carē HEALTH INSURANCE

BEST HEALTH INSURANCE COMPANY OF THE YEAR
INDIA INSURANCE SUMMIT & AWARDS 2023

group carē 360° plus

Know Your Policy Better

Policy Terms and Conditions

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 Persons (also referred as Insured) and Care Health insurance Company Ltd. (also referred as Company), 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 viceversa. The sentence construction and wordings in thePolicy 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)/Claimant, the amount of such expenses that are reasonably and necessarily incurred up to the limits specified against respective benefit in any Cover Period**.**

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 ("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 Add-on Policy and, where appropriate.

1. Definitions

1.1. Standard Definitions

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

1.2. Specific Definitions:

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

1.2.2 Add-on Policy Period means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date of the Add-on Policy as specifically appearing in the Add-on Policy Schedule.

1.2.3. Add-on Policy Period End Date means the date on which the Add-on Policy expires, as specifically appearing in the Add-on Policy Schedule.

1.2.4. Add-on Policy Period Start Date means the date on which the Add-on Policy commences, as specifically appearing in the Add-on Policy Schedule.

1.2.5. Add-on Policy Schedule is a schedule attached to and forming part of this Add-on Policy and which can be endorsed depending on the requirement of the Add on Policy.

1.2.6. Add-on Policy Year means a period of one year commencing on the Add-on Policy Period Start Date or any anniversary thereof.

1.2.7. Annexure means the document attached and marked as Annexure to this Add- on Policy.

1.2.8. Base Policy means retail Policy issued by the Company including Policy terms and conditions and Annexures thereto, the Proposal Form, Policy Schedule and to which this Add-on shall be attached.

1.2.9. Country/Place/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 Add-on Policy Schedule.

1.2.10.Diagnosis means pathological conclusion drawn by a registered Medical Practitioner, supported by acceptable Clinical, radiological, histological, histo pathological and laboratory evidence wherever applicable.

1.2.11. Mental Illness means a substantial disorder of thinking, mood, perception, orientation ormemory that grossly impairs

judgment, behavior, capacity to recognize, reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.

1.2.12. Medical device/Device - means any, instrument, apparatus or device including any component, part or accessory thereof, manufactured solely for medical purpose which intends to treatment and mitigation of amedical condition or to physically support the function of human body.

1.2.13. Therapy means the procedure for remediation of a health problem, following a medical diagnosis. It means treatment to help or cure a mental or physical illness without drugs or medical operations. This does not include any experimental therapies.

1.2.14. 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:

a. Room, boarding, nursing and operation theatre expenses as charged by the Hospital where the Insured Person availed medical treatment;

b. 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.

1.2.15. Critical Illnesses (Indemnity basis) Coverage for Critical Illnesses is limited to the below definitions and extent of coverage. These definitions should be read in conjunction with the Critical Illness opted against Benefit: Hospitalization Expenses in the Base Policy and Add-on Policy Schedule. Coverage will only be as per the Critical Illness opted.

I. Cancer (Varies from IRDAI Standard Definitions 2016)

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and\ destruction of normal tissues.This Diagnosis must be supported by histological evidence of malignancy and confirmed by a pathologist.

II. The term Cancer includes

A. Leukemia, lymphoma, and sarcoma.

B. Tumor's showing the malignant changes of carcinoma in situ and tumours which are histologically described as pre-malignant or non invasive, including but not limited to Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3

The following are excluded:

A. Benign lesions

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

C. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter;

D. Microcarcinoma of the bladder;

E. All tumours in the presence of HIV infection.

Heart Related Conditions

ii. Pulmonary Thromboembolism

Acute Pulmonary Thromboembolism: means the blockage of an artery in the lung by a clot or other tissue from another part of the body. The Pulmonary Embolus must be unequivocally diagnosed by a specialist on either a V/Q scan (the isotope investigation which shows the ventilation and perfusion of the lungs), angiography or echocardiography, with evidence of right ventricular dysfunction and conformation with D Dimer assay findings, and requiring medical or surgical treatment on an inpatient basis.

iii. Primary(Idiopathic) Pulmonary Hypertension (Varies from IRDAI Standard Definitions 2016

A. An unequivocal Diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist

or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

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

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

Following are excluded:

A. Pulmonary hypertension associated with occupational and environmental factors

B. Substance abuse (like tobacco etc.)

C. lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, any heart disease and al secondary causes.

iv. Infective Endocarditis

Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:

A. Positive result of the blood culture proving presence of the infectious organism(s)

B. Presence of at least moderate heart valve incompetence (meaning regurgitate fraction of twenty percent (20%) or above) or moderate heart valve stenosis (resulting in heart valve area of thirty percent (30%) or less o normal value) directly attributable to Infective Endocarditis; without any other valvular disease/risk factors and

C. The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a consultant cardiologist.

v. Heart Valve Replacement/repair (Varies from IRDAI Standard Definitions 2016)

A. The actual undergoing of open-heart valve surgery to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valves. The Diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

B. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty.

vi. Surgery of Aorta

The actual undergoing of major surgery/minimally invasive surgical repair(i.e. via percutaneous intra-arterial route) to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen with a graft. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The treatment will be including but not limited to Angioplasty.

vii. Cardiomyopathy

A. An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a consultant cardiologist who has been treating the patient, and which results in permanent physical impairment to the degree of New York Heart Association classification Class IV or its equivalent, based on the following classification criteria: Class IV - Inability to carry out any activity without discomfort.

B. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced.

The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance.

Irrespective of the above, Cardiomyopathy directly related to

alcohol or drug abuse is excluded.

viii. Surgery for cardiac arrhythmia

Ablative Procedure is defined as catheter ablation procedures using radiofrequency or cryothermal energy for treatment of a recurrent or persistent symptomatic arrhythmia refractory to antiarrhythmic drug therapy. Ablation procedures should immediately follow the diagnostic electorphysiology study. The ablative procedure must be certified to be absolutely necessary by a consultant cardiologist (electrophysiologist)

Pre-procedural evaluation prior to ablation procedures and ablation procedures as below should be completely documented:

A. Strips from ambulatory Holter monitoring in documenting the arrhythmia.

B. Electrocardiographic and electrophysiologic recording, cardiac mapping and localization of the arrhythmia during the ablative procedure.

ix. Angioplasty

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

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

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

x. Balloon Valvotomy/Valvuloplasty

The actual undergoing of Valvotomy or Valvuloplasty necessitated by damage of the heart valve as confirmed by a specialist in the relevant field where the procedure is performed totally via intravascular catheter based techniques.

The Diagnosis of heart valve abnormality must be supported by cardiac catheterization or Echocardiogram and the procedure must be considered Medically Necessary by a consultant cardiologist.

xi. Carotid Artery Surgery

The actual undergoing of surgery to the Carotid Artery to treat carotid artery stenosis of fifty percent (50%) and above, as proven by angiographic evidence, of one (1) or more carotid arteries. Both criteria (a) and (b) below must be met:

A. Either:

i. Actual undergoing of endarte rectomy to alleviate the symptoms; or

ii. Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy to alleviate the symptoms; and

B. The Diagnosis and medical necessity of the treatment must be confirmed by a cardio-thoracic surgeon.

xii. Coronary Artery Bypass Graft (Varies from IRDAI Standard Definitions 2016)

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is / are narrowed or blocked, by Coronary Artery Bypass Graft (CABG). The Diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

Exclusion: Any key-hole or laser surgery.

xiii. Pericardectomy

The undergoing of a pericardectomy performed by open heart surgery or keyhole techniques as a result of pericardial disease. The surgical procedures must be certified to be Medically Necessary by a consultant cardiologist. Other procedures on the pericardium including pericardial

biopsies, and pericardial drainage procedures by needle aspiration are excluded

The actual undergoing of pericardiectomy secondary to chronic constrictive pericarditis.

The following are specifically excluded:

A. Chronic constrictive pericarditis related to alcohol or drug abuse or HIV

B. Acute pericarditis due to any reason

xiv. Surgery to Place Ventricular Assist Devices or Total Artificial Hearts

This is an open chest procedure for implantation of Left Ventricular Assist Device/Ventricular Assist Device as bridges to cardiac transplantation or destination therapy for long term use for the Refractory Heart Failure with reduced ejection fraction as defined below:

NYHA Class IV symptoms who failed to respond to optimal medical management for >= 45 of the past 60 days, or have been intra-aortic balloon pump dependent for 7 days, or IV inotrope dependent for14 days.

