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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

[^]The Company Was Awarded 'Best Claim Settlement Company of The Year' Award At The 9th Annual India Insurance Summit & Awards 2025, in March 2025

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/Insured Persons (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. The sentence construction and wordings in the Policy documents should be taken in its true sense and should not be taken in a way so as to take advantage of the Company by filing a claim which deviates from the purpose of Insurance.

In return for premium paid, the Company will pay the Insured in case a valid claim is made:

In consideration of the premium paid by the Policy Holder, subject to the terms & conditions contained herein, the Company agrees to pay/indemnify the Insured Person(s), the amount of such expenses that are reasonably and necessarily incurred up to the limits specified against respective Benefit in any Policy Year.

Please check whether the details given by you about the insured persons 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 policy schedule. If you find any discrepancy, please inform us within 30 days from the date of receipt of the 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 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.

For the purposes of interpretation and understanding of the product the Company has defined, herein below some of the important words used in the product and for the remaining language and the words the Company believes to mean the normal meaning of the English language as explained in the standard language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, regulations notified by the Insurance Regulatory and Development Authority of India ("Authority") and circulars and guidelines issued by the Authority shall carry the meanings described therein. The terms and conditions, insurance coverage and exclusions, other Benefits, various procedures and conditions which have been built-in to the product are to be construed in accordance with the applicable provisions contained in the product.

The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate.

2. Definitions

2.1 Standard Definitions:

2.1.1 Accidental / Accident is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2.1.2 AYUSH Hospital is a healthcare facility wherein

medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

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

2.1.3 AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such centre which is registered with the local authorities, wherever applicable, and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

- i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
- ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.1.4	Any One Illness (not applicable for Travel and Personal Accident Insurance) means a continuous Period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where the treatment was taken.		
2.1.5	Cashless Facility means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network Provider by the insurer to the extent pre-authorization is approved.		
2.1.6	Condition Precedent shall mean a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.		
2.1.7	Congenital Anomaly refers to a condition which is present since birth, and which is abnormal with reference to form, structure or position: i. Internal Congenital Anomaly – Congenital anomaly which is not in the visible and accessible parts of the body ii. External Congenital Anomaly – Congenital anomaly which is in the visible and accessible parts of the body		
2.1.8	Co-payment is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.		
2.1.9	Cumulative Bonus shall mean any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.		
2.1.10	Day Care Centre means any institution established for day care treatment of illness and/or 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 Day Care Treatment is carried out. iv. Maintains daily records of patients and will make these accessible to the insurance company's authorized		
		personnel.	
2.1.11	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 24 consecutive hours because of technological advancement, and ii. which would have otherwise required a Hospitalization of more than 24 hours. iii. Treatment normally taken on an outpatient basis is not included in the scope of this definition.	
2.1.12	Deductible is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.		
2.1.13	Dental Treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.		
2.1.14	Disclosure to Information Norm: The Policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.		
2.1.15	Domiciliary Hospitalization means medical treatment for an illness/ disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:		
		i. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or ii. The patient takes treatment at home on account of non-availability of room in a Hospital.	
2.1.16	Emergency Care (Emergency) 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.		
2.1.17	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.

2.1.18

Hospital (not applicable for Overseas Travel Insurance) means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

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

2.1.19

Hospitalization (not applicable for Overseas Travel Insurance) means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

2.1.20

Illness means a sickness or a disease or a pathological condition leading to the impairment of normal physiological function and requires medical treatment.
(a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

- i. It needs ongoing or long-term

monitoring through consultations, examinations, check-ups, and/or tests;

- ii. It needs ongoing or long-term control or relief of symptoms;
- iii. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it;
- iv. It continues indefinitely;
- v. It recurs or is likely to recur.

2.1.21

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.

2.1.22

In-patient Care (not applicable for Overseas Travel Insurance) means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

2.1.23

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

2.1.24

ICU Charges or (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.

2.1.25

Maternity expenses shall include—

- a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).

	b. Expenses towards lawful medical termination of pregnancy during the policy period.		medical practice or by the medical community in India.
2.1.26	Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.	2.1.30	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.
2.1.27	Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.	2.1.31	Network Provider (not applicable for Overseas Travel Insurance) means the Hospitals enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a Cashless Facility.
2.1.28	Medical Practitioner (not applicable for Overseas Travel Insurance) is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.	2.1.32	Newborn baby means baby born during the Policy Period and is aged up to 90 days.
2.1.29	Medically Necessary Treatment (not applicable for Overseas Travel Insurance) means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which: a. Is required for the medical management of the Illness or Injury suffered by the Insured Person; b. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity; c. Must have been prescribed by a Medical Practitioner; d. Must conform to the professional standards widely accepted in international	2.1.33	Non - Network Provider: Non-Network means any hospital, day care centre or other provider that is not part of the network.
		2.1.34	Notification of Claim means the process of intimating a Claim to the Insurer or TPA through any of the recognized modes of communication.
		2.1.35	OPD Treatment is one in which the Insured Person 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.
		2.1.36	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.
		2.1.37	Pre-existing Disease means any condition, ailment, injury or disease i. That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or ii. For which medical advice or treatment was recommended

	by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.		Injury involved.
2.1.38	Pre-hospitalization Medical Expenses means Medical Expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that : i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.	2.1.42	Renewal defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
2.1.39	Post-hospitalization Medical Expenses means Medical Expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the Hospital provided that: i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required and ii. The inpatient Hospitalization claim for such Hospitalization is admissible by the Company.	2.1.43	Room Rent means the amount charged by a Hospital towards Room & Boarding expenses and shall include the associated medical expenses.
2.1.40	Qualified Nurse (not applicable for Overseas Travel Insurance) is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.	2.1.44	Subrogation (Applicable to other than Health Policies and health sections of Travel and PA policies) means the right of the Insurer to assume the rights of the Insured Person to recover expenses paid out under the Policy that may be recovered from any other source.
2.1.41	Reasonable and Customary Charges (not applicable for Overseas Travel Insurance) means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/	2.1.45	Surgery/Surgical Procedure: means manual and/or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a Hospital or a Day Care Centre by a Medical Practitioner.
		2.1.46	Unproven/Experimental Treatment means a treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
		2.1.47	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.
		2.1.48	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.

2.2 Specific Definitions:

- 2.2.1 **Age** means the completed age of the Insured Person as on his last birthday.
- 2.2.2 **AYUSH treatments** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems..
- 2.2.3 **Ambulance** means a vehicle operated by a licensed/ authorized service provider and equipped for the transport and paramedical treatment of persons requiring medical attention.
- 2.2.4 **Annexure** means the document attached and marked as Annexure to this Policy.
- 2.2.5 **Assistance Service Provider** means the service provider specified in the Policy Schedule appointed by the Company from time to time.
- 2.2.6 **City of Residence** means and includes any city, town or village in which the Insured Person is currently residing in India and as specified in the Insured Person's corresponding address in the Policy Schedule.
- 2.2.7 **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of the specified Benefits in respect of the Insured Person as covered under the Policy.
- 2.2.8 **Claimant** means a person who possesses a relevant and valid Insurance Policy which is issued by the Company and is eligible to file a Claim in the event of a covered loss.
- 2.2.9 **Company** (also referred as Insurer/We/Us) means Care

Health Insurance Limited.

- 2.2.10 **Diagnosis** means pathological conclusion drawn by a registered medical practitioner, supported by acceptable Clinical, radiological, histological, histo-pathological and laboratory evidence wherever applicable.
- 2.2.11 **Empanelled Provider** means any qualified diagnostic center, Hospital and Medical Practitioner that has been empanelled with the Company to provide Services under Benefit 8: Cardiac Health Check -up and Optional Benefit 4: Active Health Check-up.
- 2.2.12 **Hazardous Activities** (or Adventure sports) means any sport or activity, which is potentially dangerous to the Insured whether he is trained or not. Such sport/activity includes (but not limited to) stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, cave tubing, rock climbing/ trekking/ mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labor, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/ parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling of any type.

- 2.2.13 Indemnity/Indemnify** means compensating the Insured Person up to the extent of expenses incurred, on occurrence of an event which results in a financial loss and is covered as the subject matter of the Insurance Cover.
- 2.2.14 Insured Event** means an event that is covered under the Policy; and which is in accordance with the Policy Terms & Conditions.
- 2.2.15 Insured Person** (Insured) means a person whose name specifically appears under Insured in the Policy Schedule and with respect to whom the premium has been received by the Company.
- 2.2.16 Nominee** means the person named in the Policy Schedule or as declared with the Policyholder who is nominated to receive the benefits under this Policy in accordance with the terms of the Policy, if the Insured Person is deceased.
- 2.2.17 Policy** means these Policy terms and conditions and Annexures thereto, the Proposal Form, Policy Schedule and Optional Cover (if applicable) which form part of the Policy and shall be read together.
- 2.2.18 Policy Schedule** is a certificate attached to and forming part of this Policy.
- 2.2.19 Policy Year** means a period of one year commencing on the Policy Period Start Date or any anniversary thereof.
- 2.2.20 Policyholder** (also referred as You) means the person named in the Policy Schedule as the Policyholder.
- 2.2.21 Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date of the Policy as specifically appearing in the Policy Schedule.
- 2.2.22 Policy Period End Date** means the date on which the Policy expires, as specifically appearing in the Policy Schedule.
- 2.2.23 Policy Period Start Date** means the date on which the Policy commences, as specifically appearing in the Policy Schedule.
- 2.2.24 Senior Citizen** means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.
- 2.2.25 Single Private Room** means an air conditioned room in a Hospital where a single patient is accommodated with a couch for the attendant and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a Single room in that Hospital.
- 2.2.26 Sum Insured** means the amount specified in the Policy Schedule, for which premium is paid by the Policyholder
- 2.2.27 Third Party Administrator** or TPA means a company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services as mentioned under IRDAI (TPA-Health Services) Regulations as amended from time to time.
- 2.2.28 Total Sum Insured** is the sum total of Sum Insured and the Sum Insured accrued as No Claims Bonus, Sum Insured reinstated as Automatic Recharge, and/or OPD Benefit (Optional Benefit) and/or Home Care (Optional Benefit). It represents the Company's maximum, total and cumulative liability in respect of the Insured Person for any and all Claims incurred during the Policy Year. If the Policy Period is more than 12 months, then it is clarified that the Sum Insured shall be applied separately for each Policy Year in the Policy Period.
- 2.2.29 Associate Medical Expenses** means those Medical Expenses as listed below which vary in accordance with the Room Rent or Room Category applicable in a Hospital:
- Room, boarding, nursing and operation theatre expenses as charged by the Hospital where the Insured Person availed medical treatment;
 - Fees charged by surgeon, anesthetist, Medical Practitioner;
- Note: Associate Medical Expenses are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which

differential billing is not adopted based on the room category.

2.2.30

Activities of Daily Living are

- (a) **Washing:** the ability to wash in the bath or shower(including getting into and out of the bath or shower) or wash satisfactorily by other means;
- (b) **Dressing:** the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- (c) **Transferring:** the ability to move from a bed to an upright chair or wheelchair and vice versa;
- (d) **Mobility:** the ability to move indoors from room to room on level surfaces;
- (e) **Toileting:** the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- (f) **Feeding:** the ability to feed oneself once food has been prepared and made available.

3. Benefits Covered Under The Policy:

A. General Conditions Applicable To All The Benefits And Optional Benefits

1. The maximum, total and cumulative liability of the Company in respect of an Insured Person for any and all Claims arising under this Policy during the Policy Year shall not exceed the Total Sum Insured for that Insured Person.
 - I. On Floater Basis, the Company's maximum, total and cumulative liability, for any and all Claims incurred during the Policy Year in respect of all Insured Persons, shall not exceed the Total Sum Insured.
 - II. For any single Claim during a Policy Year, the maximum Claim amount payable shall be sum total of Sum Insured, No Claims Bonus, Automatic Recharge, OPD Care (Optional Benefit) and Home Care (Optional Benefit).
 - III. All Claims shall be payable subject

to the terms, conditions, exclusions, sub-limits and wait periods of the Policy and subject to availability of the Total Sum Insured.

IV. The Company's liability shall be restricted to the payment of the balance amount subject to the available Total Sum Insured.

2. The Co-payment proportion as specified in the Policy Schedule, shall be borne by the Policyholder / Insured Person on each Claim which will be applicable on Benefit 1 (Hospitalization Expenses), Benefit 2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses), Benefit 3 (AYUSH Treatments), Benefit 4 (Ambulance Cover) and Benefit 5 (Domiciliary Hospitalization).
3. Deductible if opted is applicable on the Benefits namely Benefit 1 (Hospitalization Expenses), Benefit 2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses), Benefit 3 (AYUSH Treatments), Benefit 4 (Ambulance Cover) and Benefit 5 (Domiciliary Hospitalization).
4. Any Claim paid for Benefits namely Hospitalization Expenses, Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses, AYUSH Treatments, Ambulance Cover, Domiciliary Hospitalization, shall reduce the Sum Insured for the Policy Year and only the balance shall be available for all the future claims for that Policy Year.
5. Admissibility of a Claim under Benefit "Hospitalization Expenses" is a pre-condition to the admission of a Claim under Pre Hospitalization Medical Expenses and Post Hospitalization Medical expenses, AYUSH Treatment, Ambulance Cover, Automatic Recharge and Home Care subject to the event giving rise to a Claim under Benefit "Hospitalization Expenses" shall be within the Policy Period for the Claim of such Benefit to be accepted.
6. If the Insured Person suffers a relapse within 45 days from the date of last discharge / consultation from the Hospital for which a Claim has been made, then

such relapse shall be deemed to be part of the same Claim and all the limits of Per Claim Limit under this Policy shall be applied as if they were under a single Claim.

