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HEALTH[®]
INSURANCE

**BEST CLAIM SETTLEMENT
COMPANY OF THE YEAR**

9th ANNUAL INDIA INSURANCE SUMMIT & AWARDS 2025



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Know Your Policy Better

Policy Terms and Conditions

1 Preamble

The proposal and declaration given by the proposer and other documents if any shall form the basis of this Contract and is deemed to be incorporated herein. The two parties to this contract are the Policy Holder/Insured(also referred as You) and Care Health Insurance Ltd. (also referred as Company/ We/Us), and all the Provisions of Indian Contract Act, 1872, shall hold good in this regard. The references to the singular include references to the plural; references to the male include the references to the female; and references to any statutory enactment include subsequent changes to the same and vice versa.

In consideration of the premium paid by the Policy Holder, subject to the terms & conditions contained herein and the Base policy, the Company agrees to pay/indemnify the Insured(s), the amount of such expenses that are reasonably and necessarily incurred up to the limits specified against respective Benefit in this policy in any Add-on Policy Year. Please check whether the details given by you about the insured in the proposal form (a copy of which was provided at the time of issuance of cover for the first time) are incorporated correctly in the Add-on Policy Schedule. If you find any discrepancy, please inform us within 30 days from the date of receipt of the Add-on policy, failing which the details relating to the person/s covered would be taken as correct.

So also the coverage details may also be gone through and in the absence of any communication from you within 30 days from the date of receipt of the Add-on policy, it would be construed that the policy issued is correct and the claims if any arise under the policy will be dealt with based on proposal /policy details.

2 Definitions

2.1 Standard Definitions:

This Add-on Policy shall follow the standard definitions as mentioned in the Base Policy.

2.2 Specific Definitions:

2.2.1 Assisted Reproductive Technology (ART) Act means the Assisted Reproductive Technology (Regulation) Act, 2021 and its amendments

2.2.2 Add-on Policy means these Policy terms and conditions and Annexures thereto, the Proposal Form, Policy Schedule and any endorsements which form part of this Policy shall be read together.

2.2.3 Add-on Policy Period means the period commencing from the Add-on Policy Period Start Date and ending on the Add-on Policy Period End Date of the Policy as

specifically appearing in the Add-on Policy Schedule.

- 2.2.4** Add-on Policy Period End Date means the date on which the Add-on Policy expires, as specifically appearing in the Add-on Policy Schedule.
- 2.2.5** Add-on Policy Period Start Date means the date on which the Add-on Policy commences, as specifically appearing in the Add-on Policy Schedule.
- 2.2.6** Add-on Policy Schedule is a schedule attached to and forming part of this Add-on Policy and which can be endorsed depending on the requirement of the Add-on Policy.
- 2.2.7** Add-on Policy Year means a period of one year commencing on the Add-on Policy Period Start Date or any anniversary thereof.
- 2.2.8** Annexure means the document attached and marked as Annexure to this Policy.
- 2.2.9** Base Policy means retail policy issued by the Company including Policy terms and conditions and Annexures thereto, the Proposal

Form, Policy Schedule and to which this Add-on shall be attached.

- 2.2.10** General Ward means a basic (cheapest) category of shared room in a Hospital with/without air-conditioning with minimum four patient beds.
- 2.2.11** Intending Couple means a couple who have a medical indication necessitating gestational surrogacy and who intend to become parents through surrogacy.
- 2.2.12** Intending Woman means an Indian woman who is a widow or divorcee between the age of 35 to 45 years and who intends to avail the surrogacy in accordance with the Surrogacy Act
- 2.2.13** Network Service Provider means any person, organization, institution that has been empaneled with the Company to provide Services under the benefits.
- 2.2.14** Medical Practitioner means a person who holds a valid registration issued by the Medical Council/Statutory Regulatory Authority for

Medical Education in that Country and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

2.2.15 Oocyte means naturally ovulating oocyte in the female genetic tract.

2.2.16 Oocyte Donor is a woman who donates her eggs to another woman, who might not be able to conceive by herself naturally.

2.2.17 Oocyte Retrieval is a procedure in order to remove Oocytes from the ovary of a woman, to enable fertilization.

2.2.18 Primary Insured Person means the person named as the policyholder in the Policy Schedule who is also covered under the Policy and responsible for paying premiums.

2.2.19 Surrogacy Act means the Surrogacy (Regulation) Act, 2021 and its amendments.

2.2.20 Surrogacy means a practice whereby one woman bears and gives birth to a child for an Intending Couple/ Intending Woman with

the intention of handing over such child to the Intending Couple / Intending Woman after the birth.

2.2.21 Surrogacy Clinic means surrogacy clinic, centre or laboratory, conducting assisted reproductive technology services, invitro fertilisation services, genetic counseling centre, genetic laboratory, Assisted Reproductive Technology Banks conducting surrogacy procedure or any clinical establishment, by whatsoever name called, conducting surrogacy procedures in any form.

2.2.22 Surrogacy Procedures means all gynaecological, obstetrical or medical procedures, techniques, tests, practices or services involving handling of human gametes and human embryo in surrogacy.

