shall be reduced in the same proportion to the Sum Insured in current Policy.

v. If the Sum Insured under the Policy has been increased at the time of Renewal the Bonus Boost benefit shall be calculated on the Sum Insured of the last completed Policy Year.

vi. If claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded Bonus Boost benefit shall be withdrawn.

vii. The entire Bonus Boost benefit will be forfeited if the Policy is not continued / renewed on or before Policy Period end date or the expiry of the grace period.

viii. The Bonus Boost benefit will be calculated on the expiring Sum Insured.

ix. In a floater Policy, the Bonus Boost so accrued in the previous Policy Year(s), will only be available to those Insured Person(s) who were Insured in the previous Policy Year(s) and continue to be Insured with the Company in the subsequent Policy Year(s).

x. In case Sum Insured under the Policy is reduced at the time of renewal, the applicable Bonus Boost benefit shall be reduced in proportion to the Sum Insured.

Illustration

| Annual SI | BB after 1 year | SI reduced by | Revised annual SI | Revised BB |
|---|---|---|---|---|
| 10 lakhs | 2.5 lakhs | 5 lakhs | 5 lakhs | 1.25 lakhs |

xi. In case Sum Insured under the Policy is increased at the time of renewal, the Bonus Boost benefit shall be calculated on the Sum Insured applicable on the last completed Policy Year.

xii. **Individual to Floater Policy Split**

If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Bonus Boost benefit for each Insured Person under the expiring Policy, and such expiring Policy has been renewed with the Company on a floater basis then the Bonus Boost benefit to be carried forward for credit in such renewed Policy shall be the lowest among all the Insured Persons

| Insured | Annual SI | BB after 1 year | New Sum insured | BB in New policy |
|---|---|---|---|---|
| 1 | 10 lakhs | 2.5 lakhs | 10 lakhs | 1.25 lakhs |
| 2 | 5 lakhs | 1.25 lakhs | | |

xiii. **Floater to Individual Policy Split**

If the Insured Persons in the expiring policy are covered on a Floater basis and such Insured Persons renew their expiring Policy with us by splitting the Floater Sum Insured in to 2 (two) or more Individual/ Floater covers, then the Bonus Boost benefit of the expiring Policy shall be apportioned to such renewed Policy in the proportion of the Sum Insured of each of the renewed Policy.

| Insured | Annual SI | BB after 1 year | New Sum insured | BB in each policy |
|---|---|---|---|---|
| 1 | 10 lakhs | 2.5 lakhs | 7.5 lakhs | 1.5 lakhs |
| 2 | | | 5 lakhs | 1 lakh |

9. **Consumables Waiver**

In consideration of the payment of additional premium, it is hereby agreed and declared that, notwithstanding anything to the contrary in this policy or in any of its conditions, the policy extends to indemnify for expenses incurred for consumables as specified in 'Annexure I – List I' which are consumed during the period of hospitalization directly related to the insured's medical or surgical treatment of illness/disease/injury. Details of Annexure I-List I,is available in Policy Wordings and our Website.

For this claim to be paid, the main claim must be admissible Under "In-patient Hospitalization" or "Daycare Treatment".
However, the following items shall be excluded from scope of this coverage:

a. Items of personal comfort, toiletries, cosmetics and convenience shall be excluded from scope of this coverage.
b. External durable devices like Bilevel Positive Airway Pressure (BIPAP) machine, Continuous Positive Airway Pressure (CPAP) machine, Peritoneal Dialysis (PD) equipment and supplies, Nimbus/water/air bed, dialyzer and other medical equipment.
c. Any item which is neither medical consumable nor medically necessary nor prescribed by Doctor.
d. Pre and post hospitalization expenses will be excluded from this cover.

**10. Ambulance plus**

In consideration of the payment of additional premium, it is hereby agreed and declared that, notwithstanding anything to the contrary in this policy or in any of its conditions, the policy extends to indemnify for expenses incurred for Road or Air Ambulance subject to if we will pay claim under section 4 – Coverage.

**A. Road Ambulance**

Expenses incurred on Road Ambulance services which are offered by a healthcare or an ambulance service provider (including inter-hospital transfer, diagnostic transfers, or return to the hospital) shall be indemnified for actuals up to Sum Insured, upon recommendation of the treating Medical Practitioner in case of life-threatening emergency.
We will not cover:

a. Any transportation of the Insured Person from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital.
b. Any transportation or Road ambulance expenses incurred outside the geographical scope of India.