7. Option of Mid-term inclusion of a Person in the Policy will be only upon marriage. Additional differential premium will be calculated on a pro rata basis.
8. Coverage amount limits for Benefits 'OPD Care' and Home Care' are covered over and above the 'Sum Insured'.
9. Optional covers opted are available for all members in a floater policy. If Insured persons belonging to the same family are covered on an Individual basis, then every Insured person can opt for different Sum Insured and different Optional Benefits.
10. Any Claims made under the Benefits :Cardiac Health Check -up ,OPD Care (Optional Benefit), International Second Opinion (Optional Benefit), Active Health Check- up (Optional Benefit) and Home Care (Optional Benefit), will not affect the no claims bonus accrual under the Benefit : No Claims Bonus

B. Specific Conditions

Specific Conditions shall be applicable only if the Specific Condition is specified to be applicable to the Insured Person in the Policy Schedule.

1. The Policyholder shall bear a Co-payment per Claim (as specified in the Policy Schedule) of the final amount admitted as payable by the Company in accordance with Clause 6.1.6 and the Company's liability shall be restricted to payment of the balance amount subject to the available Sum Insured.
2. The applicable Co-payment will increase by 10% per Claim in the Policy Year following the Insured Person (or eldest Insured Person in the case of a Floater cover) attaining Age 71. If an Insured Person (or eldest Insured Person in the case of a Floater cover) attains age 71 years during the Policy Period, additional 10% co-payment will be applicable to the Policy only at the time of subsequent renewal.

3. However, if the age of the Insured Person or eldest Insured Person (in case of Floater) at the time of issue of the first Policy with the Company is 70 years or below, then the Insured Person has an option to waive the condition for the additional 10% Co-payment upon payment of extra premium in this regard.
4. The Co-payment shall be applicable to each and every Claim made, for each Insured Person subject to Clause 3 .A.(2)

3.1 Base Policy

3.1.1 Benefit 1 : Hospitalization Expenses

If an Insured Person is diagnosed with an illness or suffers an injury and which requires the Insured Person to be admitted in a Hospital in India which should be Medically Necessary during the Policy Period and while the Policy is in force for:

- (i) **In-patient Care:** The Company will indemnify the Insured Person for Medical Expenses incurred towards Hospitalization through Cashless or Reimbursement Facility, maximum up to the Sum Insured, as specified in the 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.
- (ii) **Day Care Treatment:** The Company will indemnify the Insured Person for Medical Expenses incurred on Day Care Treatment through Cashless or Reimbursement Facility, maximum up to the Sum Insured ,as specified in the Policy Schedule, provided that the Day Care Treatment is listed as per the Annexure-I to Policy Terms & Conditions and period of treatment of the Insured Person in the Hospital/Day Care Centre does not exceed 24 hours, which would otherwise require an in-patient admission and such Day Care Treatment was prescribed in

written, by a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were Medically Necessary

(iii) Conditions applicable for Hospitalization Expenses (Benefit 1):

(a) Room/Boarding and nursing expenses as charged by the Hospital where the Insured Person availed medical treatment (Room Rent / Room Category):

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 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 Policy Schedule or the Room Rent of the entitled Room Category to the Room Rent actually incurred.

The Policy Schedule will specify the eligibility of Room Rent or Room Category applicable for the Insured Person under the Policy. The Room Rent or Room Category available under this Policy is mentioned as follows:

- 1) Single Private Room** If the Policy Schedule states 'Single Private 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 to stay in a

Single Private Room.

- 2)** If the Policy Schedule states 'up to 1% of the Sum Insured per day' as eligible Room Rent, it means the maximum eligible Room Rent of the Insured Person payable by the Company is limited to 1% of the Sum Insured per day of Hospitalization. Any amount accrued as No Claims Bonus under (Benefit 7) shall not form part of Coverage for Room Rent/Room Category
- 3)** 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.

(b) Intensive Care Unit Charges (ICU Charges):

The Policy Schedule will specify the limit of ICU Charges applicable for the Insured Person under the Policy. The ICU Charges available under this Policy are as follows:

- 1)** If the Policy Schedule states 'up to 2% of the Sum Insured per day' as eligible ICU Charges per day of Hospitalization, it means the maximum eligible ICU charges of the Insured Person payable by the Company is limited to 2% of the Sum Insured per day of Hospitalization. Any amount accrued as No Claims Bonus (Benefit 7) shall not form part of coverage for ICU Charges
- 2)** If the Policy Schedule states the eligibility of ICU Charges of the Insured Person as 'no sub-limit', it means that there is no separate restriction on ICU Charges incurred towards stay in ICU during Hospitalization.

(C) Expenses incurred on treatment for Named Ailments/Procedures

The Company will indemnify the Insured Person for Expenses incurred in respect of the below mentioned Ailments /

Procedures up to the amount specified against each and every Ailment / Procedure mentioned in the Policy Schedule in a Policy Year, provided that the treatment was taken on the advice of a Medical Practitioner.

- i. Treatment of Cataract
- ii. Treatment of Total Knee Replacement
- iii. Surgery for treatment of all types of Hernia
- iv. Hysterectomy
- v. Surgeries for Benign Prostate Hypertrophy (BPH)
- vi. Surgical treatment of stones of renal system
- vii. Treatment of Cerebrovascular disorders
- viii. Treatments/Surgeries for Cancer
- ix. Treatment of other renal complications and Disorders
- x. Treatment for breakage of bones

(iv) Advanced Technology Methods

The Company will indemnify the Insured Person for expenses incurred under Benefit 1 (Hospitalization Expenses) for treatment taken through following advance technology methods:

- a. Uterine Artery Embolization and HIFU
- b. Balloon Sinuplasty
- c. Deep Brain stimulation
- d. Oral chemotherapy
- e. Immunotherapy- Monoclonal Antibody to be given as injection
- f. Intra vitreal injections
- g. Robotic surgeries
- h. Stereotactic radio surgeries
- i. Bronchical Thermoplasty
- j. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)

- k. IONM - (Intra Operative Neuro Monitoring)
- l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

3.1.2 Benefit 2 : Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses

The Company will indemnify the Insured Person for Medical Expenses incurred which are Medically Necessary, only through Reimbursement Facility, maximum up to the amount/limit, as specified in the Policy Schedule, provided that the Medical Expenses so incurred are related to the same Illness/Injury for which the Company has accepted the Insured Person's Claim under Benefit 1 (Hospitalization Expenses) and subject to the conditions specified below:

- (i) Under Pre-hospitalization Medical Expenses, for a period of 30 days immediately prior to the Insured Person's date of admission to the Hospital, provided that the Company shall not be liable to make payment for any Pre-hospitalization Medical Expenses that were incurred before the Policy Start Date; and
- (ii) Under Post-hospitalization Medical Expenses, for a period of 60 days immediately after the Insured Person's date of discharge from the Hospital.
- (iii) If the provisions of Clause 6.1.7(d)(Payment terms) is applicable to a Claim, then:
 - a) The date of admission to Hospital for the purpose of this Benefit shall be the date of the first admission to the Hospital for the Illness deemed or Injury sustained to be Any One Illness; and
 - b) The date of discharge from Hospital for the purpose of this Benefit shall be the last

date of discharge from the Hospital in relation to the Illness deemed or Injury sustained to be Any One Illness.

3.1.3 Benefit 3: AYUSH Treatments:

The Company will indemnify the Insured Person, through Cashless or Reimbursement Facility, up to the Sum Insured specified in the Policy Schedule, towards in-patient Medical Expenses incurred with respect to the Insured Person's Medical treatment undergone at any AYUSH Hospitals or healthcare facilities for any of the treatments namely Ayurveda, Yoga, Naturopathy, Sidha, Unani and Homeopathy, provided that the Medical Expenses so incurred are related to the Illness for which the Company has accepted the Insured Person's Claim under In-patient Care of Benefit 1 (Hospitalization Expenses) and subject to conditions as specified below:

- (i) Medical Treatment should be rendered from a registered Medical Practitioner who holds a valid practicing license in respect of such AYUSH treatments; and
- (ii) Such treatment taken is within the jurisdiction of India; and
- (iii) Clause 4.2(a)(13) under Permanent Exclusions, is superseded to the extent covered under this Benefit.

3.1.4 Benefit 4: Ambulance Cover

The Company will indemnify the Insured Person, through Cashless or Reimbursement Facility, up to the amount specified against this Benefit in the Policy Schedule, provided that the Medical Expenses so incurred are related to the Illness for which the Company has accepted the Insured Person's Claim under Benefit 1 (Hospitalization Expenses) and subject to conditions as specified below:

- (i) Such ambulance transportation is offered by a Hospital or by an Ambulance service provider for the Insured Person's necessary transportation; and
- (ii) Such ambulance transportation is certified by the treating Medical Practitioner; and

- (iii) Such Transportation is from the place of occurrence of Medical Emergency of the Insured person, to the nearest Hospital; and/or
- (iv) Such Transportation is from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Person, following an Emergency.

3.1.5 Benefit 5: Domiciliary Hospitalization

The Company will indemnify the Insured Person, only through Reimbursement Facility, up to the Sum Insured as specified against this Benefit in the Policy Schedule, for the Medical Expenses incurred towards Domiciliary Hospitalization, i.e., Coverage extended when Medically Necessary treatment is taken at home (as explained in Definition 2.1.15), subject to the conditions specified below:

- (i) The Domiciliary Hospitalization continues for a period exceeding 3 consecutive days;
- (ii) The Medical Expenses are incurred during the Policy Year;
- (iii) The Medical Expenses are Reasonable and Customary Charges which are necessarily incurred;
- (iv) Any Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses (Benefit 2) shall be payable under this Benefit;
- (v) Any Medical Expenses incurred for the treatment in relation to any of the following diseases shall not be payable under this Benefit :
 1. Asthma;
 2. Bronchitis;
 3. Chronic Nephritis and Chronic Nephritic Syndrome;
 4. Diarrhoea and all types of Dysenteries including Gastro-enteritis;
 5. Diabetes Mellitus and Diabetes Insipidus;
 6. Epilepsy;
 7. Hypertension;
 8. Influenza, cough or cold;

9. All Psychiatric or Psychosomatic Disorders;
10. Pyrexia of unknown origin for less than 10 days;
11. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;
12. Arthritis, Gout and Rheumatism.

3.1.6 Benefit 6: Automatic Recharge:

If a Claim is payable under the Policy, then the Company agrees to automatically make the reinstatement of up to the Sum Insured once in a policy year which is valid for that Policy Year only, subject to the conditions specified below:

- (i) The Recharge shall be utilized only after the Sum Insured and No Claims Bonus (Benefit – 7) has been completely exhausted in that Policy Year;
- (ii) A Claim will be admissible under the Recharge only if the Claim is admissible under Benefit 1 (Hospitalization Expenses);
- (iii) The Sum Insured available under recharge can only be utilized for Benefit 1 (Hospitalization Expenses), Benefit 2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses), Benefit 3 (AYUSH Treatments), Benefit 4 (Ambulance Cover), Benefit 5 (Domiciliary Hospitalization)
- (iv) The Recharge shall be available only for all future Claims which are not in relation to any Illness or Injury for which a Claim has already been admitted for that Insured Person during that Policy Year. In case of a floater policy, the insured(s) who has not claimed will be eligible to utilize the Recharged amount for any illness or injury pertaining to that Policy Year.
- (v) No Claims Bonus (Benefit – 7) shall not be considered while calculating 'Automatic Recharge';
- (vi) Any unutilized Recharge cannot be carried forward to any subsequent Policy Year;
- (vii) If the Policy is issued on a Floater basis, then the Recharge will also be available only on Floater basis;

- (viii) For any single Claim during a Policy Year the maximum Claim amount payable shall be sum total of:
 - a) Sum Insured
 - b) No Claims Bonus (Benefit – 7)
- (ix) During a Policy Year, the aggregate Claim amount payable, subject to admissibility of the Claim, shall not exceed the sum total of:
 - a) Sum Insured
 - b) No Claims Bonus (Benefit – 7)
 - c) Automatic Recharge (Benefit – 6)

3.1.7 Benefit 7: No Claims Bonus:

At the end of each Policy Year, the Company will enhance the Sum Insured by 10% flat, on a cumulative basis, as a No Claims Bonus for each completed and continuous Policy Year, provided that no Claim has been paid by the Company in the expiring Policy Year, and subject to the conditions specified below:

- (i) In any Policy Year, the accrued No Claims Bonus, shall not exceed 50% of the Sum Insured available in the renewed Policy;
- (ii) The No Claims Bonus shall not enhance or be deemed to enhance any Conditions as prescribed under Clause 3.1.1(iii);
- (iii) For a Floater policy, the No Claims Bonus shall be available on Floater basis and shall accrue only if no Claim has been made in respect of any Insured Person during the expiring Policy Year. The No Claims Bonus which is accrued during the claim-free Policy Year will only be available to those Insured Persons who were insured in such claim-free Policy Year and continue to be insured in the subsequent Policy Year;
- (iv) The entire No Claims Bonus will be forfeited if the Policy is not continued / renewed on or before Policy Period End Date or the expiry of the Grace Period whichever is later;
- (v) The No Claims Bonus shall be applicable on an annual basis subject to continuation

of the Policy;

- (vi) If the Insured Persons in the expiring policy are covered on Individual basis and thus have accumulated the No Claims Bonus for each Insured Person in the expiring policy, and such expiring policy is renewed with the Company on a Floater basis, then the No Claims Bonus to be carried forward for credit in this Policy would be the least No Claims Bonus amongst all the Insured Persons;
- (vii) If the Insured Persons in the expiring 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 Floater / Individual covers, then the No Claims Bonus of the expiring Policy shall be apportioned to such renewed Policy in the proportion of the Sum Insured of each of the renewed Policy;
- (viii) This clause does not alter the Company's right to decline renewal or cancellation of the Policy for reasons as specified in Clause 5.1.1 (Disclosure to Information Norm);
- (ix) In the event of a Claim occurring during any Policy Year, the accrued No Claims Bonus will be reduced by 10% of the Sum Insured at the commencement of next Policy Year, but in no case shall the Total Sum Insured be reduced than the Sum Insured;
- (x) In case Sum Insured under the Policy is reduced at the time of renewal, the applicable No Claims Bonus shall also be reduced in proportion to the Sum Insured;
- (xi) In case Sum Insured under the Policy is increased at the time of renewal, the No Claims Bonus shall be calculated on the Sum Insured applicable on the last completed Policy Year;
- (xii) The Recharge amount ('Automatic Recharge') shall not be considered while calculating 'No Claims Bonus';
- (xiii) No Claims Bonus' can only be

utilized for (Base Covers) under the Policy;

- (xiv) In case no claim is made in a particular Policy Year, No Claims Bonus would be credited automatically to the subsequent Policy year.