2.2.23 Surrogate Mother means a woman who agrees to bear a child (who is genetically related to the intending couple or intending woman) through surrogacy from the implantation of embryo in her womb and fulfils the

conditions as provided in sub-clause (b) of clause (iii) of section 4 of the Surrogacy (Regulation) Act 2021;

The surrogate mother is in possession of an eligibility certificate issued by the appropriate authority on fulfilment of the following conditions, namely: —

- i no woman, other than an ever married woman having a child of her own and between the age of 25\ to 35 years on the day of implantation, shall be a surrogate mother or help in surrogacy by donating her egg or oocyte or otherwise;
- ii a willing woman shall act as a surrogate mother and be permitted to undergo surrogacy procedures as per the provisions of this Act: Provided that the intending couple or the intending woman shall approach the appropriate authority with a willing woman who agrees to act as a surrogate mother;
- iii no woman shall act as

a surrogate mother by providing her own gametes;

- iv no woman shall act as a surrogate mother more than once in her lifetime: Provided that the number of attempts for surrogacy procedures on the surrogate mother shall be such as may be prescribed; and
- v a certificate of medical and psychological fitness for surrogacy and surrogacy procedures from a registered medical practitioner;

3 Benefits Covered Under The Add-on Policy

General Condition

- 1 The Add-on Policy can only be bought along with the Base Policy either on Policy Issuance or on Renewal and cannot be bought in isolation or as a separate product or mid-term.
- 2 The Add on policy is subject to the terms and conditions and applicable endorsements stated herein and in the Base Policy.
- 3 All Claims shall be payable subject to the limits, terms, conditions, wait periods exclusions of the Add-on Policy and Base policy and subject to

availability of the amount against each and every Benefit.

- 4 Benefits can be opted in any combination.
- 5 If any benefit or coverage is opted in the Base Policy, then same or similar coverage/benefit cannot be opted in Add-on Policy.
- 6 This Add-on policy shall be available only if the same is specifically mentioned in the Policy Schedule.
- 7 This Add-on shall be available for only those Insured Person covered under Base Policy.
- 8 The maximum, total and cumulative liability of the Company towards an Insured Person for any and all Claims arising under this Add-on Policy during the Add-on Policy Year, on occurrence of an Insured event in relation to that Insured Person, shall not exceed the amount/limit of that Insured Person which is specified against every Benefit, mentioned in the Add-on Policy Schedule.
- 9 Option of Mid-term inclusion of a Person in the Policy will be only upon marriage or child birth. Additional differential premium will be calculated on a pro rata basis.
- 10 Coverage available under Benefit Additional Sum Insured for Defined Critical Illnesses, Plus Benefit, and Durable Medical Equipment, Maternity Cover, Surrogacy Care, Oocyte Care shall be over and above Base Policy Sum Insured.

3.1 Benefit 1 : Claim Shield+

If a hospitalization claim has been accepted under the Base Policy, then the items which are not payable under the Base Policy as per Annexure I(list I, II,III and IV) related to the particular claim, will become payable. The maximum claim pay-out under this benefit shall be limited to applicable Sum Insured under Base Policy.

Note: Coverage for any item as per List-I, II, III and IV under Annexure I, shall be available only if the same is not covered under any Base Benefit or Optional Benefit of Base Policy.

3.2 Benefit 2 : Claim Shield

If a hospitalization claim has been accepted under the Base Policy, then the items which are not payable under the Base Policy as per Annexure 1 (list I) related to the particular claim, will become payable. The maximum claim pay-out under this benefit shall be limited to applicable Sum Insured under Base Policy.

Note: Coverage for any item as per List-I under Annexure I, shall be available only if the same is not covered under any Base Benefit or Optional Benefit of Base Policy.

3.3 Benefit 3 : Inflation Shield

The Inflation Shield is designed

to provide additional increase in Sum Insured under Base Policy on the basis of inflation rate in previous calendar year.

The Inflation would be computed as the change in average CPI of the entire calendar year published by the National Statistical Office (NSO), Ministry of Statistics and Programme Implementation. In case inflation rate of previous year available for penultimate calendar year shall be considered.

For information on Consumer price index you can visit website:

<http://mospi.nic.in/cpi>.

The % increase will be applicable only on Sum Insured under the Base Policy and not on No Claim Bonus or any other benefit which leads to increase in Sum Insured.

In case of Sum Insured is changed at the time of renewal, any accumulated sum Insured due to Inflation Shield Benefit will be added to the applicable new Sum Insured opted by Insured at the time of renewal.

Please Note that all the accumulated Inflation Shield benefit will lapse and your Sum Insured under Base Policy will roll back to the Sum Insured opted under the Base Policy if the Add-on Policy is not renewed.

3.4 Benefit 4 : No Claim Bonus Shield

The Company shall provide No Claim Bonus (No Claim Bonus-Super, if opted) for every claim free year. If no Claim is made during Policy Year, then on renewal the Sum Insured shall be increased at a defined rate. In case a claim is made in any particular Policy Year, then accrued No Claim Bonus (No Claim Bonus Super, if opted) shall reduce at same rate at which it has accrued.

With this benefit, No Claim Bonus (No Claim Bonus-Super, if opted) accrued will not be reduced at renewals, if any total claims amount payable in the previous policy year under the Base Policy does not exceed the 25% of the Base Policy Sum Insured.

However, the total claim amount payable during the Policy Year is more than 25% of Base Policy Sum Insured, the same benefit is not available and accordingly there shall be decrease in cumulative bonus amount at same rate at which it has accrued. The increase or decrease in cumulative bonus amount shall be at a defined rate as mentioned in Base Policy.

3.5 Benefit 5 : Care Shield Plus

A. Claim Shield

If a hospitalization claim has been accepted under the Base Policy, then the items which are not payable under

the Base Policy as per Annexure 1 (list I, II,III and IV)related to the particular claim, will become payable. The maximum claim payout under this benefit shall be limited to applicable Sum Insured under Base Policy.

Note: Coverage for any item as per List-I, II,III and IV under Annexure I, shall be available only if the same is not covered under any Base Benefit or Optional Benefit of Base Policy.