The following are excluded:

A. Ventricular dysfunction or Heart failure directly related to alcohol or drug abuse

xv. Myocardial Infarction (Varies from IRDAI Standard Definitions 2016

The occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The Diagnosis for this will be evidenced by the following criteria:

A. A history of typical clinical symptoms consistent with the Diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain);

B. New characteristicel ectrocardiogram changes;

C. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following conditions are excluded:

A. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T;

B. Other acute Coronary Syndromes;

C. Any type of angina pectoris.

xvi. Implantation of Pacemaker of Heart:

Actual undergoing of Insertion of a permanent cardiac pacemaker to correct serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be Medically Necessary by a specialist in the relevant field.

Following will be excluded:

A. Cardiac arrest secondary to alcohol, substance abuse or drug misuse

xvii. Implantable Cardioverter Defibrillator:

A. Actual undergoing of insertion of an implantable cardiac defibrillator to correct serious cardiac arrhythmia which cannot be treated via other methods or the insertion of permanent cardiac defibrillator to correct sudden loss of heart function with cessation of bloody circulation around the body resulting in unconsciousness .

Insertion of Cardiac Defibrillator means surgical implantation of either Implantable Cardioverter Defibrillato (ICD), or Cardiac Resynchronization Therapy with Defibrillator (CRT-D)

B. The insertion of a permanent Cardioverter-Defibrillator (ICD) must be certified to be absolutely necessary by a specialist in the relevant field.

Following will be excluded:

i. Cardiac arrest secondary to alcohol, substance abuse or drug misuse

xviii. Heart Transplant

The actual undergoing of a transplant

of heart that resulted from irreversible end-stage failure of Heart.

The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

Following will be excluded:

i. Ventricular dysfunction or Heart failure directly related to alcohol or drug abuse

Conditions other than Heart and Cancer

xix. End Stage Renal Failure (Varies from IRDAI Standard Definitions 2016)

End stage renal disease presenting as chronic irreversible failure of both kidneys to function documented with raise level of S Creatinine and S Urea, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a Nephrologist.

xx. Multiple Sclerosis (Varies from IRDAI Standard Definitions 2016)

The definite occurrence of multiple sclerosis, the Diagnosis of which must be supported by following, and certified by a Physician/ Neurophysician:

A. Investigations including typical MRI and CSF findings, which unequivocally confirm the Diagnosis to be multiple sclerosis;

B. There must be current clinical impairment of motor or sensory function Other causes of neurological damage such as SLE and HIV are excluded.

xxi. Benign Brain Tumor (Varies from IRDAI Standard Definitions 2016)

A benign tumour in the brain where following conditions are met and Its presence must be confirmed by a neurologist or neurosurgeon:

A. Has potential to cause permanent damage to the brain;

B. If it has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit such as but not restricted to characteristic symptoms o increased intracranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment; and

C. Diagnosis is supported by findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques.

D. The treatment is advised and justified medically by a certified Neurologist

Following will be excluded:

A. Cysts; 7

B. Granulomas;

C. Vascular malformations

D. Haematomas;

E. Calcification;

xxii. Parkinson's Disease

Hospitalization for treatment directly related to progressive degenerative idiopathic Parkinson's Disease, certified and diagnosed by a consultant neurologist.

Following will be excluded:

A. Parkinson's disease secondary to drug and/ or alcohol abuse

B. Psychiatric treatment directly or indirectly related to Parkinson's disease

This benefit shall supersede exclusion of Parkinson's disease specified under Clause 4.III (13) under Specific Exclusions.

xxiii. Alzheimer's Disease

A. Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathologic changes.

B. Deterioration or loss of intellectual capacity as confirmed

by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. This Diagnosis must be supported by the clinical confirmation of an appropriate consultant neurologist and supported by the Company's appointed doctor.

Following will be excluded:

A. Non organic diseases such as neurosis and psychiatric illnesses;

B. Alcohol related brain damage;

C. Any other type of irreversible organic disorder/dementia;

D. Psychiatric treatment directly or indirectly related to Alzheimer's disease

This benefit shall supersede exclusion of Parkinson's disease specified under Clause 4.III (13) under Specific Exclusions.

xxiv. End Stage Liver Disease (Varies from IRDAI Standard Definitions 2016)

End stage liver disease resulting in cirrhosis and irreversible liver damage, evidenced by the following criteria and certified by a Gastroenterologist :

A. Permanent jaundice;

B. Uncontrollable ascites;

C. Hepatic encephalopathy;

D. Oesophageal or Gastric Varices and portal hypertension;

Liver disease arising out of or secondary to alcohol or drug misuse is excluded.

xxv. Motor Neurone Disorder

Motor neurone disease diagnosed by a Neurophysician as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction with a clear causation relation to MND.

xxvi. End Stage Lung Disease

End Stage Respiratory Failure including Chronic Interstitial Lung Disease. Following criteria must be met:

A. Requiring permanent oxygen therapy as a result of a consistent FEV1 test value of less than one litre. (Forced Expiratory Volume during the first second of a forced exhalation);

B. Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less;

c. This Diagnosis must be confirmed by a chest/ Respiratory physician.

xxvii. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. This Diagnosis must be confirmed by:

A. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture;

B. A consultant neurologist.

Bacterial Meningitis in the presence of HIV infection is excluded.

xxviii. Aplastic Anaemia

Chronic persistent bone marrow failure which results in Anaemia, Neutropenia and Thrombocytopenia requiring treatment with at least one of the

following:

A. Blood product transfusion;

B. Marrow stimulating agents;

C. Immunosuppressive agents; or

D. Bone marrow transplantation

The Diagnosis must be confirmed by a hematologist using relevant laboratory investigations including Bone Marrow Biopsy. Two out of the following three values should be present:

A. Absolute Neutrophil count of 500 per cubic millimetre or less;

B. Absolute Reticulocyte count of 20,000 per cubic millimetre or less;

C. Platelet count of 20,000 per cubic millimetre or less.

xxix. Major Organ Transplant

The actual undergoing of a transplant of:

A. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end- stage failure of the relevant organ; or

B. Human bone marrow using hematopoietic stem cells.

The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

The following are excluded:

A. Other stem-cell transplants;

B. Where only islets of Langerhans are transplanted.

xxx. Stroke (Varies from IRDAI Standard Definitions 2016)

A. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra cranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain.

B. Evidence of permanent neurological deficit lasting for has to be produced.

The following are excluded:

I. Transient ischemic attacks (TIA);

II. Traumatic Injury of the brain;

III. Vascular disease affecting only the eye or optic nerve or vestibular functions.

xxxi. Paralysis (Varies from IRDAI Standard Definitions 2016)

A. Total and irreversible loss of use of two or more limbs as a result of Injury or disease of the brain or spinal cord. A specialist Medical Practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery. Reconstruction surgeries required to attain best possible mobility will be included

B. Rehabilitative treatment, prosthesis and supporting aids like crutches/wheel chair/vehicle/home modification will be excluded

xxxii. Major Burns (Varies from IRDAI Standard Definitions 2016)

Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Insured Person's body. The condition should be confirmed by a consultant physician.

Burns arising due to self-infliction are excluded.

xxxiii. Blindness (Varies from IRDAI Standard Definitions 2016)

A. Blindness' is defined as visual acuity of less than 3/60, or a corresponding visual field loss to less than 10°, in the better eye with the best possible correction.

B. Treatments required for correction of blindness or improvement in visual acuity will be covered

Following will be excluded:

i. Treatment for Low vision: 'low vision' is defined as visual acuity of less than 6/18 but equal to or better than 3/60, or a corresponding visual field loss to less than 20°, in the better eye with the best possible correction.

ii. Cases of blindness with Low Vision before the inception of Add-on Policy

iii. Cost of enucleation related to tumor's or other eye defects

iv. Cost of prosthesis for cosmetic correction

v. Visual aids implantable or external

2. Critical Illness (benefit basis)

Coverage for Critical Illnesses is limited to the below definitions and extent of coverage. These definitions should be read in conjunction with the Critical Illness opted against Benefits under 'Critical Illness Fixed Benefit' in the Add-on Policy Schedule. Coverage will only be as per the Critical Illness opted

I. CANCER OF SPECIFIED SEVERITY

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

II. The following are excluded –

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

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

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

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

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

vi. Chronic lymphocyctic leukaemia less than RAI stage 3

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

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

ix. All tumors in the presence of HIV infection.