Note:

If Insured wishes to opt for discount on premium instead of additional Sum Insured at the time of renewal, then the Insured would be eligible for a No Claim Discount of Rs. 49 (individual cover) /Rs. 99 (floater cover) in the base premium provided and subject to :

- 1) Maximum NCB amount is not yet accrued by Insured under the Policy.
- 2) No discount shall be offered in case of claim paid in previous Policy Year.
- 3) Number of times the discount can be offered shall be same as number of times NCB amount gets accrued year on year.
- 4) Insured has the option at the time of renewal only either to opt for additional Sum Insured or discount on renewal premium due to no claim but not both.

3.1.8 Benefit 8: Cardiac Health Check-up :

On the Insured Person's request, the Company will arrange for the Insured Person's Cardiac Health Check-up on a Cashless basis for the set of medical tests specified below as per the Sum Insured (SI) at its Network Provider or any other Empanelled Providers with the Company to provide the services, in India, provided that this Benefit shall be available only once during a Policy Year for each insured covered under the Policy.

- a) Set of Medical Tests Covered in the Cardiac Health Check-up applicable for SI=2L/ 3L/4L/5L

Cardiac Health Check – up set

Complete Blood Count with ESR

Urine RE

Blood Group

HbA1C

TMT
Lipid Profile
Kidney Function test
Liver Function test
TSH
Medical Examination Report
Hbs Ag
Chest X Ray

- b) Set of Medical Tests Covered in the Cardiac Health Check-up applicable for SI=7L/10L

Cardiac Health Check – up set
Complete Blood Count with ESR
Urine RE
Blood Group
HbA1C
TMT
Lipid Profile
Kidney Function test
Liver Function test
TSH
Medical Examination Report
Hbs Ag
Chest X Ray
2D Echo
APTT

3.2 Optional Benefits:

The Policy provides the following Optional Benefits which can be opted either at the inception of the policy or at the time of renewal. The Policy Schedule will specify the Optional Benefits that are in force for the Insured Persons.

3.2.1 Optional Benefit 1: OPD Care:

The Company will indemnify the Insured Person, through Reimbursement/Cashless Facility, for availing Out-Patient consultations, Diagnostic Examinations and Pharmacy expenses, up to the amount specified against

this Benefit in the Policy Schedule, during the Policy Year, Provided that:

- Coverage for Diagnostics Examinations is limited up to 50% of the coverage amount for 'OPD Care';
- Coverage for the Benefit 'OPD Care' is provided for entire Policy Year and is available to all the Insured Persons in a Floater Policy type along with Individual Policy type;
- All the valid OPD claim expenses incurred by the Insured Person in a policy year will be payable by the Company. However, in case of reimbursement, claim can be filed with the Company, only twice during that Policy year, as and when that Insured Person may deem fit.

3.2.2 Optional Benefit 2: International Second Opinion:

In the event that the Insured Person is diagnosed with any Major Illness / Injury during the Policy Year, then at the Policyholder's / Insured Person's request, the Company shall arrange for a Second Opinion from a Medical Practitioner anywhere in the world.

It is agreed and understood that the International Second Opinion will be based only on the information and documentation provided to the Company which will be shared with the Medical Practitioner and is subject to the conditions specified below:

- This Benefit can be availed only once by an Insured Person during the Policy Year;
- The Insured Person is free to choose whether or not to obtain the Second Opinion and, if obtained under this Benefit, then whether or not to act on it;
- This Benefit is for additional information purposes only and does not and should not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.
- The Company does not provide a Second Opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other person's reliance on the same or the use to which the Second Opinion is put.
- The Company does not assume any

liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any Second Opinion or for any consequences of actions taken or not taken in reliance thereon.

- (vi) The Policyholder or Insured Person shall hold the Company harmless for any loss or damage caused by or arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions or representations made by the Medical Practitioner or for any consequences of any action taken or not taken in reliance thereon.
- (vii) Any Second Opinion provided under this Benefit shall not be valid for any medico-legal purposes.
- (viii) The Second Opinion does not entitle the Insured Person to any consultation from or further opinions from that Medical Practitioner.
- (ix) For the purpose of this Benefit only:
Major Illness / Injury means one of the following only:
 - 1. Benign Brain Tumor
 - 2. Cancer
 - 3. End Stage Lung Failure
 - 4. Myocardial Infarction
 - 5. Coronary Artery Bypass Graft
 - 6. Heart Valve Replacement
 - 7. Coma
 - 8. End Stage Renal Failure
 - 9. Stroke
 - 10. Major Organ Transplant
 - 11. Paralysis
 - 12. Motor Neuron Disorder
 - 13. Multiple Sclerosis
 - 14. Major Burns
 - 15. Total Blindness

3.2.3 Optional Benefit 3: Home Care:

The Company will indemnify the Insured

Person for the expenses incurred up to the amount per day as specified in the Policy Schedule only through Reimbursement towards the hiring of a Qualified Nurse with the purpose of providing necessary care and convenience to the Insured Person to perform his Activities of Daily Living, and are recommended and certified by a Medical Practitioner to be necessary in writing that the Insured is unable to perform at least two of the Activities of Daily Living, provided that:

- i. A Claim will be admissible under this Benefit only if a Claim is admissible under Benefit 1 (Hospitalization Expenses) limited to the ailment for which the benefit is required;
- ii. The Company shall not be liable to make payment under this Benefit for the first day of hiring the Qualified Nurse in respect of an Illness/Injury;
- iii. This Benefit can only be availed within 30 days of last Discharge Date from the Hospital.
- iv. The Company shall not be liable to make payment under this Benefit for more than 7 consecutive days arising from Any One Illness or Injury or related ailment or its direct complication; and
- v. The Company shall not be liable to make payment under this Benefit for more than 45 days per Policy Year per Insured Person.
- vi. Exclusion for only Rehabilitation measures, private duty nursing, respite care private duty nursing mentioned in Clause 4.1 (b) (2) under Permanent Exclusions, is superseded to the extent covered under this Benefit

3.2.4 Optional Benefit 4: Active Health Check-up:

On the Insured Person's request, the Company will arrange for the Insured Person's Health Check-up for the set of medical tests specified below irrespective of the Sum Insured at its Network Provider or any other Empanelled Providers with the Company to provide the services on a Cashless basis, in India provided that this Benefit shall be available only thrice (one set at a time) during a Policy Year for each insured covered under the Policy.

Please note that coverage under this Benefit is over and above the coverage for Benefit 8:

Cardiac Health Check –up. Set of Medical Tests covered under this Benefit are as below:

Active Health Check-up set
Blood Pressure
Lipid Profile
Fasting & PP Blood Sugar

4. Exclusion

4.1. Standard Exclusions:

(a) Wait Period

(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 24 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 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

(ii) Specific Waiting Period: Code-Excl02

- a. Expenses related to the treatment of the listed C o n d i t i o n s , 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:
 - a) Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism and Spinal Disorders, Joint Replacement Surgery;
 - b) 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;
 - c) Benign Prostatic

- Hypertrophy;
- d) Cataract;
- e) Dilatation and Curettage;
- f) Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Ulcers of Gastro Intestinal tract;
- g) Surgery of Genito urinary systems;
- h) All types of Hernia, Hydrocele;
- i) Hysterectomy for menorrhagia or fibromyoma or prolapse of uterus;
- j) Internal tumors, skin tumors, cysts, nodules, polyps including breast lumps;
- k) Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone / Myomectomy for fibroids;
- m) Varicose veins and varicose ulcers;
- n) Pancreatitis;
- o) End stage liver disease;
- p) Procedures for Retinal disorders;
- q) Cerebrovascular accident;
- r) Renal Failure / End Stage Renal Disease;
- s) Cardiomyopathies;
- t) Myocardial Infarction;
- u) Heart Failure, Arrhythmia / Heart blocks, ASD/VSD/PDA;
- v) All types of Cancer;
- w) Arthroscopic Knee Surgeries / ACL Reconstruction/Meniscal and Ligament Repair.

(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.
- (iv) The Waiting Periods as defined in Clauses 4.1(a)(I), 4.1(a)(ii) and 4.1(a)(iii) shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.
- (v) If coverage for Benefits (in case of change in Product Plan) or Optional Benefits are added afresh at the time of renewal of this Policy, the Waiting Periods as defined above in Clauses 4.1(a)(i), 4.1(a)(ii) and 4.1(a)(iii) shall be applicable afresh to the newly added Benefits or Optional Benefits (if applicable), from the time of such renewal.

(b) Permanent Exclusions:

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions.

The following list of permanent exclusions is applicable to all the Benefits including Optional Benefits:

- 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.
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.
 3. Obesity/ Weight Control: **(Code- Excl06)**

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

 - 1) Surgery to be conducted is upon the advice of the Doctor
 - 2) The surgery/Procedure conducted should be supported by clinical protocols
 - 3) The member has to be 18 years of age or older and
 - 4) Body Mass Index (BMI);
 - a) greater than or equal to 40 or
 - b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart
- disease
- iii. Severe Sleep Apnea
 - iv. Uncontrolled Type2 Diabetes
4. Change-of-Gender treatments: **(Code- Excl07)**

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
 5. Cosmetic or plastic Surgery: **(Code- Excl08)**

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
 6. Hazardous or Adventure sports: **(Code- Excl09)**

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
 7. Breach of law: **(Code- Excl10)**

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
 8. Excluded Providers: **(Code- Excl11)**

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website /notified to the policyholders are not admissible. However, in case of life threatening

situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

Note: Refer Annexure – III of the Policy Terms & Conditions for list of excluded hospitals.

9. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**
10. Treatments received in health spas, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13)**
11. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code- Excl14)**
12. Refractive Error: **(Code- Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.
13. Unproven Treatments: **(Code- Excl16)**
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
14. Sterility and Infertility: **(Code- Excl17)**
Expenses related to sterility and infertility. This includes:
 - (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

15. Maternity: **(Code Excl18)**

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

4.2. Specific Exclusions:

(a) Permanent Exclusions:

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions.

The following list of permanent exclusions is applicable to all the Benefits including Optional Benefits:

1. Any item or condition or treatment specified in List of Non-Medical Items (Annexure – II to Policy Terms & Conditions).
2. Treatments rendered by a Doctor who shares the same residence as an Insured Person or who is a member of an Insured Person's family.
3. Any condition caused by or associated with any sexually transmitted disease except arising out of HIV.
4. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.
5. Charges incurred for Treatment/Diagnosis in connection

with routine eye, ear and denture, artificial teeth and all other similar external appliances and/or devices whether for diagnosis or treatment.

6. Any expenses related to instruments used in treatment of sleep disorder or sleep apnea syndrome and oxygen concentrator for asthmatic condition, cost of cochlear implants and related surgery.
7. Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, remodeling clinic or similar institutions.
8. Screening, counseling or treatment of any external Congenital Anomaly or Illness or defects or anomalies or treatment relating to external birth defects.
9. Treatment of mental retardation, arrested or incomplete development of mind of a person, subnormal intelligence or mental intellectual disability.
10. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.
11. All preventive care (except eligible and entitled for Benefit 8: Cardiac Health Check-up and Optional Benefit 4: Active Health Check-up), Vaccination, including Inoculation and Immunizations (except in case of post-bite treatment), vitamins and tonics.
12. All expenses (or Treatment undergone) related to donor treatment including surgery to remove organs from the donor, in case of transplant surgery.
13. Non-Allopathic Treatment or treatment related to any unrecognized systems of medicine. This exclusion will not be applicable for Inpatient Hospitalization of the Insured to the extent covered under the Benefit 3: AYUSH Treatments.
14. Expenses incurred for Artificial life maintenance, including life support

machine use, post confirmation of vegetative state or brain dead by treating medical practitioner where such treatment will not result in recovery or restoration of the previous state of health under any circumstances.

15. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
16. Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane
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.

18. Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants unless prescribed by a medical practitioner.
19. Alopecia wigs and/or toupee and all hair or hair fall treatment and products.
20. Taking part or is supposed to participate in a naval, military, air force operation or aviation in a professional or semi-professional nature.
21. Remicade, Avastin or similar injectable treatment not requiring 24 hour hospitalization.
22. Expenses related to any kind of Advance Technology Methods other than mentioned in the Clause 3.1.1 (iv).
23. Treatment sought for any medical condition, not covered under the Benefit but arising during the Hospitalization for the condition covered under the Benefit.
24. In-case Insured Person is suffering from or has been diagnosed with or has been treated for any of the following disorders prior to the first Policy Start Date, then costs of treatment related to or arising from the disorder whether directly or indirectly will be treated as a Pre-existing Disease and will not be covered within first 24 months from the date of first issuance of the Policy
 - I Chronic Bronchitis
 - II Esophageal Stricture or stenosis;
 - III Unoperated Varicose Veins;
 - IV Deep Vein Thrombosis (DVT);
 - V Spondyloarthropathies (Spondylosis/Spondylitis /Spondylolisthesis);
 - VI Residual Poliomyelitis;
 - VII Avascular Necrosis, Idiopathic;
 - VIII Unoperated Hyperthyroidism;
 - IX Renal / Ureteric / Bladder Calculi;

X DUB/Endometriosis;

XI Unoperated Fibroid Uterus;

XII Retinal Detachment;

XIII Otosclerosis;

XIV Deafness;

XV Blindness;

XVI Any implant in the body except Cardiac stents

XVII Down's Syndrome/Turner's Syndrome/Sickle Cell Anaemia/Thalassemia Major/G6PD deficiency

25. Any Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs, alcohol, hallucinogens, smoking.

26. Any treatment or part of treatment or any expenses incurred under this Policy that is not reasonable and customary and/or not medically necessary.