B. No Claim Bonus Shield

The company shall provide No Claim Bonus (No Claim Bonus-Super, if opted) for every claim free year. If No Claim is made during Policy Year, then on renewal the Sum Insured shall be increased at a defined rate. In case a claim is made in any particular Policy Year, then accrued No Claim Bonus (No Claim Bonus - Super, if opted) shall reduce at same rate at which it has accrued.

With this benefit, No Claim Bonus (No Claim Bonus-Super, if opted) accrued will not be reduced at renewals, if any total claims amount payable in the previous policy year under the Base Policy does not exceed the 25% of the Base Policy Sum

Insured.

However, the total claim amount payable during the Policy Year is more than 25% of Base Policy Sum Insured, the same benefit is not available and accordingly there shall be decrease in cumulative bonus amount at same rate at which it has accrued. The increase or decrease in cumulative bonus amount shall be at a defined rate as mentioned in Base Policy.

C. Inflation Shield

The Inflation Shield is designed to provide additional increase in Sum Insured under Base Policy on the basis of inflation rate in previous calendar year.

The Inflation would be computed as the change in average CPI of the entire calendar year published by the National Statistical Office (NSO), Ministry of Statistics and Programme Implementation. In case inflation rate of previous year is not available at renewal, then the inflation rate available for penultimate calendar year shall be considered.

For information on Consumer price index you

can visit website:

<http://mospi.nic.in/cpi>.

The % increase will be applicable only on Sum Insured under the Base Policy and not on No Claim Bonus or any other benefit which leads to increase in Sum Insured.

In case of Sum Insured is changed at the time of renewal, any accumulated sum Insured due to Inflation Shield Benefit will be added to the applicable new Sum Insured opted by Insured at the time of renewal.

Please Note that all the accumulated Inflation Shield benefit will lapse and your Sum Insured under Base Policy will roll back to the Sum Insured opted under the Base Policy if the Add-on Policy is not renewed.

3.6 Benefit 6 : PED Wait Period Modification

Notwithstanding anything to the contrary in the Policy, by choosing this benefit, the applicable waiting period of 36 months for Claims related to Pre-existing diseases shall be modified to specific time period as mentioned in the Add-on Policy Schedule.

Hence all the provisions stated under Clause 4.1 (a) (i) holds\

good for this benefit as well, except that the claims will be admissible for any Medical Expenses incurred for Hospitalization in respect of diagnosis/treatment of any Pre Existing Disease after specific time period of continuous coverage has elapsed as mentioned in the Add-on Policy Schedule, since the inception of the first Policy with the Company.

3.7 Benefit 7 : Named Ailments Wait Period Modification

Notwithstanding anything to the contrary in the Policy, by choosing this benefit, the applicable waiting period of 24 months for Claims related to Names ailments shall be modified to specific time period as mentioned in the Add-on Policy Schedule. Hence, all the provisions stated under Clause 4.1 (a) (ii) holds good for this benefit as well, except that the claims will be admissible for any Medical Expenses incurred for Hospitalization in respect of diagnosis/treatment of any Named ailment Disease after specific time period of continuous coverage has elapsed as mentioned in the Add-on Policy Schedule, since the inception of the first Policy with the Company.

3.8 Benefit 8 : Initial Wait Period Modification

Notwithstanding anything to the contrary in the Policy, by choosing this Benefit, the applicable 30 days Initial waiting period for claim shall be modified to specific time period as mentioned in the Add-on Policy Schedule.

Hence all the provisions stated under Clause 4.1 (a) (iii) holds good for this benefit as well, except that the claims will be admissible for any Medical Expenses incurred for Hospitalization after specific time of continuous coverage has elapsed as mentioned in the Add-on Policy Schedule, since the inception of the first Policy with the Company.

3.9 Benefit 9 : Return of Premium

If the Insured Person has opted for this Benefit, then the Company shall adjust first (1st) Policy Year premium of base plan from upcoming Policy renewal premium provided there is no hospitalization related claim is made for the preceding five (5) consecutive Policy Years from the first Policy inception with the Company.

Note: The Benefit is payable only once in lifetime subject to policy renewed consecutively for five (5) years.

3.10 Benefit 10 : Policyholder-Child Protection

In case of death of Policyholder, the Company shall provide 25% discount on renewal premium till Insured dependent child's age of 30 years. Insured dependent child's maximum entry age should be up to 25 years for availing this Benefit.

Note: This benefit can be opted where child is covered under the Base Policy.

3.11 Benefit 11 : Spouse Care

If Insured Person has opted for this benefit, then the Insured Person's spouse shall be eligible for the Bonus that is already available in the Base Policy subject to spouse is added in Policy within 180 days from the date of marriage by providing marriage certificate.