II. MYOCARDIAL INFARCTION

(First Heart Attack of specific severity)

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

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

ii. New characteristic electrocardiogram changes

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

II. The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

III. OPEN CHEST CABG

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

II. The following are excluded:

i. Angioplasty and/or any other intra arterial procedures

IV. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

V. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This Diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;

ii. life support measures are necessary to sustain life; and

iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

VI. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

VII. STROKE RESULTING IN PERMANENT SYMPTOMS

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

The following are excluded:

i. Transient ischemic attack (TIA)

ii. Traumatic Injury of the brain

iii. Vascular disease affection onlythe eye or optic nerve or vestibular functions.

VIII. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung,

liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

II. The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

IX. PERMANENT PARALYSIS OF LIMBS

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

X. MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS.

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

XI. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal Diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the Diagnosis to be multiple sclerosis and

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

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

XII. BENIGN BRAIN TUMOR

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, and tumors of skull bones, and tumors of the spinal cord.

XIII. BLINDNESS

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

II. The Blindness is evidenced by

i. corrected visual acuity being

3/60 or less in both eyes or ;

ii. the field of vision being less than 10 degrees in both eyes.

III. The Diagnosis of blindness must be confirmed and must not be correctable by aides or surgical procedure.

XIV. END STAGE LUNG FAILURE

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

I. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and

ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and

iv. Dyspnea at rest.

XV. END STAGE LIVER FAILURE

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

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

XVI. THIRD DEGREE BURNS

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

XVII. PARKINSON'S DISEASE

The unequivocal Diagnosis of progressive degenerative primary idiopathic Parkinson's disease (all other forms of Parkinsonism are excluded) made by a consultant neurologist. This Diagnosis must be supported by all of the following conditions: The disease cannot be controlled with medication; and Objective signs of progressive impairment; and There is an inability of the Life assured to perform (whether aided or unaided) at least 3 of the following five (6) "Activities of Daily Living" for a continuous period of at least 6months.

The Activities of Daily Living are:

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

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

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

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

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

vi. Feeding: the ability to feed oneself once food has been prepared and made available Drug-induced or toxic causes of Parkinsonism are excluded

This benefit shall supersede exclusion of Parkinson's disease specified under Clause 4.III (13) under Specific Exclusions.

XVIII. ALZHEIMER'S DISEASE

Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardized questionnaires and cerebral imaging. The Diagnosis of Alzheimer's disease must be confirmed by an appropriate consultant and supported by the Company's appointed doctor. There must be significant reduction in mental and

social functioning requiring the continuous supervision of the Insured Person. There must also be an inability of the Insured Person to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living" for a continuous period of at least 3 months: Activities of Daily Living are defined as:

I. Bathing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

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

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

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

V. Feeding – the ability to feed oneself once food has been prepared and made available.

VI. Mobility - the ability to move from room to room without requiring any physical assistance.

The following are excluded:

I. Any other type of irreversible organic disorder/dementia

II. Non-organic disease such as neurosis and psychiatric illnesses; and

III. Alcohol-related brain damage.

This benefit shall supersede exclusion of Alzheimer's disease specified under Clause 4.III (13) under Specific Exclusions.

XIX. BACTERIAL MENINGITIS

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks.

This Diagnosis must be confirmed by the presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and a consultant neurologist.

Bacterial Meningitis in the presence of HIV infection is excluded.

XX. APLASTIC ANAEMIA

Chronic Irreversible persistent bone marrow failure which results in Anaemia, Neutropenia and Thrombocytopenia requirin treatment with at least TWO of the following:

I. Regular blood product transfusion;

II. Marrow stimulating agents;

III. Immunosuppressive agents; or

IV. Bone marrow transplantation.

The Diagnosis and suggested line of treatment must be confirmed by a Hematologist acceptable to the Company using relevant laboratory investigations, including bone marrow biopsy. Two out of the following three values should be present:

I. Absolute neutrophil count of 500 per cubic millimeter or less;

II. Absolute erythrocyte count of 20 000 per cubic millimeter or less; and

III. Platelet count of 20 000 per cubic millimeter or less. Temporary or reversible aplastic anaemia is excluded.

XXI. PULMONAR THROMBOEMBOLISM

Acute Pulmonary Thromboembolism means the blockage of an artery in the lung by a clot or other tissue from another part of the body. The Pulmonary Embolus must be unequivocally diagnosed by a specialist on either a V/Q scan (the isotope investigation which shows the ventilation and perfusion of the lungs), angiography or echocardiography, with evidence of

right ventricular dysfunction and conformation with D Dimer assay findings, and requiring medical or surgical treatment on an inpatient basis.

XXII. PRIMARY (IDIOPATHIC PULMONARY HYPERTENSION (VARIES FROM IRDAI STANDARD DEFINITIONS 2016)

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

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

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

Following are excluded:

A. Pulmonary hypertension associated with occupational and environmental factors

B. Substance abuse (like tobacco etc.)

C. lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, any heart disease and all secondary causes

XXIII. INFECTIVE ENDOCARDITIS

Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:

A. Positive result of the blood culture proving presence of the infectious organism(s)

B. Presence of at least moderate heart valve incompetence (meaning regurgitate fraction of twenty percent (20%) or above) or moderate heart valve stenosis (resulting in heart valve area of thirty percent (30%) or less of normal value) directly attributable to Infective Endocarditis; without any other valvular disease/risk factors and

The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a consultant cardiologist.

XXIV. SURGERY OF AORTA

The actual undergoing of major surgery/minimally invasive surgical repair(i.e. via percutaneous intra arterial route) to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen with a graft. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The treatment will be including but not limited to Angioplasty.

XXV. CARDIOMYOPATHY

A. An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a consultant cardiologist who has been treating the patient, and which results in permanent physical impairment to the degree of New York Heart Association classification Class IV, or its equivalent, based on the following classification criteria: Class IV - Inability to carry out any activity without discomfort.

B. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be

experienced. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance.

Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

XXVI. SURGERY FOR CARDIAC ARRHYTHMIA

Ablative Procedure is defined as catheter ablation procedures using radiofrequency or cryothermal energy for treatment of a recurrent or persistent symptomatic arrhythmia refractory to antiarrhythmic drug therapy. Ablation procedures should immediately follow the diagnostic electorphysiology study. The ablative procedure must be certified to be absolutely necessary by a consultant cardiologist (electrophysiologist).

Pre-procedural evaluation prior to ablation procedures and ablation procedures as below should be completely documented:

A. Strips from ambulatory Holter monitoring in documenting the arrhythmia.

B. Electrocardiographic and electrophysiologic recording, cardiac mapping and localization of the arrhythmia during the ablative procedure.

XXVII. ANGIOPLASTY

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

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

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

XXVIII BALLOON VALVOTOMY/ VALVULOPLASTY

The actual undergoing of Valvotomy or Valvuloplasty necessitated by damage of the heart valve as confirmed by a specialist in the relevant field where the procedure is erformed totally via intravascular catheter based techniques.

The Diagnosis of heart valve abnormality must be supported by cardiac catheterization or Echocardiogram and the procedure must be considered Medically Necessary by a consultant cardiologist

XXIX. CAROTID ARTERY SURGERY

The actual undergoing of surgery to the Carotid Artery to treat carotid artery stenosis of fifty percent (50%) and above, as proven by angiographic evidence, of one (1) or more carotid arteries. Both criteria (a) and (b) below must be met:

A. Either:

i. Actual undergoing of endarte rectomy to alleviate the symptoms; or

ii. Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy to alleviate the symptoms; and

B. The Diagnosis and medical necessity of the treatment must be confirmed by a cardio thoracic surgeon.

XXX. PERICARDECTOMY

The undergoing of a pericardectomy

performed by open heart surgery or keyhole techniques as a result of pericardial disease. The surgical procedures must be certified to be Medically Necessary by a consultant cardiologist. Other procedures on the pericardium including pericardial biopsies, and pericardial drainage procedures by needle aspiration are excluded.

The actual undergoing of pericardiectomy secondary to chronic constrictive pericarditis.

The following are specifically excluded:

A. Chronic constrictive pericarditis related to alcohol or drug abuse or HIV

B. Acute pericarditis due to any reason

XXXI. IMPLANTATION OF PACEMAKER OF HEART

Actual undergoing of Insertion of a permanent cardiac pacemaker to correct serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be Medically Necessary by a specialist in the relevant field.