**B. Air Ambulance**

We will cover the expenses on air ambulance services in respect of an Insured Person which are offered by a healthcare or an air ambulance service provider and which have been used during the Policy Period to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care, provided that:

i. Our maximum liability under this Benefit for any and all claims arising during the Policy Year will be restricted to the policy Sum insured.
ii. It is for a life-threatening emergency health condition/s of the Insured Person which requires immediate and rapid ambulance transportation from the place where the Insured Person is situated at the time of requiring Emergency Care to a hospital provided that the transportation is for Medically Necessary Treatment, is certified in writing by a Medical Practitioner, and road ambulance services cannot be provided.
iii. Such air ambulance providing the services, should be duly licensed to operate as such by a competent government Authority.
iv. This cover is limited to transportation from the area of emergency to the nearest Hospital only;
v. We will not cover:
    a. Any transportation from one Hospital to another;

b. Any transportation of the Insured Person from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital

c. Any transportation or air ambulance expenses incurred outside the geographical scope of India.

vi. We have accepted a claim under Section 41. Hospitalization in respect of the Insured Person for the same Accident/Illness for which air ambulance services were availed.

vii. We shall not be liable if Medically Necessary Treatment can be provided at the Hospital where the Insured Person is situated at the time of requiring Emergency Care.

## 11. Zone Based Discount

For the purpose of premium computation, the country has been divided into 3 zones.

| Zone | Cities |
|---|---|
| **Zone 1** | Delhi, Gurugram, Karnal, Sonipat, Rohtak, Bhiwani, Chakri Dadri, Mahendragarh, Faridabad, Jind, Panipat, Nuh, Jhajjar Rewari, Palwal, Bagpath, Bulandashahr, Noida, Ghaziabad, Hapur, Meerut, Muzaffarnagar, Shamali, Hisar, Bhiwadi, Ahmedabad, Vadodara, Surat, Mumbai (including Thane district, Navi Mumbai), Chennai, Kolkata. |
| **Zone 2** | Telangana (incl. Hyderabad), Pune, Bangalore, Andhra Pradesh, Uttarakhand, Bhopal, Indore, Lucknow, Patna, Gujrat (excluding Ahmedabad, Vadodara and Surat) |
| **Zone 3** | Rest of India excluding Zone 1&2 |

- The premium will depend on the city of residence and pin code of the insured person. Please inform Us immediately in case of any change in the address otherwise it may impact your claim admissibility or amount. The premium will be charged on prorate basis in case of midterm address change involving migration from Lower Zone to Higher Zone (means zone 3 ⟶zone1)

## 12. Pre-Existing Disease Waiting Period Reduction

In consideration of the payment of additional premium, it is hereby agreed and declared that, notwithstanding anything to the contrary in this policy or in any of its conditions by choosing this add-on cover, the applicable Pre-existing waiting period 36 month for claim related to pre-existing disease shall be reduced to 24 months, this benefit is applicable only if you are suffering with any pre-existing disease/ conditions.

## 12. REDRESSAL OF GRIEVANCE

Welcome to Shriram General Insurance and Thank You for choosing us as your insurer.

Please read your Policy and Schedule. The Policy and Policy Schedule set out the terms of your contract with us. Please read your Policy and Policy Schedule carefully to ensure that the cover meets your needs.

We do our best to ensure that our customers are delighted with the service they receive from us. If you are dissatisfied, we would like to inform you that we have a procedure for resolving issues. Please include your Policy number in any communication. This will help us deal with the issue more efficiently. If you don't have it, please call your Branch office.

**First Step** Initially, We suggest you to contact the Branch Manager / Regional Manager of the local office which has issued the Policy. The address and telephone number will be available in the Policy.

**Second Step** Naturally, We hope the issue can be resolved to your satisfaction at the earlier stage itself. But if you feel dissatisfied with the suggested resolution of the issue after contacting the local office, please e-mail or write to Grievance Cell, HO, headed by a senior executive which will be directly under the control of the MD at the below mentioned address:

**Contact Person: Chief Grievance Officer**
**Contact Address:** Shriram General Insurance Co. Ltd. E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur – 302022
**Grievance Cell No:** 1800-103-3009, 1800-300-30000, **E-mail ID:** md@shriramgi.com
**Fax No.:** 91-141-2770693
You can also reach us by email or register their complaints on the website of the Company.

In case your complaint is not fully addressed by the Company, You may use the Integrated Grievance Management System (IGMS) https://igms.irda.gov.in For registration please visit IRDAI website www.irda.gov.in.

The contact details of the ombudsman offices are mentioned below. However, We request you to visit https://www.cioins.co.in/Ombudsman or https://cioins.co.in/Complaint/Online for updated detail.