3.12 Benefit 12 : Additional Sum Insured for Defined Critical Illnesses

Notwithstanding anything in contrary, on opting this benefit then the Company shall automatically provide an additional Sum Insured up to the amount specified against this Benefit in the Add-on Policy Schedule, provided that:

- i. The 'Additional Sum Insured for Defined Critical Illnesses' shall be utilized only after the

Sum Insured, Bonus (if any) has been completely exhausted in the Base Policy;

- ii. The 'Additional Sum Insured for Defined Critical Illnesses' shall be available only for such Insured Person for whom Claim under In-Patient Care/ Day Care Treatment due to specified critical illnesses has been accepted under the Base Policy;
- iii. The 'Additional Sum Insured for Defined Critical Illnesses' shall be applied only once

For the purpose of this Benefit, Critical Illnesses shall include

Sr.no.	CI Conditions
1	Cancer Of Specified Severity\
2	Myocardial Infarction
3	Open Chest CABG
4	Stroke Resulting in Permanent Symptoms
5	
6	Open Heart Replacement Or Repair Of Heart Valves
7	Multiple Sclerosis with Persisting Symptoms
8	Major Organ /Bone Marrow Transplant
	Permanent Paralysis Of Limbs
9	Benign Brain Tumour
10	Blindness
11	Motor Neurone Disease with Permanent Symptoms

12	End Stage Lung Failure
13	Third Degree Burns
14	Coma of Specified Severity
15	Kidney Failure Requiring Regular Dialysis

A. Cancer of Specified Severity

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

The following are excluded –

1. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
2. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
3. Malignant melanoma that has not caused invasion beyond the epidermis;
4. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least

clinical TNM classification
T2N0M0

5. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
6. Chronic lymphocytic leukemia less than RAI stage 3
7. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
8. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

B. Myocardial Infarction (First Heart Attack of Specific Severity)

- a. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:
 - i. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
 - ii. new characteristic electrocardiogram changes
 - iii. elevation of infarction specific enzymes, Troponins or other

specific biochemical markers.

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

C. Open Chest CABG

- a. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
- b. The following are excluded:
 - i. Angioplasty and/or any other intra-arterial procedures

D. Stroke Resulting in Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, hemorrhage and embolization from an extra cranial source. Diagnosis has to be

confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

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

E. Open Heart Replacement or Repair of Heart Valves

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

F. Multiple Sclerosis with Persisting Symptoms

- A. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
 - i. investigations including typical MRI findings, which

unequivocally confirm the diagnosis to be multiple sclerosis;

- ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and

B. Neurological damage due to SLE is excluded.

G. Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

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

The following are excluded:

- i. Other stem-cell transplants
- ii. Where only islets of langerhans are transplanted

H. Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the

paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

I. Kidney Failure Requiring Regular Dialysis

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

J. Benign Brain Tumor

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

The following conditions are excluded:

Cysts;

Granulomas;

Malformations in the arteries or veins of the brain;

Hematoma;

Abscesses

Pituitary Tumors

Tumors of skull bones and

Tumors of the spinal cord

K. Blindness

- a. Blindness' is defined as visual acuity of less than 3/60, or a corresponding visual field loss to less than 10°, in the better eye with the best possible correction.
- b. Treatments required for correction of blindness or improvement in visual acuity will be covered

Following will be excluded:

- i. Treatment for Low vision: 'low vision' is defined as visual acuity of less than 6/18 but equal to or better than 3/60, or a corresponding visual field loss to less than 20°, in the better eye with the best possible correction.
- ii. Cases of blindness with Low Vision before the inception of policy
- iii. Cost of enucleation related to tumor's or other eye defects
- iv. Cost of prosthesis for cosmetic correction

- v. Visual aids implantable or external

L. Motor Neuron Disease with Permanent Symptoms

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

M. End Stage Lung Failure End Stage Lung Disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

- i. FEV1 test results consistently less than 1 liter measured on 3 occasions 3 months apart; and
- ii. Requiring continuous and permanent supplementary oxygen therapy for hypoxemia; and
- iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($\text{PaO}_2 < 55 \text{ mm Hg}$); and
- iv. Dyspnea at rest.

N. Third Degree Burns

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

O. Coma of Specified Severity

- a. A state of unconsciousness with no reaction or response to external stimuli or internal needs.

This diagnosis must be supported by evidence of all of the following:

- i. No response to external stimuli continuously for at least 96 hours;
 - ii. Life support measures are necessary to sustain life; and
 - iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
- b. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

3.13 Benefit 13 : Plus Benefit

An additional amount as specified in the add-on Policy Schedule will be available to the Insured Person for all claims (admissible under base plan of Base Policy)

during the Add-on Policy Year, subject to the following conditions:

- a. This Plus Benefit would be applied on the base Sum Insured only.
- b. Any unutilized amount will not be carried forward to the subsequent Add-on Policy Year.
- c. The Plus Benefit can be utilized for any number of claims admissible under the Base Policy during the Add-on Policy Year.
- d. The Plus Benefit will be applicable only after exhaustion of Base Sum Insured.
- e. Coverage as applicable for Base Policy Sum Insured shall hold good for this benefit as well.

3.14 Benefit 14 : Assisted Reproductive Treatment

The Company will indemnify the Insured Person, up to the amount specified against this Benefit in the Add-on Policy Schedule, for the medically necessary expenses incurred towards Assisted Reproductive Treatment, where indicated for sub-fertility, subject to the conditions specified below:

- i. A waiting period of 36 months from the date of first inception of this policy with the

Company for the Insured Person.

- ii. This benefit is payable only once at every block of 3 years subject to policy renewal.
- iii. To eligible for this benefit both husband and spouse shall continuously covered under this Policy at every block.

Additional Exclusions applicable to any Claim under this Benefit:

- 1. Pre and Post Hospitalization medical expenses
- 2. Sub-fertility services that are deemed to be unproven, experimental or investigational
- 3. Services not in accordance with standards of good medical practice and not uniformly recognized and professionally endorsed by the general medical community at the time it is to be provided
- 4. Reversal of voluntary sterilization
- 5. Treatment undergone for second or subsequent pregnancies except where the child from the first delivery/ previous deliveries is/are not alive at the time of treatment
- 6. Payment for services

rendered to a surrogate

7. Costs associated with cryopreservation storage of sperm, eggs and embryos
8. Selective termination of an embryo.
9. Services done at unrecognized centre
10. Surgery / procedures that enhances fertility like Tubal Occlusion, Bariatric Surgery, Diagnostic Laparoscopy with Ovarian Drilling and such other similar surgery / procedures

3.15 Benefit 15 : Modification of Robotic Surgery

Notwithstanding anything to the contrary in the Policy, if this Benefit is opted, the Company will indemnify the Insured Person up to the limit, as specified in the Add-on Policy Schedule, for expenses incurred under Hospitalization expenses for treatment taken through robotic surgery under Advance Technology Methods.