Following will be excluded:

A. Cardiac arrest secondary to alcohol, substance abuse or drug misuse

XXXII. MPLANTABLE CARDIOVERTER DEFIBRILLATOR

A. Actual undergoing of insertion of an implantable cardiac defibrillator to correct serious cardiac arrhythmia which cannot be treated via other methods or the insertion of permanent cardiac defibrillator to correct sudden loss of heart function with cessation of blood circulation around the body resulting in unconsciousness. Insertion of Cardiac Defibrillator means surgical implantation of either Implantable Cardioverter Defibrillator (ICD), or Cardiac Resynchronization Therapy with Defibrillator (CRT-D)

B. The insertion of a permanent Cardioverter-Defibrillator (ICD) must be certified to be absolutely necessary by a specialist in the relevant field.

Following will be excluded:

i. Cardiac arrest secondary to alcohol, substance abuse or drug misuse

2. Scope of Cover

General Conditions:

1. The Add-on Policy can only be bought along with the Base Policy at the time of Add-on Policy Issuance and cannot be bought in isolation or as a separate product or mid-term.
2. The applicability of any benefit is subject to the Policyholder having opted that benefit and such applicability is specified in the Add-on Policy Schedule. Coverage will be restricted to the opted Geographical Scope in Base Policy.
3. All Claims shall be payable subject to the terms, conditions, wait periods and exclusions of the Add-on Policy and subject to availability of the Coverage amount against each and every benefit.
4. Coverage amount of any benefit under this Add-on Policy cannot be greater than the Coverage amount of its respective benefit under Base Policy (wherever applicable) except Personal Accident benefit.
5. Coverage amount of benefit under this Add-on Policy will always be a part of Coverage amount of its respective benefit under Base Policy except benefits Loss of Pay due to Illness under Hospitalization Expenses, Out-patient Expenses, Daily Cash Allowance, Personal Accident, Critical Illness Fixed Benefit, Additional Benefits.
6. Deductible, Co-payment, Franchise Deductible will be applicable as opted under Base Policy unless specified otherwise under any Benefit of Add-on Policy. The Company shall be liable to make payment under the Add-on Policy for any Claim in respect of the Insured only when the Deductible (if applicable), Co-payment (if applicable), Franchise Deductible (if applicable)

on that Claim is exhausted.

7. Initial wait period, Named ailment and Pre existing Disease wait periods, will be applicable under this Add-on Policy on Base Benefits - Hospitalization Expenses, Daily Cash Allowance, Convalescence Benefit and shall be same as of Base Policy. The wait periods opted for Pre Existing Diseases (PED), Named Ailments and Maternity for any Base Benefit should be applicable to other benefits (wherever applicable). In case different wait periods are selected, then maximum wait period will be applied.

8. The maximum, total and cumulative liability of the Company towards an Insured Person, for any and all Claims arising under this Add-on Policy during the Cover Year, on occurrence of an Insured Event in relation to that Insured Person, shall not exceed the coverage amount of that Insured Person which is specified against every Base Benefit, mentioned in the Add-on Policy Schedule.

9. All the valid OPD Claim expenses incurred by the Insured Person in a Cover Year will be payable / reimbursed by the Company. However, Claim can be filed with the Company, only once on quarterly basis during that Cover Year. However, Claimant will be allowed only 1 more filing within 30 days after the Cover Year.

   Admissibility of a Claim under Hospitalization Expenses of Base Policy is a pre-condition to the admission of a Claim under Bereavement cover, Learning & Behavioural disorders, Gender Reassignment Surgery, Sleep Aponea treatment, Sterilization, Vector Borne Disease cover, Organ Transportation, Wig cover, Transportation of Imported Medicines, Terminal Illness, Loss of Pay due to Illness, Emergency Illness, Non-payable Items cover.

11. Option of Mid-term inclusion of a Member in the Add-on Policy will be only upon marriage or childbirth; Additional differential premium will be calculated on a pro rata basis

12. Coverage for Base Benefits applicable under Daily cash Allowance, Convalescence Benefit, Personal Accident, Critical Illness Fixed Benefit, Companion Benefit, Be-fit, Vector borne Disease (Benefit basis) will be on Individual basis only.

13. If geography under Base Policy chosen is either Worldwide or Worldwide excl. US, then the coverage will be restricted only to following Base Benefits of this Add-on Policy:

    i. Hospitalization Expenses (only in case of All Conditions as specified under Base Benefit 1),

    ii. Out-patient Expenses,

    iii. Daily Cash Allowance,

    iv. Convalescence Benefit,

    v. Additional Benefits

        i. Assisted Reproductive Treatment,

        ii. Assisted Reproductive Treatment Complications,

        iii. Repatriation of Mortal Remains,

        iv. Companion Benefit,

        v. Vector borne Disease (Benefit basis),

        vi. Advance Ambulance Expenses,

        vii. Non-payable Items cover

Base Benefits under this Add-on Policy:

Base Benefits under 'Hospitalization Expenses'

2.1 Base Benefit 1: Hospitalization Expenses

If Policyholder has opted for one of the following:

a. Coverage for only listed Critical Illnesses or

b. Coverage for only surgeries or

c. Coverage for all Hospitalization conditions; and

If an Insured Person is diagnosed with an Illness or suffers an Injury which requires the Insured Person to be admitted in a Hospital due to Medically Necessary conditions either as In-patient or on Day Care basis, then the Company will indemnify up to the Coverage amount opted

2.2 Base Benefit 2: Well Baby & Well Mother Expenses

Notwithstanding anything contrary under the Add-on Policy, if this benefit is opted then the Company shall be liable to make payment for any 'Well Baby Care' expenses and 'Well Mother Expenses', as specified in Add-on Policy Schedule for any Claim arising under the 'Maternity Expenses' Benefit maximum up to 50% / 100 % of 'Maternity Expenses' Coverage amount as mentioned in Policy Schedule of Base Policy. Any of the following option as chosen and mentioned in Add-on Policy Schedule, will be applicable:

a. Coverage amount opted under this benefit shall be within the 'Maternity Expenses'

Coverage amount as mentioned in Policy Schedule of Base Policy. Or

b. Coverage amount opted under this benefit shall be over and above 'Maternity Expenses' Coverage amount as mentioned in Policy Schedule of Base Policy.

Note:

All other conditions stated under 'Maternity Expenses' benefit in the Base Policy shall be applicable for this Benefit under this Add on Policy.

2.3 Base Benefit 3: Bereavement Cover

In case of death of Primary Insured Person during Hospitalization and subject to admissibility of the Hospitalization Expenses , then any deduction in the admissible claim amount due to Non-medical expenses , Deductible, Franchise Deductible and Co-pay shall be waived off. However sub-limits, if any, will be applicable.

2.4 Base Benefit 4: Learning and Behavioral Disorders

The Company will indemnify the Medical Expenses incurred for the Developmental conditions associated with Learning Difficulties (LD's) that include but are not limited to - Dyslexia , Behavioral problems associated with Attention Defici Hyperactivity Disorder(ADHD), Autism Spectrum Disorder (ASD) , up to amount specified in the Add-on Policy Schedule, during the Add-on Policy Year.

Note: Clauses 4.III (13) and 4.III (48) under Specific Exclusions are superseded to the extent covered under this Benefit.

2.5 Base Benefit 5: Gender Reassignment Surgery

The Company will indemnify Medical Expenses incurred on Gender Reassignment Surgery, up to amount specified in the Add on Policy Schedule, during the Add-on Policy Year. This benefit is available only for Insured 18 years and above.

Note: Clause 4.II (4) under Standard Exclusions is superseded to the extent covered under this Benefit.

2.6 Base Benefit 6: Sleep Apnoea Treatment

The Company will indemnify Medical Expenses incurred on surgical treatment of Sleep Apnoea and its complications, up to the amount specified in the Add-on Policy Schedule, during the Add-on Policy Year.

Note:

Clause 4.III (10) under Specific Exclusions, is superseded to the extent covered under this Benefit

2.7 Base Benefit 7: Sterilization

The Company will indemnify Medical Expenses incurred on Sterilization, Contraception and/or Reversal of sterilization treatment, up to the amount specified in the Add-on Policy Schedule.

The coverage shall also include – Expenses for treatment of medical complications due to sterilization operation.

Note:

-For the purpose of this benefit, The Medical complications (if any), have to be reported within 60 days of the Sterilization operation.

-This benefit covers only surgical procedures except in case of treatment of medical complications where non- surgical procedures are also covered.

-Clause 4.II (14) under Standard Exclusions, is superseded to the extent covered under this Benefit.

2.8 Base Benefit 8: Reasonable & Customary Charges Waive off

Notwithstanding anything to the contrary in the Add-on Policy, by opting this benefit, the Reasonable & Customary Charges shall be waived off that are part of Hospitalization Expenses.

Note:

a. For the purpose of this benefit, Reasonable & Customary Charges will comprise of the general prevailing cost of a service or Medical Expenses (including room rent) within the geographic Area.