Note to 'Permanent Exclusions': In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above Permanent Exclusions shall also be excluded.

5. General Terms and Clauses

5.1 Standard General Terms & Clauses

5.1.1 Disclosure of Information

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

Note:

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

- b. In continuation to the above clause the Company may also adjust the scope of cover and / or the premium paid or payable, accordingly.

5.1.2 Condition Precedent to Admission of Liability

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

5.1.3 Claim Settlement (provision for Penal Interest)

- i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of intimation on 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 intimation 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 15 days from the date of intimation on receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of intimation on receipt of last necessary document.
- iv. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of intimation to the date of payment of claim.

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

5.1.4 Complete Discharge

Any payment to the policyholder, Insured Person or his/ her nominees or his/ her legal representative or Assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim

5.1.5 Multiple Policies

- i. 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 insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

- ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/policies, even if the sum insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this policy.
- iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurers from whom he/she wants to claim the balance amount.
- iv. 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 treatment costs in accordance with the terms and conditions of the chosen policy.

5.1.6 Fraud

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, 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 of the fact;
- C. Any other act fitted to deceive; and
- D. Any such act or omission as the law specially declares to be fraudulent

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

5.1.7 Cancellation / Termination

- (a) The policyholder may cancel this policy by giving 7 days' written notice and in such an event, the Company shall refund proportionate premium for the unexpired policy period.
- (b) Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.
- (c) If the risk under the Policy has already commenced, or only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then the expenses such as pre- policy medical examination etc. incurred by the Company will also be deducted before refunding of premium.
- (d) The Company may cancel the Policy at any time on grounds of mis representations, non-disclosure of material facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representations, non-disclosure of material facts or fraud.

Notes:

In case of demise of the Policyholder,

- (i) Where the Policy covers only the Policyholder, this Policy shall stand null and void from the date and time of demise of the Policyholder and the Company shall refund proportionate premium for unexpired Policy Period. subject to no claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.
- (ii) Where the Policy covers other Insured Persons, this Policy shall continue till the end of Policy Period for the other Insured Persons. If the other Insured Persons wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of a policyholder provided that:
 - I. Written notice in this regard is given to the Company before the Policy Period End Date; and
 - II. A person of Age 18 years or above, who satisfies the Company's criteria applies to become the Policyholder.

5.1.8 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 atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits as per IRDAI guidelines on migration

5.1.9 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 as per IRDAI guidelines on portability.

5.1.10 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of established fraud, or non disclosure or misrepresentation by the insured person.

- (a) Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- (b) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- (c) At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period
- (d) No loading shall apply on renewals based on individual claims experience.

5.1.11 Withdrawal of Policy

- (a) In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
- (b) Insured Person will have a one-time option to renew the existing product, if renewal falls within the 90 days from the date of withdrawal of the product or the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period, as per IRDAI guidelines, provided the policy has been maintained without a break

5.1.12 Moratorium Period

After completion of five continuous years under the policy no look back to be applied. This period of five years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of five continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be

contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

5.1.13 Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company may revise or modify the terms of the policy including the premium rates. The insured person shall be notified before the changes are affected.

5.1.14 Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured 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 Company on medical examination of the insured person and the stamp duty charges or
- b. Where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
- c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

5.1.15 Grievances

In case of any grievance the insured person may contact the company through

Website/link:

<https://www.careinsurance.com/customer-grievance-redressal.html>

Mobile App: Care Health - Customer App

Tollfree (WhatsApp Number): 8860402452

Courier: Any of Company's Branch Office or Corporate Office

Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance.

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at Branch Office or corporate office. For updated details of grievance officer, kindly refer the link <https://www.careinsurance.com/customer-grievance-redressal.html>

If Insured Person is not satisfied with the redressal of grievance through above methods,

the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

Grievance may also be lodged at IRDAI integrated Grievance Management System -

<https://bimabharosa.irdai.gov.in/>

Note: The Contact details of the Insurance Ombudsman offices have been provided as Annexure VI.

5.1.16 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. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy

5.2 Specific General Terms & Clauses

5.2.1 Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business at his own expense. The Company may adjust the scope of cover and / or the premium paid or payable, accordingly.

5.2.2 Records to be maintained

The Policyholder or 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 under this Policy at any time during the Policy Period or Policy Year or until final adjustment (if any) and resolution of all Claims under this Policy.

5.2.3 No constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder or Insured Person which is in possession of the Company other than that information expressly disclosed in the Proposal Form or otherwise in writing to the Company, shall not be held to be binding or prejudicially affect the Company.

5.2.4 Policy Disputes

Any and all disputes or differences under or in relation to the validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and in accordance with Indian law.

5.2.5 Limitation of liability

Any Claim under this Policy for which the notification or intimation of Claim is received after 12 calendar months of the event or occurrence giving rise to the Claim shall not be admissible, unless the Policyholder proves to the Company's satisfaction that the delay in reporting of the Claim was for reasons beyond his control.

5.2.6 Communication

- a. Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule. Any communication meant for the Policyholder/ Insured Person will be sent by the Company to his last known address or the address as shown in the Policy Schedule.
- b. All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule. Agents are not authorized to receive notices and declarations on the Company's behalf.
- c. Notice and instructions will be deemed

served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

5.2.7 Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company. However, change or alteration with respect to increase/ decrease of the Sum Insured shall be permissible only at the time of renewal of the Policy.

5.2.8 Out of all the details of the various Benefits provided in the Policy Terms and Conditions, only the details pertaining to Benefits chosen by policyholder as per Policy Schedule shall be considered relevant.

5.2.9 Electronic Transactions

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

6. Other Terms and Clauses

6.1 Claims Procedure and Management

This section explains about procedures involved to file a valid Claim by the Insured Person and related processes involved to manage the Claim by the Company.

6.1.1 Pre-requisite for admissibility of a Claim:

Any claim being made by an Insured Person or attendant of Insured Person during

Hospitalization on behalf of the Insured person, should comply with the following conditions:

- (i) The Condition Precedent Clause has to be fulfilled.
- (ii) The health damage caused, Medical Expenses incurred, subsequently the Claim being made, should be with respect to the Insured Person only. The Company will not be liable to indemnify the Insured Person for any loss other than the covered Benefits and any other person who is not accepted by the Company as an Insured Person.
- (iii) The holding Insurance Policy should be in force at the event of the Claim. All the Policy Terms and Conditions, wait periods and exclusions are to be fulfilled including the realization of Premium by their respective due dates.
- (iv) All the required and supportive Claim related documents are to be furnished within the stipulated timelines. The Company may call for additional documents wherever required.

6.1.2 Claim settlement - Facilities

(a) Cashless Facility

The Company extends Cashless Facility as a mode to indemnify the medical expenses incurred by the Insured Person at a Network Provider. For this purpose, the Insured Person will be issued a "Health card" at the time of Policy purchase, which has to be preserved and produced at any of the Network Providers in the event of Claim being made, to avail Cashless Facility. The following is the process for availing Cashless Facility:-

- (i) Submission of Pre-authorization Form: A Pre-authorization form which is available on the Company's Website or with the Network Provider, has to be duly filled and signed by the Insured Person and the treating Medical Practitioner, as applicable, which has to be submitted

electronically by the Network Provider to the Company for approval. Only upon due approval from the Company, Cashless Facility can be availed at any Network Hospital.

- (ii) Identification Documents: The "Health card" provided by the Company under this Policy, along with one Valid Photo Identification Proof of the Insured Person are to be produced at the Network Provider, photocopies of which shall be forwarded to the Company for authentication purposes. Valid Photo Identification Proof documents which will be accepted by the Company are Voter ID card, Driving License, Passport, PAN Card, Aadhar Card or any other identification proof as stated by the Company.
- (iii) Company's Approval: The Company will confirm in writing, authorization or rejection of the request to avail Cashless Facility for the Insured Person's Hospitalization.
- (iv) Company's Authorization:
 - a) If the request for availing Cashless Facility is authorized by the Company, then payment for the Medical Expenses incurred in respect of the Insured Person shall not have to be made to the extent that such Medical Expenses are covered under this Policy and fall within the amount authorized in writing by the Company for availing Cashless Facility.
 - b) An Authorization letter will include details of Sanctioned Amount, any specific limitation on the Claim, and any other details specific to the Insured Person, if any, as applicable.
 - c) In the event that the cost of Hospitalization exceeds the authorized limit, the Network Provider shall request the Company for an enhancement of Authorization Limit stating details of specific circumstances which have led to the need for increase in the previously authorized limit. The Company will verify the eligibility and evaluate the request for enhancement on the availability of further limits.
- (v) Event of Discharge from Hospital: All original bills and evidence of treatment for the Medical Expenses incurred in respect of the Hospitalization of the Insured Person and all other information and documentation specified under Clauses 6.1.4 and 6.1.5 shall be submitted by the Network Provider immediately and in any event before the Insured Person's discharge from Hospital.
- (vi) Company's Rejection: If the Company does not authorize the Cashless Facility due to insufficient Sum Insured or insufficient information provided to the Company to determine the admissibility of the Claim, then payment for such treatment will have to be made by the Policyholder / Insured Person to the Network Provider, following which a Claim for reimbursement may be made to the Company which shall be considered subject to the Insured Person's Policy limits and relevant conditions. Please note that rejection of a Pre-authorization request is in no way construed as rejection of coverage or treatment. The Insured Person can proceed with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.
- (vii) Network Provider related: The Company may modify the list of Network Providers or modify or restrict the extent of Cashless Facilities that may be availed at any particular Network Provider. For an updated list of Network Providers and the extent of Cashless Facilities available at each Network Provider, the Insured Person may refer to the list of Network Providers available on the Company's website or at the call center.
- (viii) Claim Settlement: For Claim settlement under Cashless Facility, the payment shall be made to the

Network Provider whose discharge would be complete and final.

(b) Re-imbursement Facility

- (i) It is agreed and understood that in all cases where intimation of a Claim has been provided under Reimbursement Facility and/or the Company specifically states that a particular Benefit is payable only under Reimbursement Facility, all the information and documentation specified in Clause 6.1.4 and Clause 6.1.5 shall be submitted to the Company at Policyholder's/ Insured Person's own expense, immediately and in any event within 30 days of Insured Person's discharge from Hospital.
- (ii) The Company shall give an acknowledgement of collected documents. However, in case of any delayed submission, the Company may examine and relax the time limits mentioned upon the merits of the case.
- (iii) In case a reimbursement claim is received after a Pre-Authorization letter has been issued for the same case earlier, before processing such claim, a check will be made with the Network Provider whether the Pre-authorization has been utilized. Once such check and declaration is received from the Network Provider, the case will be processed.
- (iv) 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) and in case of no nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.
- (v) Date of Loss' under Reimbursement Facility is the 'Date of Admission' to Hospital in case of Hospitalization & actual Date of Loss for non-Hospitalization related Benefits.

6.1.3 Duties of a Claimant/ Insured Person in the event of Claim

It is agreed and understood that as a Condition Precedent for a Claim to be considered under this Policy:

- (i) The Policyholder / Insured Person shall check the updated list of Network Provider before submission of a pre-authorization request for Cashless Facility.
- (ii) All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim that may be made under this Policy.
- (iii) Intimation of the Claim, notification of the Claim and submission or provision of all information and documentation shall be made promptly and in any event in accordance with the procedures and within the timeframes specified in Clause 6.1 (Claims Procedure and Management) of the Policy.
- (iv) The Insured Person will, at the request of the Company, submit himself / herself for a medical examination by the Company's nominated Medical Practitioner as often as the Company considers reasonable and necessary. The cost of such examination will be borne by the Company.
- (v) The Company's Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Person's medical and Hospitalization records and to investigate the facts and examine the Insured Person.
- (vi) The Company shall be provided with complete necessary documentation and information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum.

6.1.4 Claims Intimation

Upon the occurrence of any Illness or Injury that may result in a Claim under this Policy, then as a Condition Precedent to the Company's liability under the Policy, all of the following shall be undertaken:

- (i) If any Illness is diagnosed or discovered or any Injury is suffered or any other

contingency occurs which has resulted in a Claim or may result in a Claim under the Policy, the Company shall be notified with full particulars within 48 hours from the date of occurrence of event either at the Company's call center or in writing.

- (ii) Claim must be filed within 30 days from the date of discharge from the hospital in case of hospitalization and actual date of loss in case of non-hospitalization Benefits.

Note: 6.1.4 (i) and 6.1.4 (ii) are precedent to admission of liability under the policy.

- (iii) The following details are to be disclosed to the Company at the time of intimation of Claim:

1. Policy Number;
2. Name of the Policyholder;
3. Name of the Insured Person in respect of whom the Claim is being made;
4. Nature of Illness or Injury and Benefit under which the Claim is being made
5. Name and address of the attending Medical Practitioner and Hospital;
6. Date of admission to Hospital or proposed date of admission to Hospital for planned Hospitalization;
7. Any other necessary information, documentation or details requested by the Company.

- (iv) In case of an Emergency Hospitalization, the Company shall be notified either at the Company's call center or in writing immediately and in any event within 48 hours of Hospitalization commencing or before the Insured Person's discharge from Hospital.