3.16 Benefit 16 : Be-fit+

The Insured Person, who is above 12 years of age, may avail unlimited visits to the Fitness Centers in a Policy year at the Company's network.

Note: The services availed would

be subject to the following conditions:

- a. The services will be provided through an empaneled Fitness center only. Choice of the Insured Person in utilizing the services of Fitness Center will be entirely his/ her own and Company will have no liability towards the quality of services provided by the Fitness Centers.
- b. Global access to specified workout classes related to Strength Training, Power Yoga, Functional Training, etc.
- c. Health risk assessment.
- d. The Company shall not be responsible for any disputes or loss in account of availing the services or arising between the Insured Person and the Fitness center.
- e. Any unutilized sessions cannot be carried forward to the next Add-on Policy Year.

3.17 Benefit 17 : Instant Cover

Notwithstanding anything to the contrary in the Policy, by opting this Benefit the Company shall waive off the applicable PED waiting period on

Option 1: Diabetes / Hypertension/ Hyperlipidemia/ Asthma; or

Option 2: Diabetes / Hypertension/ Hyperlipidemia/

Asthma / Chronic Obstructive Pulmonary Disease (COPD)/ Obesity/ Coronary Artery Disease with PTCA done prior to 1 year)

Note: The above Benefit can be opted only if this policy is issued for the first time with the Company and on continuous renewal without break in policy.

3.18 Benefit 18 : Waiver of Proportional Charge

Notwithstanding anything to the contrary in the Policy, by opting this benefit, the Insured Person will not bear the ratable Proportion on Associate Medical Expenses except Room Rent charges.

3.19 Benefit 19 : Durable Medical Equipment

The Company will indemnify up to the amount specified in the Add-on Policy Schedule subject to deductible, for the Reasonable and Customary charges necessarily incurred by the Insured Person, for procuring, fitting or hiring instruments, apparatuses or devices which medically prescribed at the time of discharge as a medical aid and not limited to compression stockings, hearing aids, speaking aids (electronic larynx), standard wheelchairs, crutches, orthopaedic supports/ braces/ corrective splints, orthotics and stoma supplies following a

Hospitalization during the Policy Year and this benefit should be availed within 60 days of hospitalization or as defined by medical practitioner in discharge summary.

Note: Spectacles, Thermometer, contact lenses, blood pressure monitoring machine and diabetes monitoring machine are not included

3.20 Benefit 20 : Maternity Cover

a. The Company shall indemnify up to the amount specified against this Benefit in the Add-on Policy Schedule for the Maternity Expenses including Pre-natal & Post-natal Medical Expenses incurred in respect of the Hospitalization of the Insured Person for the delivery of the child during the Add-on Policy Period.

b. It is agreed and understood that:

i. The Company shall be liable under this Benefit only if the Primary Insured Person for whom the Claim is made under this Benefit is covered for a continuous period as specified in the Add-on Policy Schedule.

ii. Medical Expenses for ectopic pregnancy are not covered under this Benefit.

iii. The Company shall be liable

to make payment in respect of any Hospitalization arising due to involuntary medical termination of pregnancy, as per MTP Act, 1971(amended) and other applicable laws and rules.

- c. Claim under this Benefit shall be admissible only if the age of the Insured Person and/or Primary Insured Person's spouse is 18 to 45 years.
- d. Wait Period shall be applicable as specified against this benefit in the Add-on policy schedule.
- e. Medical Expenses incurred on assisted reproductive treatment shall also be covered.
- f. New Born Baby shall be covered within Maternity Expenses Sum Insured limit

Note: Either Benefit 14 or the Benefit 20 can be opted but not both.

3.21 Benefit 21 : Surrogacy Care

If an Insured Person requires to be admitted in a Hospital in India only for complication arising during Surrogacy pregnancy & Post-partum delivery in respect of the Surrogate Mother then the Company shall indemnify the Insured Person for Medical Expenses incurred towards Hospitalization through Cashless or Reimbursement Facility,

maximum up to the amount, as specified in the Add-on Policy Schedule, provided that the Hospitalization is for a minimum period of 24 consecutive hours and was prescribed in writing, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

Conditions applicable to this Benefit are:

- a This Benefit shall be available for Insured Person who has opted for Policy with minimum 3 years Policy tenure.
- b Maximum coverage available for a surrogate mother under this Benefit is for period of thirty-six (36) continuous months from the date of initiation of the treatment/ procedure.
- c Waiting periods mentioned under Clause 4.1(a) (i),(ii) are not applicable for this Benefit.
- d Medical Expenses that are not payable under this Benefit are:
 - i Delivery expenses (Normal Delivery or caesarean section)
 - ii New Born baby through Surrogacy to the Surrogate Mother;
 - iii Miscarriage (including

miscarriage due to accident) except in case of life threatening medical condition to the Surrogate Mother, during the policy period of the Surrogate Mother;