2.9 Base Benefit 9: Stem Cell/ Umbilical Cord Preservation

The Company will indemnify expenses incurred for Stem Cell / Umbilical Cord Preservation of the New Born at the registered stem cell banks, up to the amount specified in the Add-on Policy Schedule.

Note:

a. For the purpose of this benefit, Maternity

Benefit has to be mandatorily opted, as part of Base Policy.

b. The applicable Waiting Period and Age criteria shall remain same as that of Base Policy Maternity Benefit.

c. This benefit shall be payable only once under this Add-on Policy per child.

d. Clause 4.III (40) under Specific Exclusions, is superseded to the extent covered under this Benefit.

2.10 Base Benefit 10: Home Care Treatment

The Company will indemnify Medical Expenses incurred for Home Care Treatment, up to the amount specified in the Add-on Policy Schedule during the Add-on Policy Year.

Home Care Treatment means treatment availed by the Insured Person at home, which in normal course would require treatment at a Hospital but is actually taken at home maximum up to 15 days per illness (including co-morbidities) provided that:

a. The Medical Practitioner advices the Insured Person to undergo treatment at home.

b. There is a continuous active line of treatment with monitoring of the health status by a Medical Practitioner for each day through the duration of the home care treatment.

c. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

d Insured shall be permitted to avail the services as prescribed by the Medical Practitioner.

e. In case of Insured intends to avail the services of non-network provider Claim shall be subject to reimbursement, a prior approval from the Company needs to be taken before availing such services.

Note:

-Clause 4.III (16) under Specific Exclusions, is superseded to the extent covered under this Benefit.

Coverage under this Benefit shall not be available if same is admissible under Domiciliary Hospitalization Benefit or vice versa.

All limits/ Co-pay / Deductible as applicable for any treatment condition under Hospitalization shall also be applicable if the same treatment is taken under this Benefit

2.11 Base Benefit 11: Vector Borne Disease cover

Notwithstanding anything to the contrary in the Add-on Policy, by opting this benefit, the coverage under the Base Policy shall be limited to Medical Expenses incurred for the treatment of Insured Person suffering from the Vector Borne Diseases that solely and directly require the Hospitalization of the Insured Person, during Add-on Policy Year up to the amount specified in Add-on Policy Schedule.

2.12 Base Benefit 12: Organ Transportation

The Company will indemnify expenses associated with the transportation of organs required by Insured Person for organ transplant surgery, strictly on written advice of Medical Practitioner, up to the amount specified in the Add-on Policy Schedule, during the Add-on Policy Year.

Note:

This benefit shall be payable only if 'Hospitalization Expenses' benefit is admissible under Base Policy.

2.13 Base Benefit 13: Wig cover

The Company will indemnify the cost of Wig, subject to loss of hair occurred as part of treatment due to Chemotherapy or Radiotherapy only, up to the amount specified in the Add-on Policy Schedule, during the Add-on Policy Year.

Note:

-Chemotherapy/ Radiotherapy (if undergone) should be admissible under Hospitalization Expenses

-Provided claims is made within 6 months of end of treatment or during the process of Chemotherapy/ Radiotherapy.

-The cover shall be applicable, for one Wig in a block of three continuous cover years.

-Clause 4.III (37) under Specific Exclusions, is superseded to the extent covered under this Benefit

2.14 Base Benefit 14: Transportation of Imported Medicines

The Company will indemnify expenses incurred for transportation of imported medicines through any registered service provider, on written advice of Medical Practitioner, on reimbursement basis to India from any foreign country up to the amount specified in the Add-on Policy Schedule, during the Add-on Policy Year.

Note:

a) Coverage under this benefit shall be available only if the Claim is admissible under Hospitalization Expenses

Exclusion

Any travel expenses incurred by any person to bring medicine in India.

2.15 Base Benefit 15: Terminal Illness

The Company will indemnify Medical Expenses incurred for Terminal Illness (non curable illnesses), maximum up to no. of days , on written advice of Medical Practitioner at home, up to the amount specified in the Add-on Policy Schedule, during the Add-on Policy Year subject to –

1. Medical Practitioner shall declare the Insured as a terminally ill.
2. The following expenses incurred during the course of treatment shall be covered during the Add-on Policy Year :
   a. Expenses for Nursing charges
   b. All equipment to support Insured
   c. Diagnostics, Pharmacy and Consultations

Note:

- Clause 4.II (2) under Standard Exclusions is superseded to the extent covered under this Benefit

Exclusion

Any service, equipment or treatment related to terminal illness cure is not admissible under this benefit

2.16 Base Benefit 16: Loss of Pay due to Illness

If the Insured Person is diagnosed with Illness during the Cover Year, which completely prevents Insured Person from performing his employment or occupation, while that Insured Person is under the regular care of, and acting in accordance with, the instructions or on the written advice from the treating Medical Practitioner and is confined to bed, then the Company will pay a fixed lump sum, for each continuous and completed week or proportionate in case of part of a week as specified in the Add-on Policy Schedule, subject to Deductible (if applicable) provided that:

I. For a single Claim, maximum duration till which this benefit will be payable is 104 weeks from the date of Hospitalization and if the Insured Person is hospitalized for a part of a week, then only a proportionate part of the weekly benefit will be payable.

ii. The Company will not pay any amount in excess of the Insured Person's base monthly income (including taxable income) and this will specifically exclude overtime, bonuses, incentives, PF, Gratuity, tips, commissions, special compensation or any compensation of similar nature.

iii. If an Insured Person suffers a relapse / recurrence of same Illness after a Claim has been admitted under this benefit and during the Add-on Policy Year due to the same or related causes, the subsequent period shall be deemed to be a continuation of the prior period of Illness, unless the Insured Person has worked for at least 7 (Seven) days between the 2 (Two) illness periods. For the purpose of this provision, the Deductible specified in the Add-on Policy Schedule shall be calculated from the date of Hospitalization in each Claim.

iv. Claim shall be payable only post exhaustion of all Paid leave.

v. The Company shall not be liable to make any payment under this benefit:
   i. In the event of termination, dismissal, temporary suspension or retrenchment from employment.
   ii. Any job under which no salary or any remuneration is provided to the Insured
   iii. Any suspension from employment on account of any pending enquiry being conducted by the employer/ Public Authority
   iv. Any unemployment due to resignation, retirement whether

voluntary or otherwise.

Note : "Week" means 7 continuous days.

2.17 Base Benefit 17: Emergency Illness cover

Notwithstanding anything to the contrary in the Add-on Policy, by choosing this benefit, the Company agrees to limit the coverage under 'Hospitalization Expenses' only to Emergency illness treatment where the Company will indemnify Medical Expenses incurred if the Insured Person suffers an Injury or is diagnosed with an illness which is an Emergency condition that required emergency room visit and continued Medically Necessary Hospitalization, up to the amount specified in the Add-on Policy Schedule. The coverage will not be applicable in case Insured Person takes direct admission without visiting emergency room.

Base Benefits under Out-Patient Expenses:

Notwithstanding anything stated under clause 4.III (14) of Specific Exclusions, by opting the following benefits under Out-patient Expenses, the Insured would be covered up to the purview of cover -

2.18 Base Benefit 18: Learning and Behavioral Disorders

The Company will indemnify the Insured for Out –patient Therapy expenses incurred for developmental conditions/problems (E.g. Dyslexia, behavioral problems like attention deficit hyperactivity disorder (ADHD), including but not limited to Autism Spectrum Disorder), up to the amount specified in the Add-on Policy Schedule, during Add-on Policy Year.

The scope of the cover shall include the following Therapy(s):

a. Behavioral therapy (Eg. Cognitive Behavioral Therapy (CBT) etc.)

b. Interpersonal therapy

c. Psychotherapy

d. Psychodynamic therapy

e. Any other Treatment therapy (availed on written advice of Medical Practitioner)

Note: Clauses 4.III (13) and 4.III (48) under Standard Exclusions are superseded to the extent covered under this Benefit.

2.19 Base Benefit 19: Hormone Replacement Therapy

The Company will indemnify Medical Expenses incurred for the Hormone Replacement Therapy treatment, upon the Prescription of Medical Practitioner, up to the amount specified in the Add-on Policy Schedule, during Add-on Policy Year.

Note:

The above benefit includes treatment given in all forms i.e. a) Pill (oral) b) Injection (intra venous /intra muscular) or even applied as a patch or gel (Skin) for individuals who experience menopause symptoms (Females), or are with conditions such as diabetes,

-adrenal deficiency, hyper- or hypothyroidism, infertility, certain cancers, hyper- or hypopituitarism, obesity and several other hormonal imbalances.