**Grievance Redressal Cell for Senior Citizens**
Our customers who are above 60 years of age we have created special cell to address any health insurance related grievances.
Our senior citizen customers can reach us through the below dedicated channels to enable us to service them promptly.
**Grievance Cell No: 1800-103-3009, 1800-300-30000**
**Exclusive Email address:** seniorcitizen@shriramgi.com

The contact details of the ombudsman offices are mentioned below. However, We request you to visit https://www.shriramgi.com for updated.
**Insurance Ombudsman –**The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-II

**No loading shall apply on renewals based on individual claims experience. Insurance is the subject matter of solicitation**

## TABLE OF BENEFITS

| Name | Shri Health Suraksha Insurance Policy |
|---|---|
| Product Type | Individual/ Floater |
| Category of Cover | Indemnity |
| Sum insured | INR<br>On Individual basis – SI shall apply to each individual family member<br>On Floater basis – SI shall apply to the entire family |
| Policy Period | 1,2,3 Year |
| Eligibility | Policy can be availed by persons age 18 years and above, as Proposer. Proposer with higher age can obtain policy for family, without covering self.<br>Policy can be availed for Self and the following family members<br>**a.** Legally wedded Spouse<br>**b.** Parents and Parents-in-law<br>**c.** Dependent children i.e. (natural or legally adopted) between the age of 3 month to 25 years If the child above 18 years is financially independent, he or she shall be ineligible for coverage in the subsequent renewals |
| Grace Period | The grace period for payment of the premium for all types of insurance policies shall be: 15 days where premium payment mode is monthly and 30 days in all other cases. |
| Hospitalisation Expenses | Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible |
| | Time limit of 24 hrs shall not apply when the treatment is undergone in a Day Care Center |
| Pre Hospitalisation | For 30 days prior to the date of hospitalization |
| Post Hospitalisation | For 60 days from the date of discharge from the hospital |
| Sublimit for room/doctor's fee | 1. Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.<br>2. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital / Nursing Home up to 5% of the sum insured subject to maximum of Rs.10,000/-, per day |
| Cataract Treatment | Up to 25% of Sum insured or Rs.40,000/-, whichever is lower, per eye, under one policy year. |
| AYUSH | Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems of medicines shall be covered upto the Sum Insured and Cumulative Bonus, during each Policy Year as specified in the policy schedule. |
| Pre-Existing Disease | Only PEDs declared in the Proposal Form and accepted for coverage by the Insurer shall be covered after a waiting period of 36 months |
| Cumulative bonus | Increase by 5% of SI in respect of each claim free year of insurance maximum up to 50% of SI. In the event of claims the cumulative bonus shall be reduced at same rate. |
| Co Pay | 5% co pay on all claims |
| Optional Cover | If opted by the insured |

| Add-ons Coverages | Revised Limits |
|---|---|
| 1. Pre /Post Hospitalization | 60/90 Days |
| 2. Room Capping | Up to 2% of the sum insured subject to maximum of Rs.10000/-, per day |
| 3. ICU Capping | Up to 5% of the sum insured subject to maximum of Rs.20,000/- per day |
| 4. Co-Pay Waiver | 5% co-payment not applicable on Claim |
| 5. Single AC Room | Up to the Policy Sum Insured |
| 6. ICU No Limit | Up to the Policy Sum Insured |

| | |
|---|---|
| 7. Restoration Benefit | Upon complete exhaustion of the Sum Insured and Cumulative Bonus Sum Insured will restore unlimited times subject to maximum 100% of Sum Insured each time for unrelated disease |
| 8. Bonus Boost | Inbuilt cumulative bonus will be replaced with Bonus Boost benefit where Sum insured will increase by 25% of SI in respect of each claim free year of insurance maximum up to 250% of SI. In the event of claims the Bonus Boost shall be reduced at same rate. |
| 9. Consumable Waiver | Pay for expenses incurred on consumables as specified in List -1 of Annexure - I |
| 10. Ambulance Plus | Up to the Policy Sum Insured |
| 11. Zone Based Discount | You are eligible for discount as per the Your Zone. |
| 12. Pre-existing disease waiting period reduction | On payment of additional premium, PED wating period will reduce from 36 month to 24 month it is applicable if You are suffering with any pre-existing disease / conditions |


E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur Rajasthan) – 302022, Phone: +91-141-3928400, 3951111, Website: www.shriramgi.com, E-mail customer.feedback@shriramgi.in
Toll Free: 1800-103-3009, 1800-300-30000, ISO/IEC 27001:2013 certified , CIN - U66010RJ2006PLC029979 IRDA Registration Number: 137