- iv Surrogacy Treatment Procedure cost (Injection, tests, Ultra sound, Embryo transfer, Ovum pickup).
- v Surrogacy which is for commercial purposes.
- vi Costs associated with cryopreservation and storage of sperm, eggs and embryos.
- vii Services done at unrecognized center
- viii Surgery / procedures that enhance fertility like Tubal Occlusion, Bariatric Surgery, Diagnostic Laparoscopy with Ovarian Drilling and such other similar surgery / procedures.
- ix Reversal of voluntary sterilization.
- x Selective termination of an embryo.
- xi Pre and Post Hospitalization expenses

3.22 Benefit 22 : Oocyte Care

If an Insured Person requires to be admitted in a Hospital in India

only for complications arising due to Oocyte retrieval in respect of the Oocyte Donor then the Company shall indemnify the Insured Person for Medical Expenses incurred towards Hospitalization, maximum up to the amount, as specified in the Add-on Policy Schedule, provided that the Hospitalization is for a minimum period of 24 consecutive hours and was prescribed in writing, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary.

Conditions applicable to this Benefit are:

- a. This Benefit shall be available for Policy period of 1 year.
- b. Maximum coverage available for a Oocyte donor under this Benefit is for period of twelve continuous months from the date of initiation of the treatment/procedure
- c. Waiting periods mentioned under Clause 4.1(a) (i),(ii) are not applicable for this Benefit.
- d. Medical Expenses that are not payable under this Benefit are:
 - i. Delivery expenses (Normal Delivery or caesarean section)
 - ii. Costs associated with cryopreservation and storage of sperm, eggs and embryos.
- iii. Reversal of voluntary sterilization.

- iv. Selective termination of an embryo.
- v. Services done at unrecognized center
- vi. Surgery / procedures that enhance fertility like Tubal Occlusion, Bariatric Surgery, Diagnostic Laparoscopy with Ovarian Drilling and such other similar surgery / procedures.
- vii. Pre and Post Hospitalization expense

Conditions applicable for Benefit 21- Surrogacy Care and Benefit 22- Oocyte Care:

- i. The Proposal for insurance has to be made 30 days before the embryo transfer for the surrogate mother and /or 30 days before ovarian stimulation for oocyte donor.
- ii. Proposer has to be one of the Intending Couple/ Intending Woman.

3.23 Benefit 23 : Unlimited Care

The Company shall cover the Hospitalization Expenses of the Insured Person without any restriction/ limits on the Sum Insured for any one claim in the policy lifetime subject to the following conditions:

- i. This Benefit can be opted only during the inception of the policy irrespective of Policy

tenure.

- ii. Once opted the Insured Person should continue this Benefit for 5 continuous Policy Years.
- iii. This cover shall be applicable only once in lifetime of the Policy for the claim admissible under Hospitalization Expenses.
- iv. Once a claim is made under this Benefit, the cover shall cease and not be available for re-selection during the subsequent renewal.
- v. The total payout under this Benefit will also constitute: Base Sum Insured+ Bonus (if any).
- vi. This Benefit shall be applicable only within India.
- vii. This Benefit would however be subject to all limits, sub limits, co-payments, deductibles as per the Base Policy

3.24 Benefit 24 : Cumulative Bonus Booster

At the end of each Policy Year, the Company will enhance the Sum Insured by 100% flat, on a cumulative basis, irrespective of claim for unlimited period on continuous renewal of Policy and subject to the conditions specified below:

- a. The entire Cumulative Bonus Booster will be forfeited if the

Policy is not continued / renewed on or before Add-on Policy Period End Date or the expiry of the Grace Period whichever is later.

- b. In the event of a Claim there is no impact on the accrual of Cumulative Bonus Booster.
- c. The Cumulative Bonus Booster shall be applicable on an annual basis subject to continuation of the Policy.
- d. If the Insured Person in the expiring Base Policy is covered on Individual basis and thus have accumulated the Cumulative Bonus Booster for each Insured Person in the expiring policy, and such expiring policy is renewed with the Company on a Floater basis, then the Cumulative Bonus Booster to be carried forward for credit in this Policy would be the least Cumulative Bonus amongst all the Insured Persons.
- e. If the Insured Person in the expiring Base Policy are covered on a Floater basis and such Insured Persons renew their expiring Policy with the Company by splitting the Floater Sum Insured in to 2 (two) or more Individual/ Floater covers, then the Cumulative Bonus Booster of the expiring Policy shall be apportioned to such renewed Policy in the proportion of the Sum Insured of each of the

renewed Policy.

- f. At the time of Policy renewal if the Insured Person chooses not to renew this Add-on Policy, then the Cumulative Bonus Booster under the expiring Policy shall be forfeited.
- g. In case Sum Insured under the Policy is reduced at the time of renewal, the applicable Cumulative Bonus Booster shall be reduced in proportion to the Base Sum Insured of Base Policy.
- h. In case Sum Insured under the Policy is increased at the time of renewal, the Cumulative Bonus Booster shall be calculated on the Base Sum Insured of Base Policy applicable on the last completed Policy Year.
- i. Cumulative Bonus Booster would be credited automatically to the subsequent Policy year, even in case of multi-year Policies.
- j. The Cumulative Bonus Booster will be applicable only after exhaustion of Base Sum Insured, Bonus (if any) of Base Policy. Restored Sum Insured will not be taken into consideration.