- Clause 4.III (42) under Specific Exclusions, is superseded to the extent covered under this Benefit

2.20 Base Benefit 20: Oral Chemotherapy

The Company will indemnify the Insured Person up to Coverage amount as specified in the Add-on Policy Schedule for availing Oral chemotherapy treatment on written advice of Medical Practitioner.

Note:

The Claim shall be admissible under this benefit, only if same is not payable as part of Pre-Hospitalization and Post –Hospitalization Medical Expenses under 'Hospitalization Expenses'.

2.21 Base Benefit 21: Sleep Apnoea

The Company will indemnify expenses incurred related to sleep tests and machinery purchased (APAP -auto-adjustable positive airway pressure, CPAP- continuous positive airway pressure , BiPAP - Bilevel or two level positive airway pressure , etc.) on basis of written Prescription of Medical Practitioner , up to the amount specified in the Add-on Policy Schedule, during Add-on Policy Year.

Note:

- Sleep tests can be taken once during the Add on Policy Year and machinery can be

purchased only once at every block of 3 years subject to policy renewal.

- Machinery repair / purchase of parts of Machinery are not covered under this Benefit.
- Clause 4.III (10) under Specific Exclusions, is superseded to the extent covered under this Benefit

2.22 Base Benefit 22: Vaccination for Adults

The Company will indemnify Reasonable and Customary expenses incurred for vaccinations or immunization required by the Insured Person (aged 18 years and above), up to the amount specified in the Add-on Policy Schedule, during Add-on Policy Year.

Note:

-The coverage shall be limited to only WHO recommended vaccinations (including COVID-19 and Animal bite vaccinations)

Note: Clause 4.III (25) under Specific Exclusions, is superseded to the extent covered under this Benefit

2.23 Base Benefit 23: Rehabilitation

The Company will indemnify Medical Expenses incurred on treatment taken as part of Rehabilitation on out-patient basis as prescribed by Medical Practitioner, up to the amount specified in the Add-on Policy Schedule, during Add-on Policy Year.

Coverage under this benefit is limited to treatment /rehabilitation program for substance abuse de-addiction such as Alcohol, drug, tobacco or any other substance abuse i.e. related to addictive condition.

Note:

- Clause 4.II (9) under Standard Exclusions is superseded to the extent covered under this Benefit.

2.24 Base Benefit 24: Embryo/Egg Freezing

The Company will indemnify expenses incurred for Egg freezing (Oocyte cryopreservation) and Embryo freezing (Embryo cryopreservation) process up to the amount specified in the Add-on Policy Schedule, during Add-on Policy Year.

Note:

-The above benefit shall also include medication (including injectable, oral, patches, suppositories, etc.), labs and consultations incurred as part of Egg freezing (Oocyte cryopreservation) and Embryo freezing (Embryo cryopreservation) process.

-The Claim shall be admissible for one successful cycle under this benefit in Insured Person's lifetime.

-Clause 4.III (40) under Specific Exclusions, is superseded to the extent covered under this Benefit

2.25 Base Benefit 25: Insect/Reptile/Animal bite

The Company will indemnify Medical Expenses incurred on out-patient basis due to Injury caused by bite, attack and/or sting of an animal, reptile or insect (except vector borne diseases) through direct violent skin contact that occurs during the Add-on Policy Year, up to the amount specified in the Add on Policy Schedule.

Base Benefits under 'Daily Cash'

2.26 Base Benefit 26: Daily Cash Allowance

Notwithstanding anything to the contrary in the Add-on Policy, by choosing this benefit, the Company agrees to modify the maximum payable duration under 'Daily Cash Allowance' as specified in the Add-on Policy Schedule.

2.27 Base Benefit 27: ICU Cash

Notwithstanding anything to the contrary in the Add-on Policy, by choosing this benefit, the Company agrees to modify the maximum payable duration under 'ICU Cash' Allowance' as specified in the Add-on Policy Schedule.

Base Benefit under 'Convalescence Benefit'

2.28 Base Benefit 28: Convalescence Benefit

If the Insured Person undergoes Medically Necessary Hospitalization, during the cover year, then Company will pay the amount specified against this benefit in the Add-on Policy Schedule, for every completed period (which has defined number of days, as specified in the Add-on Policy Schedule) of Hospitalization for each Claim provided that:

i. The Company shall be liable to make payment under this benefit for any Claim

in respect of the Insured Person only when the Minimum Hospitalization Duration (Deductible) on that Claim is exhausted.

ii. This benefit will be payable for a maximum of 'X' times in a Cover Year (for different Injury causing events leading to Hospitalization) and maximum 'Y' payments per Hospitalization.

The combination of Coverage amount, Minimum Hospitalization Duration and Period of Hospitalization should be same for all the policies under the group

Note: 'X' and 'Y' are the numbers to be opted by the Policy Holder

Base Benefits under 'Personal Accident'

2.29 Base Benefit 29: Common Disaster Benefit

If an Insured Person suffers an Injury which results in Accidental Death (or Permanent Total Disablement, if offered in the Base Policy), within 12 months of such Injury sustained which lead solely and directly due to an Accident, occurred during the Add- on Policy Year, whilst mounting into or dismounting from or travelling in a Common Carrier on a valid ticket, the Company will pay additional 100% of Coverage amount of Accidental Death (or Permanent Total Disablement, if applicable)

In case of an Insured Event, where only 50% of Coverage amount is payable, the Company will pay additional 50% of

Coverage amount under this benefit.

2.30 Base Benefit 30: Coma Benefit

The Company will pay a fixed amount incase Insured is hospitalized due to injury , up to the amount specified in the Add-on Policy Schedule, during the Add-on Policy Year, provided that such Injury solely and directly results in the Insured Person being in Coma for more than 30 days from the date of the Accident.

Note :-

This benefit shall be payable subject to the following:

The Company shall accept only one Claim under this benefit in the lifetime of the Insured Person.

2.31 Base Benefit 31: Medical Extension

The Company will indemnify Medical Expenses incurred for Hospitalization and Out-patient treatment, arising due to Injury, up to the amount specified in the Add-on Policy Schedule, during the Add-on Policy Year, provided that such Injury solely and directly results in the Insured Person's Death / Permanent Total Disablement (PTD) / Permanent Partial Disablement (PPD) / Temporary Total Disablement (TTD) - within 365 days from the date of the Accident.

Note:-

The admissibility of the Claim under this benefit shall be eligible , only if the Claim under the Accidental Death or Permanent Total Disablement (PTD) or Permanent Partial Disablement (PPD) or Temporary Total Disablement (TTD) is admissible

2.32 Base Benefit 32: Mishap Cover

If an Insured Person commits suicide during the Add-on Policy Year, then the Company will pay the amount specified against this benefit in the Add-on Policy Schedule, to the Nominee or Legal heir of the Insured Person subject to 1 year wait period from the inception of Cover.

The coverage amount opted under this benefit shall be a percentage (%) of 'Accidental Death' coverage amount.

Note: Clause 4.III (29) under Specific Exclusions, is superseded to the extent covered under this Benefit

Base Benefit under Critical Illness Fixed Benefit

2.33 Base Benefit 33: Modification of Survival Period

Notwithstanding anything to the contrary in the Add-on Policy, by choosing this benefit, the Company agrees to modify the 'Survival Period' of 30 days to the Survival Period as specified in the Add-on Policy Schedule.

2.34 Base Benefit 34: Modification of Initial Wait Period

Notwithstanding anything to the contrary in the Add-on Policy, by choosing this benefit, the Company agrees to modify the 'Initial Wait Period' of 30 / 90 days to the Initial Wait Period as specified in the Add-on Policy Schedule.

2.35 Base Benefit 35: Critical Illness Fixed Benefit Modification

Notwithstanding anything to the contrary in the Add-on Policy, by choosing this benefit, the Company agrees to modify the no. of Critical Illness covered under 'Critical Illness Fixed Benefit ' to 32 Critical illness, as specified in the Add-on Policy Schedule.

Additional Benefits

The following Additional Benefits shall be opted with any Base Policy benefits or as specified under each Additional Benefit

2.36 Base Benefit 36: Assisted Reproductive Treatment

The Company will indemnify Medical Expenses up to the amount specified in the Add-on Policy Schedule during the Add-on Policy Year, incurred on Assisted Reproduction Treatment - Including but not limited to In vitro fertilization-embryo transfer (IVF-ET), gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), and frozen embryo transfer (FET).