- (v) In case of an Planned Hospitalization, the Company shall be notified either at the Company's call center or in writing at least 48 hours prior to planned date of admission to Hospital

of Claim

The following information and documentation shall be submitted in accordance with the procedures and within the timeframes specified in Clause 6.1 in respect of all Claims and claim will be registered only on submission of below documents. The date of submission of such information shall be deemed as date of claim registration for the purpose of claim processing:

1. Duly filled and signed Claim form by the Insured Person;
2. Copy of Photo ID and address proof of Insured Person;
3. Medical Practitioner's first consultation paper and referral letter advising Hospitalization;
4. Medical Practitioner's prescription advising drugs or diagnostic tests or consultations;
5. Original numbered bills/ receipts and discharge summary from the Hospital/Medical Practitioner;
6. Original numbered bills from licensed pharmacy/chemists;
7. Original pathological/diagnostic test reports/radiology reports and payment receipts;
8. Operation Theatre Notes(if applicable);
9. Emergency Notes, Initial Assessment Sheet and Indoor case papers(if applicable);
10. Original investigation test reports and payment receipts supported by Doctor's reference slip;
11. Ambulance Receipt;
12. Doctor prescription, Nursing invoice and care notes (for Home care benefit)
13. Any other document as required by the Company to assess the Claim, in case fraud is suspected.

Notes:

- The Company may give a waiver to one or few of the above mentioned documents depending upon the case.
- Additional documents as specified against any Benefit shall be submitted to the company.

6.1.5 Documents to be submitted for registration

- The Company will accept bills/invoices which are made in the Insured Person's name only.
- The company may seek any other document as required to assess the Claim.
- Only in the event that original bills, receipts, prescriptions, reports or other documents have already been given to any other insurance company, the company will accept properly verified photocopies of such documents attested by such other insurance company along with an original certificate of the extent of payment received from such insurance company.

However, claims filed even beyond the timelines mentioned above should be considered if there are valid reasons for any delay.

6.1.6 Claim Assessment

- a. The Company shall scrutinize the Claim and supportive documents, once received. In case of any deficiency, the Company may call for any additional documents or information as required, based on the circumstances of the Claim.
- b. All admissible Claims under this Policy shall be assessed by the Company in the following progressive order:
 - (i) If a Room accommodation has been opted for where the Room Rent or Room Category is higher than the eligible limit as applicable for that Insured Person as specified in the Policy Schedule, then the Associate Medical Expenses payable shall be pro-rated as per the applicable limits in accordance with Clause 3.1.1(iii)(a).
 - (ii) If any sub-limits on Room Rent/Category for Medical Expenses are applicable as specified in the Policy Schedule, the Company's liability to make payment shall be limited to the extent of the applicable sub-limit for that Medical Expense.
 - (iii) The Deductible (if applicable) shall be applied to the aggregate of all Claims that

are either paid or payable under this Policy. The Company's liability to make payment shall commence only once the aggregate amount of all Claims payable or paid exceed the Deductible. Similarly, if 'Deductible per claim' is applicable, the Company's liability to make payment shall commence only once the 'Deductible per claim' limit is exceeded.

- (iv) Co-payment (if applicable) shall be applicable on the admissible claim amount payable by the Company
- (v) The balance amount, if any, subject to the applicability of sub-limits on Expenses in accordance with Clause 3.1.1 (iii) (c), the Company's liability to make payment shall be limited to such extent as applicable and shall be the Claim payable.
- c. The Claim amount assessed in Clause 6.1.6 (b) above would be deducted from the following amounts in the following progressive order:
 - (i) Sum Insured;
 - (ii) No Claims Bonus (if applicable);
 - (iii) Automatic Recharge (if applicable).
- d. All claims incurred in India are dealt by the Company directly.

6.1.7 Payment Terms

- (a) This Policy covers only medical treatment taken entirely within India. All payments under this Policy shall be made in Indian Rupees and within India.
- (b) The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Person during the Policy Period, once the Sum Insured for that Insured Person is exhausted.
- (c) The Company shall settle or reject any

Claim within 15 days of intimation on receipt of all the necessary documents / information as required for settlement of such Claim and sought by the Company. The Company shall provide the Policyholder / Insured/ Person an offer of settlement of Claim and upon acceptance of such offer by the Policyholder / Insured Person the Company shall make payment within 7 days from the date of receipt of such acceptance.

- (d) If the Policyholder / Insured Person suffers a relapse within 45 days of the date of discharge from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim and all the limits for Any One Illness under this Policy shall be applied as if they were under a single Claim.
- (e) The Claim shall be paid only for the Policy Year in which the Insured event which gives rise to a Claim under this Policy occurs.
- (f) The Premium for the policy will remain the same for the policy period mentioned in the Policy Schedule.
- (g) The Policy covers Reasonable and Customary Charges incurred towards medical treatment taken or any other expenses triggers under any Benefit during the Policy Period.
- (h) Under this Policy, the Company's total, cumulative, maximum liability during the Policy Year is maximum up to the Sum Insured unless any additional Sum Insured available or accrued under any Benefit.
- (I) For diseases or conditions or procedure that have a specified sub-limit then all related expenses shall be covered up to the sub-limit specified for that disease or condition or procedure. In case there is a specified sub-limit then the Company's total, cumulative, maximum liability during the Policy Year is maximum up to the specified sub-limit subject to the available Sum Insured in the Policy Year.

For example- if the Policy specifies a sub-limit of Rs. 50,000 for a particular disease then all expenses

related to the treatment of that disease (including but not limited to pre-hospitalization, hospitalization and post- hospitalization) will be covered up to Rs. 50,000, subject to Sum Insured availability in the Policy Year even if the overall Sum Insured is higher.

Annexure I - List of Day Care Surgeries

1. **Cardiology Related:**
 1. CORONARY ANGIOGRAPHY
 2. **Critical Care Related:**
 2. INSERT NON-TUNNEL CVCATH
 3. INSERT PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
 4. REPLACE PICC CATH (PERIPHERALLY INSERTED CENTRAL CATHETER)
 5. INSERTION CATHETER, INTRA ANTERIOR
 6. INSERTION OF PORTACATH
 3. **Dental Related:**
 7. SPLINTING OF AVULSED TEETH
 8. SUTURING LACERATED LIP
 9. SUTURING ORAL MUCOSA
 10. ORAL BIOPSY IN CASE OF ABNORMAL TISSUE PRESENTATION
 11. FNAC
 12. SMEAR FROM ORAL CAVITY
 4. **ENT Related:**
 13. MYRINGOTOMY WITH GROMMET INSERTION
 14. TYMPANOPLASTY (CLOSURE OF AN EAR DRUM PERFORATION/RECONSTRUCTION OF THE AUDITORY OSSICLES)
 15. REMOVAL OF A TYMPANIC DRAIN
 16. KERATOSIS REMOVAL UNDER GA
 17. OPERATIONS ON THE TURBINATES (NASAL CONCHA)
 18. TYMPANOPLASTY (CLOSURE OF AN EAR DRUM PERFORATION/RECONSTRUCTION OF THE AUDITORY OSSICLES)
 19. REMOVAL OF KERATOSIS OBTURANS
 20. STAPEDOTOMY TO TREAT VARIOUS LESIONS IN MIDDLE EAR
 21. REVISION OF A STAPEDECTOMY
 22. OTHER OPERATIONS ON THE AUDITORY OSSICLES
 23. MYRINGOPLASTY (POST - AURA/ENDAURAL APPROACH AS WELL AS SIMPLE TYPE - I TYMPANOPLASTY)
 24. FENESTRATION OF THE INNER EAR
 25. REVISION OF A FENESTRATION OF THE INNER EAR
 26. PALATOPLASTY
 27. TRANSORAL INCISION AND DRAINAGE OF APHARYNGEAL ABSCESS
 28. TONSILLECTOMY WITHOUT
- ADENOIDECTOMY
 29. TONSILLECTOMY WITH ADENOIDECTOMY
 30. EXCISION AND DESTRUCTION OF A LINGUAL TONSIL
 31. REVISION OF A TYMPANOPLASTY
 32. OTHER MICROSURGICAL OPERATIONS ON THE MIDDLE EAR
 33. INCISION OF THE MASTOID PROCESS AND MIDDLE EAR
 34. MASTOIDECTOMY
 35. RECONSTRUCTION OF THE MIDDLE EAR
 36. OTHER EXCISIONS OF THE MIDDLE AND INNER EAR
 37. INCISION (OPENING) AND DESTRUCTION (ELIMINATION) OF THE INNER EAR
 38. OTHER OPERATIONS ON THE MIDDLE AND INNER EAR
 39. EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE NOSE
 40. OTHER OPERATIONS ON THE NOSE
 41. NASAL SINUS ASPIRATION
 42. FOREIGN BODY REMOVAL FROM NOSE
 43. OTHER OPERATIONS ON THE TONSILS AND ADENOIDS
 44. ADENOIDECTOMY
 45. LABYRINTHECTOMY FOR SEVERE VERTIGO
 46. STAPEDECTOMY UNDER GA
 47. STAPEDECTOMY UNDER LA
 48. TYMPANOPLASTY (TYPE IV)
 49. ENDOLYMPHATIC SAC SURGERY FOR MENIERE'S DISEASE
 50. TURBINECTOMY
 51. ENDOSCOPIC STAPEDECTOMY
 52. INCISION AND DRAINAGE OF PERICHONDRIITIS
 53. SEPTOPLASTY
 54. VESTIBULAR NERVE SECTION
 55. THYROPLASTY TYPE I
 56. PSEUDOCYST OF THE PINNA - EXCISION
 57. INCISION AND DRAINAGE - HAEMATOMA AURICLE
 58. TYMPANOPLASTY (TYPE II)
 59. REDUCTION OF FRACTURE OF NASAL BONE
 60. THYROPLASTY TYPE II

61. TRACHEOSTOMY
 62. EXCISION OF ANGIOMA SEPTUM
 63. TURBINOPLASTY
 64. INCISION & DRAINAGE OF RETRO PHARYNGEAL ABSCESS
 65. UVULO PALATOPHARYNGOPLASTY
 66. ADENOIDECTOMY WITH GROMMET INSERTION
 67. ADENOIDECTOMY WITHOUT GROMMET INSERTION
 68. VOCAL CORD LATERALISATION PROCEDURE
 69. INCISION & DRAINAGE OF PARA PHARYNGEAL ABSCESS
 70. TRACHEOPLASTY
5. **Gastroenterology Related:**
71. CHOLECYSTECTOMY AND CHOLEDOCHO-JEJUNOSTOMY/ DUODENOSTOMY/ GASTROSTOMY/ EXPLORATION COMMON BILE DUCT
 72. ESOPHAGOSCOPY, GASTROSCOPY, DUODENOSCOPY WITH POLYPECTOMY/ REMOVAL OF FOREIGN BODY / DIATHERMY OF BLEEDING LESIONS
 73. PANCREATIC PSEUDOCYST EUS & DRAINAGE
 74. RF ABLATION FOR BARRETT'S OESOPHAGUS
 75. ERCP AND PAPILLO TOMY
 76. ESOPHAGOSCOPE AND SCLEROSANT INJECTION
 77. EUS + SUBMUCOSAL RESECTION
 78. CONSTRUCTION OF GASTROSTOMY TUBE
 79. EUS + ASPIRATION PANCREATIC CYST
 80. SMALL BOWEL ENDOSCOPY (THERAPEUTIC)
 81. COLONOSCOPY, LESION REMOVAL
 82. ERCP
 83. COLONOSCOPY STENTING OF STRICTURE
 84. PERCUTANEOUS ENDOSCOPIC GASTROSTOMY
 85. EUS AND PANCREATIC PSEUDO CYST DRAINAGE
 86. ERCP AND CHOLEDOCHOSCOPY
 87. PROCTOSIGMOIDOSCOPY VOLVULUS DETORSION
 88. ERCP AND SPHINCTEROTOMY
 89. ESOPHAGEAL STENT PLACEMENT
 90. ERCP + PLACEMENT OF BILIARY STENTS
 91. SIGMOIDOSCOPY W/ STENT
 92. EUS + COELIAC NODE BIOPSY
 93. UGI SCOPY AND INJECTION OF ADRENALINE, SCLEROSANTS BLEEDING ULCERS
6. **General Surgery Related:**
94. INCISION OF A PILONIDAL SINUS / ABSCESS
 95. FISSURE IN ANO SPHINCTEROTOMY
 96. SURGICAL TREATMENT OF A VARICOCELE AND A HYDROCELE OF THE SPERMATIC CORD
 97. ORCHIDOPEXY
 98. ABDOMINAL EXPLORATION IN CRYPTORCHIDISM
 99. SURGICAL TREATMENT OF ANAL FISTULAS
 100. DIVISION OF THE ANAL SPHINCTER (SPHINCTEROTOMY)
 101. EPIDIDYMECTOMY
 102. INCISION OF THE BREAST ABSCESS
 103. OPERATIONS ON THE NIPPLE
 104. EXCISION OF SINGLE BREAST LUMP
 105. INCISION AND EXCISION OF TISSUE IN THE PERIANAL REGION
 106. SURGICAL TREATMENT OF HEMORRHOIDS
 107. OTHER OPERATIONS ON THE ANUS
 108. ULTRASOUND GUIDED ASPIRATIONS
 109. SCLEROTHERAPY, ETC.
 110. LAPAROTOMY FOR GRADING LYMPHOMA WITH SPLENECTOMY/ LIVER/ LYMPH NODE BIOPSY
 111. THERAPEUTIC LAPAROSCOPY WITH LASER
 112. APPENDICECTOMY WITH/ WITHOUT DRAINAGE
 113. INFECTED KELOID EXCISION
 114. AXILLARY LYMPHADENECTOMY
 115. WOUND DEBRIDEMENT AND COVER
 116. ABSCESS- DECOMPRESSION
 117. CERVICAL LYMPHADENECTOMY
 118. INFECTED SEBACEOUS CYST
 119. INGUINAL LYMPHADENECTOMY
 120. INCISION AND DRAINAGE OF ABSCESS
 121. SUTURING OF LACERATIONS
 122. SCALP SUTURING