## Annexure-I: Items for which optional cover may be offered by Insurers

List I – Consumable 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 |


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Toll Free: 1800-103-3009, 1800-300-30000, ISO/IEC 27001:2013 certified , CIN - U66010RJ2006PLC029979 IRDA Registration Number: 137

| | |
|---|---|
| 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 |

Annexure – II

The contact details of the **Insurance Ombudsman** offices are as below-

| **Office Location** | **Contact Details** | **Jurisdiction of Office Union Territory, District)** |
|---|---|---|
| AHMEDABAD | Office of the Insurance Ombudsman,<br>Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001.<br>Tel.: 079 - 25501201/02<br>Email: oio.ahmedabad@cioins.co.in | Gujarat, Dadra & Nagar Haveli, Daman and Diu. |
| BENGALURU | Office of the Insurance Ombudsman,<br>Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078.<br>Tel.: 080 - 26652048 / 26652049<br>Email: oio.bengaluru@cioins.co.in | Karnataka. |
| BHOPAL | Office of the Insurance Ombudsman,<br>1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462 011.<br>Tel.: 0755 - 2769201 / 2769202 / 2769203<br>Email: oio.bhopal@cioins.co.in | Madhya Pradesh, Chhattisgarh. |
| BHUBANESHWAR | Office of the Insurance Ombudsman,<br>62, Forest park, Bhubneshwar – 751 009.<br>Tel.: 0674 - 2596461/2596455/ 2596429 / 2596003<br>Email: oio.bhubaneswar@cioins.co.in | Orissa. |
| CHANDIGARH | Office of the Insurance Ombudsman,<br>Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017.<br>Tel.: 0172-2706468<br>Email: oio.chandigarh@cioins.co.in | Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh. |
| CHENNAI | Office of the Insurance Ombudsman,<br>Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018.<br>Tel.: 044 - 24333668 / 24333678<br>Email: oio.chennai@cioins.co.in | Tamil Nadu, Tamil Nadu<br>Puducherry Town and Karaikal (which are part of Puducherry) |
| DELHI | Office of the Insurance Ombudsman,<br>2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.<br>Tel.: 011 - 46013992/23213504/23232481<br>Email: oio.delhi@cioins.co.in | Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh. |

| | | |
|---|---|---|
| GUWAHATI | Office of the Insurance Ombudsman,<br>Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM).<br>Tel.: 0361 - 2632204 / 2602205 / 2631307<br>Email: oio.guwahati@cioins.co.in | Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura. |
| HYDERABAD | Office of the Insurance Ombudsman,<br>6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.<br>Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325<br>Email: oio.hyderabad@cioins.co.in | Andhra Pradesh, Telangana,Yanam and part of Union Territory of Puducherry. |
| JAIPUR | Office of the Insurance Ombudsman,<br>Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.<br>Tel.: 0141 - 2740363<br>Email: oio.jaipur@cioins.co.in | Rajasthan. |
| ERNAKULAM /KOCHI | Office of the Insurance Ombudsman,<br>10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi-682011. Tel.: 0484 - 2358759<br>Email: oio.ernakulam@cioins.co.in | Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry. |
| KOLKATA | Office of the Insurance Ombudsman,<br>Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue,<br>KOLKATA - 700 072.<br>Tel.: 033 - 22124339 / 22124341<br>Email: bimalokpal.kolkata@cioins.co.in | West Bengal, Sikkim, Andaman & Nicobar Islands. |
| LUCKNOW | Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001.<br>Tel.: 0522 - 4002082 / 3500613<br>Email: oio.lucknow@cioins.co.in | Districts of Uttar Pradesh :<br>Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar. |
| MUMBAI | Office of the Insurance Ombudsman,<br>3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.<br>Tel.: 022 - 69038800/27/29/31/32/33<br>Email: oio.mumbai@cioins.co.in | List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and excluding areas of Navi Mumbai. |

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| NOIDA | Office of the Insurance Ombudsman,<br>Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301.<br>Tel.: 0120-2514252 / 2514253<br>Email: oio.noida@cioins.co.in | State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur. |
| PATNA | Office of the Insurance Ombudsman,<br>2nd Floor, Lalit Bhawan, Bailey Road, Patna 800001. Tel.: 0612-2547068<br>Email: oio.patna@cioins.co.in | Bihar, Jharkhand. |
| PUNE | Office of the Insurance Ombudsman,<br>Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030.<br>Tel.: 020-24471175<br>Email: oio.pune@cioins.co.in | State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district,Palghar District, Raigad district & Mumbai Metropolitan Region |
| THANE | Office of the Insurance Ombudsman,<br>2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West)-400604 , Tel.: 022-20812868/69<br>Email: oio.thane@cioins.co.in | Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T." |