3.1 Benefit 25: Room Rent Modification

Notwithstanding anything to the contrary in the Policy, if this Benefit is opted, the Company

agrees to modify the Room Category/ Room Rent of Base Policy to Single Private AC room / Twin sharing room/General Ward/ General ward maximum up to Rs. 3000 per day as specified in Add-on Policy schedule. If the Insured Person is admitted in a Hospital room where the Room Category opted or Room Rent incurred is higher than the eligible Room Category/ Room Rent as specified in the Policy Schedule, then, the Policyholder/Insured Person shall bear the ratable proportion of the total Associate Medical Expenses (including applicable surcharge and taxes thereon) in the proportion of the difference between the Room Rent actually incurred and the Room Rent specified in the Add-on Policy Schedule or the Room Rent of the entitled Room Category to the Room Rent actually incurred.

i. Single Private AC Room If the Policy Schedule states 'Single Private AC Room' as eligible Room Category, it means the maximum eligible Room Category in case of Hospitalization of the Insured Person payable by the Company is limited for stay in a Single Private AC Room.

ii. Twin Sharing Room If the Policy Schedule states 'Twin Sharing Room' as eligible Room Category, it means the

maximum eligible Room Category in case of Hospitalization of the Insured Person payable by the Company is limited for stay in a Twin Sharing Room.

iii. General Ward If the Policy Schedule states 'General ward' as eligible Room Category, it means the maximum eligible Room Category in case of Hospitalization of the Insured Person payable by the Company is limited for stay in a General ward.

iv. General Ward maximum up to Rs. 3000 per day If the Policy Schedule states 'General ward maximum up to Rs. 3000 per day' as eligible Room Category, it means the maximum eligible Room Category in case of Hospitalization of the Insured Person payable by the Company is limited for stay in a General ward with maximum up to Rs. 3000 per day.

Note:

1 The nomenclature of Room categories may vary from one hospital to the other. Hence, the final consideration will be as per the definition of the Rooms mentioned in the Policy.

2 No limit on ICU charges under this Optional

Benefit.

4 Exclusions

4.1. Standard Exclusions:

a. Waiting Periods:

i. 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 insurer.
- 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 Insurer.

ii. Named Ailment Waiting Period: Code- Excl02

- a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage, as may be the case after the date of inception of the first policy with the Company. This exclusion shall not be applicable for claims arising due to an accident.
- b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e. If the Insured Person is continuously covered

without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f. List of specific diseases/procedures:

1. Any treatment related to Arthritis (if non infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism, Spinal Disorders, Joint Replacement Surgery, Arthroscopic Knee Surgeries/ACL Reconstruction/ Meniscal and Ligament Repair
2. Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal Septum Deviation, Sinusitis and related disorders
3. Benign Prostatic Hypertrophy
4. Cataract
5. Dilatation and

Curettage

6. Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers
7. Surgery of Genito-urinary system unless necessitated by malignancy
8. All types of Hernia & Hydrocele
9. Hysterectomy for menorrhagia or Fibromyoma or prolapse of uterus unless necessitated by malignancy
10. Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant
11. Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone
12. Myomectomy for fibroids
13. Varicose veins and varicose ulcers
14. Parkinson's or Alzheimer's disease or Dementia

**iii.30-day waiting period-
Code- Excl03**

a. 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.

b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c. The referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

Notes:

i. The Waiting Periods as defined above shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

ii. If Coverage for Benefits (if applicable) are added afresh at the time of renewal of this Policy, the Waiting Periods as defined above shall be applicable afresh to the newly added

Benefits (if applicable), from the time of such renewal.

b. Permanent Exclusion:

This Add-on policy shall follow exclusions as mentioned in the Base policy.

4.2. Specific Exclusions:

This Add-on policy shall follow exclusions as mentioned in the Base policy.

5 General Terms And Clauses

5.1. Disclosure of Information

Conditions under this section are same as Base Policy.

5.2. Condition Precedent to Admission of Liability

Conditions under this section are same as Base Policy.

5.3. Claim Settlement (provision for Penal Interest)

Conditions under this section are same as Base Policy.

5.4. Complete Discharge

Conditions under this section are same as Base Policy.

5.5. Multiple Policies

Conditions under this section are same as Base Policy.

5.6. Fraud

Conditions under this section

are same as Base Policy.

5.7. Cancellation / Termination

Conditions under this section are same as Base Policy.

5.8. Migration

Conditions under this section are same as Base Policy.

5.9. Portability

Conditions under this section are same as Base Policy.

5.10. Renewal of Policy

Conditions under this section are same as Base Policy.

5.11. Withdrawal of Policy

Conditions under this section are same as Base Policy.

5.12. Moratorium Period

Conditions under this section are same as Base Policy.

5.13. Premium payment Installment

Conditions under this section are same as Base Policy.

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

Conditions under this section are same as Base Policy.

5.15. Free Look Period

Conditions under this section are same as Base Policy.

5.16. Grievances

Conditions under this section are same as Base Policy.

5.17. Nomination:

Conditions under this section are same as Base Policy.

5.18. Material Change

Conditions under this section are same as Base Policy.

5.19. Records to be maintained

Conditions under this section are same as Base Policy.

5.20. No constructive Notice

Conditions under this section are same as Base Policy.

5.21. Policy Disputes

Conditions under this section are same as Base Policy.

5.22. Limitation of liability

Conditions under this section are same as Base Policy.

5.23. Communication

Conditions under this section are same as Base Policy.

5.24. Alterations in the Policy

Conditions under this section are same as Base Policy.

5.25. Electronic Transactions

Conditions under this section are same as Base Policy.