123. INFECTED LIPOMA EXCISION
 124. MAXIMAL ANAL DILATATION
 125. PILES
 126. A) INJECTION SCLEROTHERAPY
 127. B) PILES BANDING
 128. LIVER ABSCESS- CATHETER DRAINAGE
 129. FISSURE IN ANO- FISSURECTOMY
 130. FIBROADENOMA BREAST EXCISION
 131. O E S O P H A G E A L V A R I C E S SCLEROTHERAPY
 132. ERCP - PANCREATIC DUCT STONE REMOVAL
 133. PERIANAL ABSCESS I&D
 134. PERIANAL HEMATOMA EVACUATION
 135. UGI SCOPY AND POLYPECTOMY OESOPHAGUS
 136. BREAST ABSCESS I&D
 137. FEEDING GASTROSTOMY
 138. OESOPHAGOSCOPY AND BIOPSY OF GROWTH OESOPHAGUS
 139. ERCP- BILE DUCT STONE REMOVAL
 140. ILEOSTOMY CLOSURE
 141. COLONOSCOPY
 142. POLYPECTOMY COLON
 143. SPLENIC ABSCESES LAPAROSCOPIC DRAINAGE
 144. UGI SCOPY AND POLYPECTOMY STOMACH
 145. RIGID OESOPHAGOSCOPY FOR FB REMOVAL
 146. FEEDING JEJUNOSTOMY
 147. COLOSTOMY
 148. ILEOSTOMY
 149. COLOSTOMY CLOSURE
 150. SUBMANDIBULAR SALIVARY DUCT STONE REMOVAL
 151. P N E U M A T I C R E D U C T I O N O F INTUSSUSCEPTION
 152. VARICOSE VEINS LEGS - INJECTION SCLEROTHERAPY
 153. RIGID OESOPHAGOSCOPY FOR PLUMMER VINSON SYNDROME
 154. P A N C R E A T I C P S E U D O C Y S T S ENDOSCOPIC DRAINAGE
 155. ZADEK'S NAIL BED EXCISION
 156. SUBCUTANEOUS MASTECTOMY
 157. EXCISION OF RANULA UNDER GA
 158. RIGID OESOPHAGOSCOPY FOR DILATION OF BENIGN STRICTURES
 159. EVERSION OF SAC
 160. UNILATERAL
 161. ILATERAL
 162. LORD'S PLICATION
 163. JABOULAY'S PROCEDURE
 164. SCROTOPLASTY
 165. CIRCUMCISION FOR TRAUMA
 166. MEATOPLASTY
 167. INTERSPHINCTERIC ABSCESS INCISION AND DRAINAGE
 168. PSOAS ABSCESS INCISION AND DRAINAGE
 169. THYROID ABSCESS INCISION AND DRAINAGE
 170. TIPS PROCEDURE FOR PORTAL HYPERTENSION
 171. ESOPHAGEAL GROWTH STENT
 172. PAIR PROCEDURE OF HYDATID CYST LIVER
 173. TRUE CUT LIVER BIOPSY
 174. PHOTODYNAMIC THERAPY OR ESOPHAGEAL TUMOUR AND LUNG TUMOUR
 175. EXCISION OF CERVICAL RIB
 176. LAPAROSCOPIC REDUCTION OF INTUSSUSCEPTION
 177. MICRODOCECTOMY BREAST
 178. SURGERY FOR FRACTURE PENIS
 179. SENTINEL NODE BIOPSY
 180. PARASTOMAL HERNIA
 181. REVISION COLOSTOMY
 182. PROLAPSED COLOSTOMY- CORRECTION
 183. TESTICULAR BIOPSY
 184. LAPAROSCOPIC CARDIOMYOTOMY(HELLERS)
 185. SENTINEL NODE BIOPSY MALIGNANT MELANOMA
 186. LAPAROSCOPIC PYLOROMYOTOMY(RAMSTEDT)
7. **Gynecology Related:**
187. OPERATIONS ON BARTHOLIN'S GLANDS (CYST)
 188. INCISION OF THE OVARY

189. INSUFFLATIONS OF THE FALLOPIAN TUBES
190. OTHER OPERATIONS ON THE FALLOPIAN TUBE
191. DILATATION OF THE CERVICAL CANAL
192. CONISATION OF THE UTERINE CERVIX
193. THERAPEUTIC CURETTAGE WITH COLPOSCOPY / BIOPSY / DIATHERMY / CRYOSURGERY
194. LASER THERAPY OF CERVIX FOR VARIOUS LESIONS OF UTERUS
195. OTHER OPERATIONS ON THE UTERINE CERVIX
196. INCISION OF THE UTERUS (HYSTERECTOMY)
197. LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE VAGINA AND THE POUCH OF DOUGLAS
198. INCISION OF VAGINA
199. INCISION OF VULVA
200. CULDOTOMY
201. SALPINGO-OOPHORECTOMY VIA LAPAROTOMY
202. ENDOSCOPIC POLYPECTOMY
203. HYSTEROSCOPIC REMOVAL OF MYOMA
204. D&C
205. HYSTEROSCOPIC RESECTION OF SEPTUM
206. THERMAL CAUTERISATION OF CERVIX
207. MIRENA INSERTION
208. HYSTEROSCOPIC ADHESIOLYSIS
209. LEEP
210. CRYOCAUTERISATION OF CERVIX
211. POLYPECTOMY ENDOMETRIUM
212. HYSTEROSCOPIC RESECTION OF FIBROID
213. LLETZ
214. CONIZATION
215. POLYPECTOMY CERVIX
216. HYSTEROSCOPIC RESECTION OF ENDOMETRIAL POLYP
217. VULVAL WART EXCISION
218. LAPAROSCOPIC PARA OVARIAN CYST EXCISION
219. UTERINE ARTERY EMBOLIZATION
220. LAPAROSCOPIC CYSTECTOMY
221. HYMENECTOMY (IMPERFORATE HYMEN)
222. ENDOMETRIAL ABLATION

223. VAGINAL WALL CYST EXCISION
224. VULVAL CYST EXCISION
225. LAPAROSCOPIC PARATUBAL CYST EXCISION
226. REPAIR OF VAGINA (VAGINAL ATRESIA)
227. HYSTEROSCOPY, REMOVAL OF MYOMA
228. TURBT
229. URETEROCOELE REPAIR - CONGENITAL INTERNAL
230. VAGINAL MESH FOR POP
231. LAPAROSCOPIC MYOMECTOMY
232. SURGERY FOR SUI
233. REPAIR RECTO- VAGINA FISTULA
234. PELVIC FLOOR REPAIR (EXCLUDING FISTULA REPAIR)
235. URS + LL
236. LAPAROSCOPIC OOPHORECTOMY
237. NORMAL VAGINAL DELIVERY AND VARIANTS

8. **Neurology Related:**

238. FACIAL NERVE PHYSIOTHERAPY
239. NERVE BIOPSY
240. MUSCLE BIOPSY
241. EPIDURAL STEROID INJECTION
242. GLYCEROL RHIZOTOMY
243. SPINAL CORD STIMULATION
244. MOTOR CORTEX STIMULATION
245. STEREOTACTIC RADIOSURGERY
246. PERCUTANEOUS CORDOTOMY
247. INTRATHECAL BACLOFEN THERAPY
248. ENTRAPMENT NEUROPATHY RELEASE
249. DIAGNOSTIC CEREBRAL ANGIOGRAPHY
250. VP SHUNT
251. VENTRICULOATRIAL SHUNT

9. **Oncology Related:**

252. RADIO THERAPY FOR CANCER
253. CANCER CHEMOTHERAPY
254. IV PUSH CHEMOTHERAPY
255. HBI-HEMIBODY RADIO THERAPY
256. INFUSIONAL TARGETED THERAPY
257. SRT-STEREOTACTIC ARC THERAPY
258. SC ADMINISTRATION OF GROWTH FACTORS

259. CONTINUOUS INFUSIONAL CHEMOTHERAPY
 260. INFUSIONAL CHEMOTHERAPY
 261. CCRT-CONCURRENT CHEMO+RT
 262. 2D RADIOTHERAPY
 263. 3D CONFORMAL RADIOTHERAPY
 264. IGRT- IMAGE GUIDED RADIOTHERAPY
 265. IMRT- STEP & SHOOT
 266. INFUSIONAL BISPHOSPHONATES
 267. IMRT- DMLC
 268. ROTATIONAL ARC THERAPY
 269. TELE GAMMA THERAPY
 270. FSRT-FRACTIONATED SRT
 271. VMAT-VOLUMETRIC MODULATED ARC THERAPY
 272. SBRT- STEREOTACTIC BODY RADIOTHERAPY
 273. HELICAL TOMOTHERAPY
 274. SRS-STEREOTACTIC RADIOSURGERY
 275. X-KNIFE SRS
 276. GAMMA KNIFE SRS
 277. TBI- TOTAL BODY RADIOTHERAPY
 278. INTRALUMINAL BRACHYTHERAPY
 279. ELECTRON THERAPY
 280. TSET-TOTAL ELECTRON SKIN THERAPY
 281. EXTRACORPOREAL IRRADIATION OF BLOOD PRODUCTS
 282. TELECOBALT THERAPY
 283. TELECESIUM THERAPY
 284. EXTERNAL MOULD BRACHYTHERAPY
 285. INTERSTITIAL BRACHYTHERAPY
 286. INTRACAVITY BRACHYTHERAPY
 287. 3D BRACHYTHERAPY
 288. IMPLANT BRACHYTHERAPY
 289. INTRAVESICAL BRACHYTHERAPY
 290. ADJUVANT RADIOTHERAPY
 291. AFTERLOADING CATHETER BRACHYTHERAPY
 292. CONDITIONING RADIOTHERAPY FOR BMT
 293. EXTRACORPOREAL IRRADIATION TO THE HOMOLOGOUS BONE GRAFTS
 294. RADICAL CHEMOTHERAPY
 295. NEOADJUVANT RADIOTHERAPY
 296. LDR BRACHYTHERAPY
 297. PALLIATIVE RADIOTHERAPY
 298. RADICAL RADIOTHERAPY
 299. PALLIATIVE CHEMOTHERAPY
 300. TEMPLATE BRACHYTHERAPY
 301. NEOADJUVANT CHEMOTHERAPY
 302. ADJUVANT CHEMOTHERAPY
 303. INDUCTION CHEMOTHERAPY
 304. CONSOLIDATION CHEMOTHERAPY
 305. MAINTENANCE CHEMOTHERAPY
 306. HDR BRACHYTHERAPY
- 10. Operations on the salivary glands & salivary ducts:**
307. INCISION AND LANCING OF A SALIVARY GLAND AND A SALIVARY DUCT
 308. EXCISION OF DISEASED TISSUE OF A SALIVARY GLAND AND A SALIVARY DUCT
 309. RESECTION OF A SALIVARY GLAND
 310. RECONSTRUCTION OF A SALIVARY GLAND AND A SALIVARY DUCT
 311. OTHER OPERATIONS ON THE SALIVARY GLANDS AND SALIVARY DUCTS
- 11. Operations on the skin & subcutaneous tissues:**
312. OTHER INCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
 313. SURGICAL WOUND TOILET (WOUND DEBRIDEMENT) AND REMOVAL OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
 314. LOCAL EXCISION OF DISEASED TISSUE OF THE SKIN AND SUBCUTANEOUS TISSUES
 315. OTHER EXCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
 316. SIMPLE RESTORATION OF SURFACE CONTINUITY OF THE SKIN AND SUBCUTANEOUS TISSUES
 317. FREE SKIN TRANSPLANTATION, DONOR SITE
 318. FREE SKIN TRANSPLANTATION, RECIPIENT SITE
 319. REVISION OF SKIN PLASTY
 320. OTHER RESTORATION AND RECONSTRUCTION OF THE SKIN AND SUBCUTANEOUS TISSUES.
 321. CHEMOSURGERY TO THE SKIN.
 322. DESTRUCTION OF DISEASED TISSUE IN THE SKIN AND SUBCUTANEOUS TISSUES

381. ORIF WITH K WIRE FIXATION- SMALL BONES
 382. RELEASE OF MIDFOOT JOINT
 383. ORIF WITH PLATING- SMALL LONG BONES
 384. IMPLANT REMOVAL MINOR
 385. K WIRE REMOVAL
 386. POP APPLICATION
 387. CLOSED REDUCTION AND EXTERNAL FIXATION
 388. ARTHROTOMY HIP JOINT
 389. SYME'S AMPUTATION
 390. ARTHROPLASTY
 391. PARTIAL REMOVAL OF RIB
 392. TREATMENT OF SESAMOID BONE FRACTURE
 393. SHOULDER ARTHROSCOPY / SURGERY
 394. ELBOW ARTHROSCOPY
 395. AMPUTATION OF METACARPAL BONE
 396. RELEASE OF THUMB CONTRACTURE
 397. INCISION OF FOOT FASCIA
 398. CALCANEUM SPUR HYDROCORT INJECTION
 399. GANGLION WRIST HYALASE INJECTION
 400. PARTIAL REMOVAL OF METATARSAL
 401. REPAIR / GRAFT OF FOOT TENDON
 402. REVISION/REMOVAL OF KNEE CAP
 403. AMPUTATION FOLLOW-UP SURGERY
 404. EXPLORATION OF ANKLE JOINT
 405. REMOVE/GRAFT LEG BONE LESION
 406. REPAIR/GRAFT ACHILLES TENDON
 407. REMOVE OF TISSUE EXPANDER
 408. BIOPSY ELBOW JOINT LINING
 409. REMOVAL OF WRIST PROSTHESIS
 410. BIOPSY FINGER JOINT LINING
 411. TENDON LENGTHENING
 412. TREATMENT OF SHOULDER DISLOCATION
 413. LENGTHENING OF HAND TENDON
 414. REMOVAL OF ELBOW BURSA
 415. FIXATION OF KNEE JOINT
 416. TREATMENT OF FOOT DISLOCATION
 417. SURGERY OF BUNION
 418. INTRAARTICULAR STEROID INJECTION

419. TENDON TRANSFER PROCEDURE
 420. REMOVAL OF KNEE CAP BURSA
 421. TREATMENT OF FRACTURE OF ULNA
 422. TREATMENT OF SCAPULA FRACTURE
 423. REMOVAL OF TUMOR OF ARM/ ELBOW UNDER RA/GA
 424. REPAIR OF RUPTURED TENDON
 425. DECOMPRESS FOREARM SPACE
 426. REVISION OF NECK MUSCLE (TORTICOLLIS RELEASE)
 427. LENGTHENING OF THIGH TENDONS
 428. TREATMENT FRACTURE OF RADIUS & ULNA
 429. REPAIR OF KNEE JOINT