The benefit is subjected to the following conditions:

1. The Company will pay for only one Assisted Reproductive procedure per Add-on Policy Year.
2. A waiting period as specified in the Add-on Policy Schedule shall be applicable from the date of first inception of this Add-on Policy with the Company for the Insured Person.
3. The coverage under this benefit shall be available for both Hospitalization Expenses and Out-patient expenses.
4. The Company shall be liable to make payment in respect of surrogate, as per the then applicable surrogacy laws in India Clause 4.II (14) under Standard Exclusions and Clause 4.III (4) under Specific Exclusions is superseded to the extent covered under this Benefit.

2.37 Base Benefit 37: Assisted Reproductive Treatment Complications

The Company will indemnify Medical Expenses incurred for any complication arising due to Assisted Reproduction Treatment - Including but not limited to In vitro fertilization-embryo transfer (IVF ET), gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), and frozen embryo transfer (FET), up to the amount specified in the Add-on Policy Schedule during the Add-on Policy Year.

The benefit is subjected to the following conditions:

1. A waiting period as specified in the Add-on Policy Schedule shall be applicable from the date of first inception of this Add-on Policy with the Company for the Insured Person.
2. The coverage under this benefit shall be available for both Hospitalization Expenses and Out-patient expenses.
3. The Company shall be liable to make payment in respect of surrogate, as per the then applicable surrogacy laws in India

   Note:

   -Clause 4.II (14) under Standard Exclusions and Clause 4.III (4) under Specific Exclusions is superseded to the extent covered under this Benefit.

2.38 Base Benefit 38: Repatriation of Mortal Remains

If the Insured Person's demise happens solely and directly due to an Illness during Hospitalization within Cover year, then the Company will indemnify the Insured Person's Nominee or the legal heir, up to the amount specified in the Add-on Policy Schedule, for the costs of repatriation of the mortal remains of that Insured Person to the City of Residence or for the costs of a local burial / cremation at the place where death has occurred.

Note: This Benefit is payable only if Hospitalization Expenses claim for the same incident is admissible

2.39 Base Benefit 39: Companion Benefit

By choosing this benefit, the Company will pay a fixed amount as specified against thi benefit in the Add-on Policy Schedule if the Insured Person has been Hospitalized for minimum number of consecutive days for Any one illness or Accident provided that:

Note:

- The Company shall not be liable to make

payment under this benefit more than once under Any one illness or Accident condition in an Add-on Policy Year.

2.40 Base Benefit 40: Mortuary Charges

The Company will indemnify the mortuary charges incurred (up to 72 hours) within India, up to the amount specified in the Add on Policy Schedule, during the Add-on Policy Year.

2.41 Base Benefit 41: Emergency room visit

The Company will indemnify the Medical Expenses incurred at Emergency room visit, up to the amount specified in the Add-on Policy Schedule, during the Add-on Policy Year.

Note:

-Claim under this benefit is admissible only in case of no further continuous Hospitalization post Emergency room visit.

-If any claim under this Benefit is admissible, then the same cannot be made under any other Benefit

2.42 Base Benefit 42: Blood purchase

The Company will indemnify expenses incurred for the Purchase of Blood from a registered Blood Bank in India, upon the written advice of the treating Medical Practitioner, up to the amount specified in the Add-on Policy Schedule, during the Add-on Policy Year.

Note:-

This benefit shall be payable only if Hospitalization Expenses claim for the same incident is admissible.

2.43 Base Benefit 43: Advance Ambulance Services

The Company will indemnify expenses incurred on availing Ambulance services through any mode of transport other than Road, E.g. Air, Train, Boat, etc. offered by a Hospital or by an Ambulance Service Provider, up to amount as specified in the Add-on Policy Schedule, during the Add-on Policy Year, for the Insured Person's necessary transportation provided that the necessity of such Ambulance transportation is certified by the treating Medical Practitioner and subject to the conditions specified below:

i. Such Transportation is from the place of occurrence of Medical Emergency of the Insured Person, to the nearest Hospital; and/or

ii. Such Transportation is from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Person, following an Emergency.

Note:

-This benefit shall be payable only if Hospitalization Expenses claim for the same incident is admissible.

2.44 Base Benefit 44: Be-Fit Benefit

The Insured Person, who is above 12 years of age, may avail unlimited visits to the Fitness Centers in during the Add-on Policy Year at the Company's network.

Note: The services availed would be subject to the following conditions:

a. The services will be provided through an empanelled Fitness center only. Choice of the Insured Person in utilizing the services of Fitness Center will be entirely his/her own and Company will have no liability towards the quality of services provided by the Fitness Centers.

b. The Company shall not be responsible for any disputes or loss on account of availing the services or arising between the Insured Person and the Fitness center.

c. Clause 4.III (41) under Specific Exclusions, is superseded to the extent covered under this Benefit

2.45 Base Benefit 45: Digital-Fit Benefit

The Insured can avail the following services-

a. Access to Digital Fitness Coaching

b. Access to Artificial Intelligence Fitness Coaching

c. Access to Nutritionist/Wellness Coach

The above services (a, b, c) shall be available at Company's Network and available to Insured Person aged above 12 years subject to the following conditions:

a. The services will be provided through an empanelled Provider only. Choice of the Insured Person in utilizing the

services of Provider will be entirely his/ her own and Company will have no liability towards the quality of services provided by the Provider.

b. The Company shall not be responsible for any disputes arising between the Insured Person and the empanelled Provider.

c. The network under this benefit, does not constitute Medical Advice of any kind and it is not intended to be, and should not be, used to diagnose or identify treatment for a medical or mental health condition.

2.46 Base Benefit 46: Fitness Equipment

The Company will indemnify expenses incurred for the purchase of Fitness Equipment(s), up to the amount specified in the Add-on Policy Schedule, during the Add-on Policy Year. For the purpose of the benefit Fitness equipment shall mean - any apparatus used in the supply of fitness services including (for example) free weights, machine weights, treadmills, exercise bikes and rowing machines, etc.

Claim under this Benefit can be admissible only once in Add-on Policy Year

2.47 Base Benefit 47: Vector Borne Disease

The Company shall pay fixed amount specified in the Add-on Policy schedule upon the positive Diagnosis of any Vector Borne Diseases , that may require Hospitalization of the Insured Person, during Add-on Policy Year

Note:

-The treatment has to be commenced on the written Medical Advice of the Treating Medical Practitioner.

2.48 Base Benefit 48: Reducing Sum Insured Method

If, during the Add-on Policy Year, an Insured Member makes an admissible Claim under :- a) Any Critical Illness condition offered on Fixed benefit basis and specified in the Add on Policy Schedule or b) Accidental Death or c) Permanent Total Disablement (PTD) , then the Company will pay an amount equal to the outstanding loan principal amount , subject to this amount not exceeding the coverage amount specified in the Add-on Policy Schedule.

The coverage amount shall decrease as per the loan repayment schedule selected by Insured during the individual's loan term. On occurrence of any of the above event(s), the Company shall pay 100% of the outstanding loan principal amount.

Any admissible claim under this Benefit will be payable to the Insured/nominee/ appointee / legal heir / assignee or as the case may be to the extent of outstanding loan amount (if any) as on date of loss which shall be calculated in accordance with the loan schedule as provided.

Note:-

Benefit payout under 'a) any of Critical Illness condition' is subject to Survival Period as specified in Add-on Policy Schedule.

This Benefit can be sourced only under credit linked policies.

2.49 Base Benefit 49: Non-payable items cover

If a claim has been accepted under this benefit, then the items which are not payable as per Annexure I related to the particular claim, will become payable. The maximum claim payout under this benefit shall be limited to applicable Sum Insured under the Policy.

Notes:

- Coverage for any item as per List-I & V under Annexure I, shall be available only if the same is not covered under any other Benefit.
- This Benefit is available with any health indemnity policy and can be opted only with Personal Accident (Optional Benefit 6) offered under Base Policy.

3. Special Conditions

The following special conditions are available and as applicable to the Benefits and Additional Benefits (if opted):

1. Area of Cover – As per Base Policy
2. Floater Cover - As per Base Policy
3. Co-payment - As per Base Policy
4. Deductible / Franchise Deductible- As per Base Policy
5. Premium Installment facility - As per Base Policy
6. Additional Services - As per Base Policy

4. Exclusions

I. Wait Periods applicable under this Add-on Policy (Applicable for Base Benefits under: Hospitalization Expenses, Daily Cash Allowance and Convalescence Benefit):

a. Initial wait period

As per Base Policy

b. Specific Wait Period for Named Ailments

As per Base Policy

c. Wait Period for Pre-existing Diseases:

As per Base Policy

d. 90-Day Initial wait period

As per Base Policy

II. Standard Exclusions:

The following list of standard exclusions is applicable to all the Benefits.