6. Other Terms And Clauses

6.1. Claims procedure and management

Claim Procedure and Management under this Add-on Policy shall be same as in the Base Policy. Original supportive documents to be submitted for claim admissibility under this Add-on Policy

**Annexure I - List of Expenses Generally Excluded ("Non-medical")
in Hospital Indemnity Policy**

SR. NO.	List I – Optional Items	
1	Baby Food	30 Medical Certificate
2	Baby Utilities Charges	31 Medical Records
3	Beauty Services	32 Photocopies Charges
4	Belts/ Braces	33 Mortuary Charges
5	Buds	34 Walking Aids Charges
6	Cold Pack/hot Pack	35 Oxygen Cylinder (for Usage Outside The Hospital)
7	Carry Bags	36 Spacer
8	Email / Internet Charges	37 Spirometre
9	Food Charges (other Than Patient's Diet Provided By Hospital)	38 Nebulizer Kit
10	Leggings	39 Steam Inhaler
11	laundry Charges	40 Armsling
12	mineral Water	41 Thermometer
13	Sanitary Pad	42 Cervical Collar
14	Telephone Charges	43 Splint
15	Guest Services	44 Diabetic Foot Wear
16	Crepe Bandage	45 Knee Braces (long/ Short/ Hinged)
17	Diaper Of Any Type	46 Knee
18	Eyelet Collar	Immobilizer/shoulder
19	Slings	Immobilizer
20	Blood Grouping And Cross	47 Lumbo Sacral Belt
21	Matching Of Donors Samples	48 Nimbus Bed Or Water Or Air Bed Charges
22	Service Charges Where Nursing Charge Also Charged	49 Ambulance Collar
23	Television Charges	50 Ambulance Equipment
24	Surcharges	51 Abdominal Binder
25	Attendant Charges	52 Private Nurses Charges
26	Extra Diet Of Patient (other Than That Which Forms Part Of Bed Charge)	Special Nursing Charges
27	Birth Certificate	53 Sugar Free Tablets
28	Certificate Charges	54 Creams Powders Lotions (toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals)
29	Courier Charges	
30	Conveyance Charges	

	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	Trolley Cover
66	Urometer, Urine Jug
67	Ambulance
68	Vasofix Safety

Sr. No.	List II – Items That Are To Be Subsumed Into Room Charges
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
10	Tissue Paper
11	Tooth Paste

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

Sr. No.	List III – Items That Are To Be subsumed into Procedure Charges
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

Sr. No.	List iv – Items that are to be subsumed into costs of treatment
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

OFFICE OF THE OMBUDSMAN	CONTACT DETAILS	JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)
Ahmedabad	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Prakash, 6th floor, Tilak Marg, Near S.V College Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 E-mail : bimalokpal.ahmedabad@cioins.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
Bengaluru	Office of the Insurance Ombudsman, Jeevan Soudha Building ,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
Bhopal	Office of the Insurance Ombudsman, LIC of India Zonal Office Building, 1st Floor, South Wing, Jeevan Shikha, opp. Gayatri Mandir, 60-B, Hoshangabad Road, Bhopal-462011 Tel.: 0755 - 2769201 / 2769202/ 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh & Chhattisgarh
Bhubaneswar	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455/ 2596429/ 2596003 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa
Chandigarh	Office of the Insurance Ombudsman, Jeevan Deep, Ground Floor, LIC of India Building, SCO 20-27, Sector 17-A, Chandigarh – 160 017. Tel.: 0172 – 2706468/ 2707468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh
Chennai	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
Delhi	Office of the Insurance Ombudsman, 2/2 A, 1st Floor, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481 / 23213504/ 46013992 Email: bimalokpal.delhi@cioins.co.in	Delhi, Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.
Guwahati	Office of the Insurance Ombudsman, Jeevan Nivesh Building, 5th Floor, Nr. Panbazar, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 – 2632204/ 2632205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
Hyderabad	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai Showroom, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122/ 23376599/ 23376991/ 23328709/ 23325325 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana and Yanam – a part of Territory of Pondicherry
Jaipur	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Ambedkar Circle Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@cioins.co.in	Rajasthan

Kochi	Office of the Insurance Ombudsman, 10TH Floor, LIC Building, Jeevan Prakash Opp. Maharaj College Ground M. G. Road, Ernakulam - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe – a part of Pondicherry
Kolkata	Office of the Insurance Ombudsman, 7th Floor of Hindusthan Bldg.(Annex), 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Andaman & Nicobar Islands, Sikkim
Lucknow	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 – 4002082/ 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
Mumbai	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz West, Mumbai - 400 054. Tel.: 022 –69038800/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
Patna	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Baily Road, Patna Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand
Noida	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120- 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, Etah, Kanoor, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
Pune	Office of the Insurance Ombudsman, Jeevan Darshan- LIC of India Bldg., 3rd Floor, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

The updated details of Insurance Ombudsman are available on website of IRDAI: www.irda.gov.in, on the website of General Insurance Council: www.gicouncil.org.in, on the Company's website www.carehealthinsurance.com or from any of the Company's offices. Address and contact number of Executive Council of Insurers –

Office of the 'Executive Council of Insurers'

3rd Floor, Jeevan Seva Annexe,

S.V. Road, Santacruz(W),

Mumbai – 400 054.

Tel : 022-69038800/33

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Registered Office: 5th Floor, 19 Chawla House, Nehru Place, New Delhi-110019
Correspondence Office: Vipul Tech Square, Tower C, 3rd Floor, Golf Course Road, Sector-43,
Gurugram-122009 (Haryana)

CIN: U66000DL2007PLC161503 UIN: CHIHIA25043V012425

IRDAI Registration Number - 148

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Care Health-
Customer App



WhatsApp
8860402452

Self Help Portal:
www.careinsurance.com/self-help-portal.html

Submit Your Queries/Requests:
www.careinsurance.com/contact-us.html