15. Other operations on the mouth & face:

430. EXTERNAL INCISION AND DRAINAGE IN THE REGION OF THE MOUTH, JAW AND FACE
 431. INCISION OF THE HARD AND SOFT PALATE
 432. EXCISION AND DESTRUCTION OF DISEASED HARD AND SOFT PALATE
 433. INCISION, EXCISION AND DESTRUCTION IN THE MOUTH
 434. OTHER OPERATIONS IN THE MOUTH

16. Pediatric surgery Related:

435. EXCISION OF FISTULA-IN-ANO
 436. EXCISION JUVENILE POLYPS RECTUM
 437. VAGINOPLASTY
 438. DILATATION OF ACCIDENTAL CAUSTIC STRICTURE OESOPHAGEAL
 439. PRESACRAL TERATOMAS EXCISION
 440. REMOVAL OF VESICAL STONE
 441. EXCISION SIGMOID POLYP
 442. STERNOMASTOID TENOTOMY
 443. INFANTILE HYPERTROPHIC PYLORIC STENOSIS PYLOROMYOTOMY
 444. EXCISION OF SOFT TISSUE RHABDOMYOSARCOMA
 445. MEDIASTINAL LYMPH NODE BIOPSY
 446. HIGH ORCHIDECTOMY FOR TESTIS TUMOURS
 447. EXCISION OF CERVICAL TERATOMA
 448. RECTAL-MYOMECTOMY
 449. RECTAL PROLAPSE (DELOME'S PROCEDURE)
 450. DETORSION OF TORSION TESTIS

323. RECONSTRUCTION OF DEFORMITY / DEFECT IN NAIL BED
 324. EXCISION OF BURSITIS
 325. TENNIS ELBOW RELEASE
- 12. Operations on the Tongue:**
326. INCISION, EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TONGUE
 327. PARTIAL GLOSSECTOMY
 328. GLOSSECTOMY
 329. RECONSTRUCTION OF THE TONGUE
 330. OTHER OPERATIONS ON THE TONGUE
- 13. Ophthalmology Related:**
331. SURGERY FOR CATARACT
 332. INCISION OF TEAR GLANDS
 333. OTHER OPERATIONS ON THE TEAR DUCTS
 334. INCISION OF DISEASED EYELIDS
 335. EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE EYELID
 336. OPERATIONS ON THE CANTHUS AND EPICANTHUS
 337. CORRECTIVE SURGERY FOR ENTROPION AND ECTROPION
 338. CORRECTIVE SURGERY FOR BLEPHAROPTOSIS
 339. REMOVAL OF A FOREIGN BODY FROM THE CONJUNCTIVA
 340. REMOVAL OF A FOREIGN BODY FROM THE CORNEA
 341. INCISION OF THE CORNEA
 342. OPERATIONS FOR PTERYGIUM
 343. OTHER OPERATIONS ON THE CORNEA
 344. REMOVAL OF A FOREIGN BODY FROM THE LENS OF THE EYE
 345. REMOVAL OF A FOREIGN BODY FROM THE POSTERIOR CHAMBER OF THE EYE
 346. REMOVAL OF A FOREIGN BODY FROM THE ORBIT AND EYEBALL
 347. CORRECTION OF EYELID PTOSIS BY LEVATOR PALPEBRAE SUPERIORIS RESECTION (BILATERAL)
 348. CORRECTION OF EYELID PTOSIS BY FASCIALATA GRAFT (BILATERAL)
 349. DIATHERMY / CRYOTHERAPY TO TREAT RETINAL TEAR
 350. ANTERIOR CHAMBER PARACENTESIS / CYCLODIATHERMY / CYCLOCRYOTHERAPY / GONIOTOMY / TRABECULOTOMY AND FILTERING AND ALLIED OPERATIONS TO TREAT GLAUCOMA
- 14. Orthopedics Related:**
351. ENUCLEATION OF EYE WITHOUT IMPLANT
 352. DACRYOCYSTORHINOSTOMY FOR VARIOUS LESIONS OF LACRIMAL GLAND
 353. LASER PHOTOCOAGULATION TO TREAT RATINAL TEAR
 354. BIOPSY OF TEAR GLAND
 355. TREATMENT OF RETINAL LESION
 356. SURGERY FOR MENISCUS TEAR
 357. INCISION ON BONE, SEPTIC AND ASEPTIC
 358. CLOSED REDUCTION ON FRACTURE, LUXATION OR EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
 359. SUTURE AND OTHER OPERATIONS ON TENDONS AND TENDON SHEATH
 360. REDUCTION OF DISLOCATION UNDER GA
 361. ARTHROSCOPIC KNEE ASPIRATION
 362. SURGERY FOR LIGAMENT TEAR
 363. SURGERY FOR HEMOARTHROSIS / PYOARTHROSIS
 364. REMOVAL OF FRACTURE PINS / NAILS
 365. REMOVAL OF METAL WIRE
 366. CLOSED REDUCTION ON FRACTURE, LUXATION
 367. REDUCTION OF DISLOCATION UNDER GA
 368. EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
 369. EXCISION OF VARIOUS LESIONS IN COCCYX
 370. ARTHROSCOPIC REPAIR OF ACL TEAR KNEE
 371. CLOSED REDUCTION OF MINOR FRACTURES
 372. ARTHROSCOPIC REPAIR OF PCL TEAR KNEE
 373. TENDON SHORTENING
 374. ARTHROSCOPIC MENISCECTOMY - KNEE
 375. TREATMENT OF CLAVICLE DISLOCATION
 376. HAEMARTHROSIS KNEE - LAVAGE
 377. ABSCESS KNEE JOINT DRAINAGE
 378. CARPAL TUNNEL RELEASE
 379. CLOSED REDUCTION OF MINOR DISLOCATION
 380. REPAIR OF KNEE CAPTENDON

451. EUA+BIOPSY MULTIPLE FISTULA IN ANO
 452. CYSTIC HYGROMA - INJECTION TREATMENT
17. **Plastic Surgery Related:**
453. CONSTRUCTION SKIN PEDICLE FLAP
 454. GLUTEAL PRESSURE ULCER-EXCISION
 455. MUSCLE-SKIN GRAFT, LEG
 456. REMOVAL OF BONE FOR GRAFT
 457. MUSCLE-SKIN GRAFT DUCT FISTULA
 458. REMOVAL CARTILAGE GRAFT
 459. MYOCUTANEOUS FLAP
 460. FIBROMYOCUTANEOUS FLAP
 461. BREAST RECONSTRUCTION SURGERY AFTER MASTECTOMY
 462. SLING OPERATION FOR FACIAL PALSY
 463. SPLIT SKIN GRAFTING UNDER RA
 464. WOLFE SKIN GRAFT
 465. PLASTIC SURGERY TO THE FLOOR OF THE MOUTH UNDER GA
18. **Thoracic surgery Related:**
466. THORACOSCOPY AND LUNG BIOPSY
 467. EXCISION OF CERVICAL SYMPATHETIC CHAIN THORACOSCOPIC
 468. LASER ABLATION OF BARRETT'S OESOPHAGUS
 469. PLEURODESIS
 470. THORACOSCOPY AND PLEURAL BIOPSY
 471. EBUS+BIOPSY
 472. THORACOSCOPY LIGATION THORACIC DUCT
 473. THORACOSCOPY ASSISTED EMPYEMA DRAINAGE
19. **Urology Related:**
474. HAEMODIALYSIS
 475. LITHOTRIPSY/NEPHROLITHOTOMY FOR RENAL CALCULUS
 476. EXCISION OF RENAL CYST
 477. DRAINAGE OF PYONEPHROSIS / PERINEPHRIC ABSCESS
 478. INCISION OF THE PROSTATE
 479. TRANSURETHRAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
 480. TRANSURETHRAL AND PERCUTANEOUS DESTRUCTION OF PROSTATE TISSUE
 481. OPEN SURGICAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
 482. RADICAL PROSTATE VESICULECTOMY
 483. OTHER EXCISION AND DESTRUCTION OF PROSTATE TISSUE
 484. OPERATIONS ON THE SEMINAL VESICLES
 485. INCISION AND EXCISION OF PERIPROSTATIC TISSUE
 486. OTHER OPERATIONS ON THE PROSTATE
 487. INCISION OF THE SCROTUM AND TUNICA VAGINALIS TESTIS
 488. OPERATION ON A TESTICULAR HYDROCELE
 489. EXCISION AND DESTRUCTION OF DISEASED SCROTAL TISSUE
 490. OTHER OPERATIONS ON THE SCROTUM AND TUNICA VAGINALIS TESTIS
 491. INCISION OF THE TESTES
 492. EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TESTES
 493. UNILATERAL ORCHIDECTOMY
 494. BILATERAL ORCHIDECTOMY
 495. SURGICAL REPOSITIONING OF AN ABDOMINAL TESTIS
 496. RECONSTRUCTION OF THE TESTIS
 497. IMPLANTATION, EXCHANGE AND REMOVAL OF A TESTICULAR PROSTHESIS
 498. OTHER OPERATIONS ON THE TESTIS
 499. EXCISION IN THE AREA OF THE EPIDIDYMIS
 500. OPERATIONS ON THE FORESKIN
 501. LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE PENIS
 502. AMPUTATION OF THE PENIS
 503. OTHER OPERATIONS ON THE PENIS
 504. CYSTOSCOPICAL REMOVAL OF STONES
 505. CATHETERISATION OF BLADDER
 506. LITHOTRIPSY
 507. BIOPSY OF TEMPORAL ARTERY FOR VARIOUS LESIONS
 508. EXTERNAL ARTERIO-VEIN SHUNT
 509. AV FISTULA - WRIST
 510. URSL WITH STENTING
 511. URSL WITH LITHOTRIPSY
 512. CYSTOSCOPIC LITHOLAPAXY
 513. ESWL
 514. BLADDER NECK INCISION
 515. CYSTOSCOPY & BIOPSY

- 516. CYSTOSCOPY AND REMOVAL OF POLYP
- 517. SUPRAPUBIC CYSTOSTOMY
- 518. PERCUTANEOUS NEPHROSTOMY
- 519. CYSTOSCOPY AND "SLING" PROCEDURE.
- 520. TUNA- PROSTATE
- 521. EXCISION OF URETHRAL DIVERTICULUM
- 522. REMOVAL OF URETHRAL STONE
- 523. EXCISION OF URETHRAL PROLAPSE
- 524. MEGA-URETER RECONSTRUCTION
- 525. KIDNEY RENOSCOPY AND BIOPSY
- 526. URETER ENDOSCOPY AND TREATMENT
- 527. VESICO URETERIC REFLUX CORRECTION
- 528. SURGERY FOR PELVI URETERIC
JUNCTION OBSTRUCTION
- 529. ANDERSON HYNES OPERATION
- 530. KIDNEY ENDOSCOPY AND BIOPSY
- 531. PARAPHIMOSIS SURGERY
- 532. INJURY PREPUCE- CIRCUMCISION
- 533. FRENULAR TEAR REPAIR
- 534. MEATOTOMY FOR MEATAL STENOSIS
- 535. SURGERY FOR FOURNIER'S GANGRENE
SCROTUM
- 536. SURGERY FILARIAL SCROTUM
- 537. SURGERY FOR WATERING CAN PERINEUM
- 538. REPAIR OF PENILE TORSION
- 539. DRAINAGE OF PROSTATE ABSCESS
- 540. ORCHIECTOMY
- 541. CYSTOSCOPY AND REMOVAL OF FB

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

Sr. No.	List - I - Optional Item	Sr. No.	List - I - Optional Item
1	Baby Food	50	Ambulance Equipment
2	Baby Utilities Charges	51	Abdominal Binder
3	Beauty Services	52	Private Nurses Charges- Special Nursing Charges
4	Belts/ Braces	53	Sugar Free Tablets
5	Buds	54	Creams Powders Lotions (toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)
6	Cold Pack/hot Pack	55	Ecg Electrodes
7	Carry Bags	56	Gloves
8	Email / Internet Charges	57	Nebulisation Kit
9	Food Charges (other Than Patient's Diet Provided By Hospital)	58	Any Kit With No Details Mentioned [delivery Kit, Orthokit, Recovery Kit, Etc]
10	Leggings	59	Kidney Tray
11	Laundry Charges	60	Mask
12	Mineral Water	61	Ounce Glass
13	Sanitary Pad	62	Oxygen Mask
14	Telephone Charges	63	Pelvic Traction Belt
15	Guest Services	64	Pan Can
16	Crepe Bandage	65	Trolley Cover
17	Diaper Of Any Type	66	Urometer, Urine Jug
18	Eyelet Collar	67	Ambulance
19	Slings	68	Vasofix Safety
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		

[illegible]