Any Claim in respect of any Insured Member 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.

1. Investigation & Evaluation:

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:

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:

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:

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:

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:

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:

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:

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 – II of the Base Policy Terms & Conditions for list of excluded Hospitals.

9. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

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

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

12. Refractive Error:

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

13. Unproven Treatments:

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:

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:

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.

III. Specific Exclusions:

The following list of Specific exclusions is applicable to all the benefits under this Add-on Policy.

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.

1. Any item or condition or treatment specified in List of Non-medical Items (Annexure – I of Base Policy Terms and conditions).

2. Any Pre-existing Injury / illness or disability and any complications thereof and its associated medical conditions unless we had agreed otherwise in writing;

3. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind;

4. Any treatment directly related to surrogacy whether the member is acting as surrogate, or is the intended parent;

5. Any treatment begun or for which the need has arisen during the first ninety (90) days after birth, for any child conceived by artificial means or any form of assisted conception or if the child is born via surrogacy;

6. 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;

7. Charges incurred in connection with routine eye examinations and ear examinations, dentures, crowns, artificial teeth and all other similar external appliances and / or devices

whether for Diagnosis or treatment;

8. Expenses incurred on advanced treatment methods other than as mentioned in Base Policy
9. Any expenses incurred on providing or fitting any external prosthesis or orthosis or appliance or medical aids or durable medical equipment of any kind, like wheelchairs, walkers, crutches, ambulatory devices, unless allowed under the Policy, cost of Cochlear implants;
10. Any treatment related to sleep disorder or sleep apnea syndrome, general debility convalescence and any treatment in an establishment that is not a Hospital
11. Treatment of any external Congenital Anomaly or Illness or defects or anomalies including their associated medical conditions or chronic medical conditions or vegetative state cover (on the basis of declaration by the treating doctor) or treatment relating to external birth defects;

    We define vegetative state as a condition of profound non-responsiveness with no sign of awareness or consciousness or a functioning mind, even if the Insured can open their eyes and breathe unaided, and the person does not respond to stimuli such as calling their name or touching. This state must have remained for at least four (4) weeks with no sign of improvement or there could be no recovery;
12. Treatment whilst staying in a Hospital for more han ninety (90) continuous days for permanent neurological damage on the basis of declaration by the treating doctor. It is stated that treatment up to 90 days for permanent neurological damage will be covered under this Policy;
13. Treatment of mental retardation, arrested or incomplete development of mind of a person, subnormal intelligence or mental intellectual disability
14. Out-patient treatment;
15. Treatment received outside India;
16. Domiciliary Hospitalization or treatment;
17. An Insured Person operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft o Scheduled Airline or any airline personal;
18. An Insured Person flying in an aircraft other than as a fare paying passenger in a Scheduled Airline;
19. Participation in actual or attempted felony, riot, civil commotion or criminal misdemeanor or activity;
20. Professional fees charged by a member of the Insured Person's Immediate Family or by a person normally resident in the household of the Insured or under his employment;
21. Training for or participating in professional sport of any kind or any sport for which the Insured receives a salary or monetary reimbursement, including grants or sponsorship;
22. The Insured Person serving in any branch of the military, navy, air force or any branch of armed forces or any paramilitary forces;
23. Radioactive contamination whether arising directly or indirectly ionizing radiation, toxic, explosive or other hazardous properties of nuclear material;
24. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident;
25. All Preventive Care, Vaccination including Inoculation and Immunizations (except in case of post-bite treatment) and tonics;
26. All expenses related to donor treatment, including screening, surgery to remove organs from the donor, in case of transplant surgery;
27. Non-Allopathic Treatment or treatment related to any unrecognized systems of medicine;
28. 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;
29. Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, Areca nut intoxicating drugs and alcohol or hallucinogens;
30. Any charges incurred to procure documents related to treatment or Illness pertaining to any period of Hospitalization or Illness or any administration costs or any other charges of a Non-medical nature in connection with the provision and/or performance of medical supplies and/or services;
31. Personal comfort and convenience items or services including but not limited to T.V.

(wherever specifically charged separately), charges for access to cosmetics, hygiene articles, body care products and bath additives, as well as similar incidental services and supplies;

32. Expenses related to any kind of RMO charges, Service charge, Surcharge, night charges levied by the Hospital under whatever head or any room upgrades, menu items not included as standard or visitors meals;

33. 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;

    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 is also excluded.

34. Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants unless prescribed by a Medical Practitioner;

35. Continuous ambulatory peritoneal dialysis. Coverage for 'Continuous ambulatory peritoneal dialysis' is available on OPD basis and as part of Pre-Post Hospitalization Expenses;

36. Charges for items not listed in the Policy Schedule applicable to the member or considered as not Medically Necessary or which may be considered as elective;

37. Alopecia wigs and/or toupee and all hair or hair fall treatment and products including any investigations; all forms of acne;

38. 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;

39. Any medical or physical condition or treatment or service, which is specifically excluded under the Policy Schedule including the associated medical conditions shown on the endorsement;

40. Cryopreservation or harvesting or storage of stem cells as a preventive measure against possible disease/illness/Injury, or implantation or re-implantation of living cells or living tissue whether autologous or provided by a donor;

41. Any other weight management services, treatment and supplies unless requires Hospitalization and surgery ;

42. Hormone Replacement Therapy;

43. The evacuation would involve moving Insured Person from a remote location where there is no or limited access;

44. Dental, Orthodontics, Periodontics, Endodontics or any preventative dentistry no matter who gives the treatment;

45. Charges for residential stays in Hospital which are not Medically Necessary or are incurred for social or domestic reasons or for reasons which are not directly connected with treatment or where the Hospital has effectively become the place of domicile or permanent abode;

46. Any charges made by the Medical Practitioner, Hospital, laboratory or any such medical services which are not Reasonable and Customary;

47. Genetic tests undertaken to establish whether or not the Insured may be genetically disposed to the development of a medical condition in the future unless requires for current medical treatment;

48. Insured Person suffering from or has been diagnosed with or has been treated for Down's Syndrome/Turner's Syndrome/Sickle Cell Anaemia/

Thalassemia Major/G6PD deficiency 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 48 months from the date of first issuance of the Policy

49. Ear or body piercing and tattoing or treatment needed as a result of any of these;
50. Any charges for treatment incurred during a period for which the premium is not paid;
51. Any Claim or part of a Claim in which the member has to pay a Deductible or Co insurance (where applicable). In such a Claim, we will only pay the balance of the Claim after we have deducted the excess (or Deductible or Co-insurance) amount;
52. All bank or credit or foreign exchange charges when the Claims payment is made in a currency other than the Policy currency upon the member's request;
53. Bacterial infections (except pyogenic infection which occurs through an Accidental cut or wound);
54. Any other conditions at the discretion of Underwriter

Note: 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 Specific Exclusions shall also be excluded.

5. Claims Intimation, Assessment and Management

Conditions under this section are same as Base Policy. Original bills/documentary proof for expenses incurred to be submitted for claim assessment under this Add-on Policy.

6. General Terms and Conditions

Conditions under this section are same as Base Policy.

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

Sl No.	List I – Optional Items
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR

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

Sl No.	List II – Items that are to be subsumed into Room Charges
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES

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

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

Sl 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
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer & Strips
18	URINE BAG

Sl No.	List V – Additional Non Payable Items
1	BRUSH
2	COSY TOWEL
3	MOISTURISER PASTE BRUSH
4	POWDER
5	BARBER CHARGES
6	OIL CHARGES
7	BED UNDER PAD CHARGES
8	SOFTOVAC
9	STOCKINGS
10	HOME VISIT CHARGES
11	DONOR SCREENING CHARGES
12	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES
13	BLADE
14	MAINTAINANCE CHARGES
15	PREPARATION CHARGES
16	WASHING CHARGES
17	MEDICINE BOX
18	COMMODE
19	DIGESTION GELS
20	NOVARAPID
21	VOLINI GEL/ ANALGESIC GEL
22	ZYTEE GEL
23	AHD
24	VISCO BELT CHARGES
25	EXAMINATION GLOVES
26	OUTSTATION CONSULTANT'S/ SURGEON'S FEES
27	PAPER GLOVES
28	REFERAL DOCTOR'S FEES
29	SOFNET

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IRDAI Registration Number - 148

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