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

Annexure III - List of Hospitals where Claim will not be admitted

S.No.	HOSPITAL NAME	ADDRESS	ZONE
1	Nulife Hospital and Maternity Centre	1616 Outram Lines, Kingsway Camp, Guru Teg Bahadur Nagar, New Delhi	North
2	Taneja Hospital	Q-Block, South City-2, Sohna Road, Main Sector-47, Preet Vihar, New Delhi	North
3	Shri Komal Hospital & Dr. Saxena's Nursing Home	Silver Plaza Complex, Opposite Rupali Cinema, Rander Road, Rewari, Haryana	North
4	Sona Devi Memorial Hospital & Trauma Centre	Sohna Road, Badshahpur, Badshahpur, Gurgaon, Haryana	North
5	Amar Hospital	Sector-70, S.A.S.Nagar, Mohali, Sector 70, Mohali, Punjab	North
6	Brij Medical Centre	Sec-6, Jain Narayan Vyas Colony, Kavi Nagar Industrial Area Sec.-17, Ghaziabad, U.P.	North
7	Famliy Medicare	A-55, Sector 61, Rajat Vihar Sector 62, Noida, U.P.	North
8	Jeevan Jyoti Hospital	162, Lowther Road, Bai Ka Bagh, Allahabad, U.P.	North
9	City Hospital & Trauma Centre	C-1, Cinder Dump Complex, Opposite Krishna Cinema Hall, Kanpur Road, Alambagh, Lucknow, U.P.	North
10	Dayal Maternity & Nursing Home	No.953/23, D.C.F.Chowk, DLF Colony, Rohtak, Haryana	North
11	Metas Adventist Hospital	No.24, Ring-Road, Athwalines, Surat, Gujarat	West
12	Surgicare Medical Centre	Sai Dwar Oberoi Complex, S.A.B.T.V. Lane Road, Lokhandwala, Andheri, Mumbai, Maharashtra	West
13	Paramount General Hospital & I.C.C.U.	42-1, Chettipalayam Road, Palladam, Andheri, Mumbai, Maharashtra	West
14	Gokul Hospital	Battan Lal Road, District Fatehgarh Sahib, Kandivali East, Mumbai, Maharashtra	West
15	Shree Sai Hospital	Gokul Nagri I, Thankur Complex, Western Express Highway, Kandivali East, Mumbai, Maharashtra	West
16	Shreedevi Hospital	Akash Arcade, Bhanu Nagar, Dr. Deepak Shetty Road, Kalyan D.C., Thane, Maharashtra	West
17	Saykhedkar Hospital And Research Centre Pvt. Ltd.	Trimurthy Chowk, Kamatwada Road, Cidco Colony, Nashik, Maharashtra	West
18	Arpan Hospital And Research Centre	No.151/2, Imli Bazar, Near Rajwada, Imli Bazar, Indore, Madhya Pradesh	West
19	Ramkrishna Care Hospital	Aurobindo Enclave, Pachpedhi Naka, Dhamtri Road, National Highway No 43, Raipur, Chhattisgarh	East
20	Gupta Multispeciality Hospital	Mezzanine Floor, Shakuntal B, Near Sanghvi Tower, Gujrat, Gas Circle, Adajan Road, Vivek Vihar, Delhi	North
21	R.K.Hospital	3C/59, BP, Near Metro Cinema, New Industrial Township 1, Faridabad, Haryana	North
22	Prakash Hospital	D -12, 12A, 12B, Noida, Sector 33, Noida, Uttar Pradesh	North
23	Aryan Hospital Pvt. Ltd.	Old Railway Road, Near New Colony, New Colony, Gurgaon, Haryana	North
24	Medilink Hospital Research Centre Pvt. Ltd.	Near Shyamal Char Rasta, 132, Ring Road, Satellite, Ahmedabad, Gujarat	West
25	Mohit Hospital	Khoya B-Wing, Near National Park, Borivali(E), Kandivali West, Mumbai, Maharashtra	West
26	Scope Hospital	628, Niti Khand-I, Indirapuram, Indirapuram, Ghaziabad, Uttar Pradesh	North
27	Agarwal Medical Centre	E-234, -, Greater Kailash 1, New Delhi	North
28	Oxygen Hospital	Bhiwani Stand, Durga Bhawan, Rohtak, Haryana	North
29	Prayag Hospital & Research Centre Pvt. Ltd.	J-206 A/1, Sector 41, Noida, Uttar Pradesh	North
30	Karnavati Superspeciality Hospital	Opposite Sajpur Tower, Naroda Road, Naroda Road, Ahmedabad, Gujarat	West
31	Palwal Hospital	Old G.T. Road, Near New Sohna Mod, Palwal, Haryana	North
32	B.K.S. Hospital	No.18, 1st Cross, Gandhi Nagar, Adyar, Bellary, Karnataka	South
33	East West Medical Centre	No.711, Sector 14, Sector 14, Gurgaon, Haryana	North
34	Jagtap Hospital	Anand Nagar, Singhgood Road, Anandnagar, Pune, Maharashtra	West
35	Dr. Malwankar's Romeen Nursing Home	No 14, Cunningham Road, Sheriffs Chamber, Vikhroli East, Mumbai, Maharashtra	West
36	Noble Medical Centre	C.K. Emerald No., N.S. Palya, Kaveriappa Industrial Area, Borivali West, Mumbai, Maharashtra	West
37	Rama Hospital	Sonepat Road, Bahalgarh, Bahalgarh, Sonapat, Haryana	North
38	S.B.Nursing Home & ICU	Lake Bloom 16 to 18 Opp. Solaris Estate, L.T. Gate No.6, Tunga Gaon, Powai, Mumbai, Maharashtra	West

S.No.	HOSPITAL NAME	ADDRESS	ZONE
39	Saraswati Hospital	103-106, Vrurel Appt., Opp. Navjivan Post Office, Ajwa Road, Malad West, Mumbai, Maharashtra	West
40	Shakuntla Hospital	3-B Tashkant Marg, Near St. Joseph Collage, Allahabad, Uttar Pradesh	North
41	Mahaveer Hospital & Trauma Centre	Plot No-25,B/H Old Mount Carmel School, Near Lokmat Square, Panki, Kanpur, Uttar Pradesh	North
42	Eashwar Lakshmi Hospital	Plot No. 9, Near Sub Registrar Office, Gandhi Nagar, Hyderabad, Andhra Pradesh	South
43	Amrapali Hospital	Plot No. NH-34,P-2, Omega -1, Greater Noida, Noida, Uttar Pradesh	North
44	Hardik Hospital	29C, Budh Bazar, Vikas Nagar, New Delhi, Delhi	North
45	Jabalpur Hospital & Research Centre Pvt. Ltd.	Russel Crossing, Naptier Town, Jabalpur, Madhya Pradesh	West
46	Panvel Hospital	Plot No. 260A, Uran Naka, Old Panvel, Navi Mumbai, Maharashtra	West
47	Santosh Hospital	L-629/631, Hapur Road, Shastri Nagar, Meerut, Uttar Pradesh	North
48	Sona Medical Centre	5/58, Near Police Station, Vikas Nagar, Lucknow, Uttar Pradesh	North
49	City Super Speciality Hospital	Near Mohan Petrol Pump, Gohana Road, Rohtak, Haryana	North
50	Navjeevan Hospital & Maternity Centre	753/21, Madanpuri Road, Near Pataudi Chowk, Gurgaon, Haryana	North
51	Abhishek Hospital	C-12, New Azad Nagar, Kanpur, Uttar Pradesh	North
52	Raj Nursing Home	23-A, Park Road, Allahabad, Uttar Pradesh	North
53	Sparsh Medicare and Trauma Centre	Shakti Khand - III/54 , Indirapuram, Ghaziabad, Uttar Pradesh	North
54	Saras Healthcare Pvt. Ltd.	K-112, SEC-12, Pratap Vihar, Ghaziabad, Uttar Pradesh	North
55	Getwell Soon Multispeciality Institute Pvt. Ltd.	S-19, Shalimar Garden Extn. , Near Dayanand Park, Sahibabad, Ghaziabad, Uttar Pradesh	North
56	Shivalik Medical Centre Pvt. Ltd.	A-93 , Sector 34, Noida, Uttar Pradesh	North
57	Aakanksha Hospital	126, Aaradhnanagar Soc., B/H. Bhulkabhavan School, Aanand-Mahal Rd., Adajan, Surat, Gujarat	West
58	Abhinav Hospital	Harsh Apartment, Nr Jamna Nagar Bus Stop, God Dod Road, Surat, Gujarat	West
59	Adhar Ortho Hospital	Dawer Chambers, Nr. Sub Jail, Ring Rd., Surat, Gujarat	West
60	Aris Care Hospital	A 223-224, Mansarovar Soc, 60 Feet , Godadara Road, Surat, Gujarat	West
61	Arzoo Hospital	Opp. L.B. Cinema, Bhatar Rd., Surat, Gujarat	West
62	Auc Hospital	B-44 Gujarat Housing Board ,Nandeshara, Surat, Gujarat	West
63	Dharamjivan General Hospital & Trauma Centre	Karmayogi - 1, Plot No. 20/21, Near Piyush Point, Pandesara, Surat, Gujarat	West
64	Dr. Santosh Basotia Hospital	Bhatar Road, Surat, Gujarat	West
65	God Father Hospital	344, Nandvan Soc., B/H. Matrushakti Soc., Puna Gam, Surat, Gujarat	West
66	Govind-Prabha Arogya Sankool	Opp. Ratna-Sagar Vidhyalaya, Kaji Medan, Gopipura, Surat, Gujarat	West
67	Hari Milan Hospital	L H Road, Surat, Gujarat	West
68	Jaldhi Ano-Rectal Hospital	103, Payal Apt., Nxt To Rander Zone Office, Tadwadi, Surat, Gujarat	West
69	Jeevan Path Gen. Hospital	2nd Floor, Dwarkesh Nagri, Nr. Laxmi Farsan, Sayan, Surat, Gujarat	West
70	Kalrav Children Hospital	Yashkamal Complex, Nr. Jivan Jyot, Udhna, Surat, Gujarat	West
71	Kanchan General Surgical Hospital	Plot No. 380, Ishwarnagar Soc, Bhamroli-Bhatar, Pandesara, Surat, Gujarat	West
72	Krishnavati General Hospital	Bamroli Road, Surat, Gujarat	West

S.No.	HOSPITAL NAME	ADDRESS	ZONE
73	Niramayam Hosptial & Prasutigruah	Shraddha Raw House, Near Natures Park, Surat, Gujarat	West
74	Patna Hospital	25, Ashapuri Soc - 2, Bamroli Road, Surat, Surat, Gujarat	West
75	Poshia Children Hospital	Harekrishan Shoping Complex 1St Floor, Varachha Road, Surat, Gujarat	West
76	R.D. Janseva Hospital	120 Feet Bamroli Road, Pandesara, Surat, Gujarat	West
77	Radha Hospital & Maternity Home	239/240 Bhagunagar Society, Opp Hans Society, L H Road, Varachha Road, Surat, Gujarat	West
78	Santosh Hospital	L H Road, Surat, Gujarat	West
79	Sparsh Multy Specality Hospital & Trauma Care Center	G.I.D.C Road, Nr Udhana Citizan Co-Op.Bank, Surat, Gujarat	West

Notes:

1. For an updated list of Hospitals, please visit the Company's website.
2. Only in case of a medical emergency, Claims would be payable if admitted in the above Hospitals on a reimbursement basis.

For Change in Occupation / Nature of Job
(Refer Clause 5.2.1 of Policy Terms and Conditions)

If there is insufficient space, please provide further details on a separate sheet. All attached documents form part of this service request.

This form has to be filled in and submitted to the company whenever the nature of job / occupation of any insured covered under the Policy changes subsequent to the issuance of the Policy.

☐ Mr. ☐ Ms. ☐ M/S. Policy No :

[illegible]

☐ Mr. ☐ Ms. ☐ M/S.

[illegible][illegible]

I hereby declare, on my behalf and on behalf of all persons insured, that the above statement(s), answer(s) and / or particular(s) given by me are true and complete in all respects to the best of my knowledge and that I am authorized to provide / request for updation of the details on behalf of Insured Persons.

Date : / / (DD/MM/YYYY)

Place :

Signature of the Policyholder : _____

(On behalf of all the persons insured under the Policy)

Note: The Company shall update its record with respect to the information provided above. Subsequently, the Company may review the risk involved and may alter the coverage and / or premium payable accordingly.

Annexure V - Benefit / Premium illustration

Illustration No. 1

Age of members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)
32	6,935	3,00,000	6,935	2.5%	6,761	3,00,000	11,741	NA	11,741	3,00,000
24	6,473	3,00,000	6,473	2.5%	6,311	3,00,000				
Total Premium for all members of family is Rs. 13,408, when each member is covered separately.			Total Premium for all members of family is Rs. 13,073 , when they are covered under a single policy				Total Premium when policy is opted on floater basis is Rs. 11,741			
Sum Insured available for each individual is Rs. 3,00,000			Sum Insured available for each family member is Rs. 3,00,000				Sum Insured of Rs. 3,00,000 is available for entire family			

Illustration No. 2

Age of members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)
54	14,120	3,00,000	14,120	2.5%	13,767	3,00,000	24,083	NA	24,083	3,00,000
48	11,377	3,00,000	11,377	2.5%	11,092	3,00,000				
Total Premium for all members of family is Rs. 25,497, when each member is covered separately. Sum Insured available for each individual is Rs. 3,00,000			Total Premium for all members of family is Rs. 24,859, when they are covered under a single policy Sum Insured available for each family member is Rs. 3,00,000				Total Premium when policy is opted on floater basis is Rs. 24,083 Sum Insured of Rs. 3,00,000 is available for entire family			

Illustration No. 3

Age of members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a single Policy (Sum Insured is available for each member of family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount (if any)	Premium after discount (Rs.)	Sum Insured (Rs.)
75	42,789	3,00,000	42,789	2.5%	41,719	3,00,000	68,403	NA	68,403	3,00,000
71	42,789	3,00,000	42,789	2.5%	41,719	3,00,000				
Total Premium for all members of family is Rs. 85,578 , when each member is covered separately			Total Premium for all members of family is Rs. 83,438 , when they are covered under a single policy				Total Premium when policy is opted on floater basis is Rs. 68,403			
Sum Insured available for each individual is Rs. 3,00,000			Sum Insured available for each family member is Rs. 3,00,000				Sum Insured of Rs. 3,00,000 is available for entire family			

Notes:

- 1. Premium rates (excl taxes) specified in above illustration shall be standard premium rates without considering any loading.
- 2. Premium shown is for Zone 1 with 20% Copay option for New Entrants till age 70 years and then @ 30% Copay for subsequent renewals/new entrants.

Annexure VI - Office of the Ombudsman

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, Ist 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 Hindustan 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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Care Health Insurance Limited

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: CHIHLIP26053V032526

IRDAI Registration Number - 148

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Care Health - Customer App:
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www.careinsurance.com/self-help-portal.html



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