STAR GROUP HEALTH INSURANCE BENEFIT PLUS – PLATINUM
Unique Identification No.: SHAHLGP23146V012223

A. PREAMBLE

This is a legal contract between the Group Administrator and Us subject to the receipt of full premium, Disclosure to information norm including the information provided by the Insured Person in the proposal form/enrolment form and the terms, conditions and exclusions of this Policy. The declaration and other documents, if any shall be the basis of this contract and are deemed to be incorporated herein.

B. DEFINITIONS

Standard Definitions

Accident: An Accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

Any one illness: Any one illness means continuous period of illness and includes relapse within 45 Days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

AYUSH Treatment: AYUSH Treatment refers to the medical and / or Hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Break in policy means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or Grace Period.

Condition Precedent: Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Congenital Anomaly: Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

a) **Internal Congenital Anomaly:** Congenital Anomaly which is not in the visible and accessible parts of the body

b) **External Congenital Anomaly:** Congenital Anomaly which is in the visible and accessible parts of the body

Critical illness: The definition of the certain illness is provided below and these terms, wherever used in the Policy shall have the meaning as set out below. In addition, please also see the Critical illness defined under the heading "Specific Definitions".

1. **CANCER OF SPECIFIED SEVERITY:** A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This Diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

   The following are excluded –

   i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
   ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
   iii. Malignant melanoma that has not caused invasion beyond the epidermis.
   iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
   v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
   vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;.

2. **MYOCARDIAL INFARCTION:** 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 theDiagnosis 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.
   The following are excluded:
   A. Other acute Coronary Syndromes
   B. Any type of angina pectoris
   C. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

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

4. **REPAIR / REPLACEMENT OF HEART VALVES:** The actual undergoing of open-heart valve surgery to replace or repair one or more heart valves or Trans catheter aortic valve implantation (TAVI) under anesthesia, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve. The Diagnosis of the valve abnormality must be supported by an echocardiography/ a cardiac catheterization and the realization of surgery has to be confirmed by a specialist Medical Practitioner. Catheter based techniques apart from TAVI (Trans catheter aortic valve implantation), including but not limited to, balloon valvotomy/valvuloplasty are excluded. “

5. **COMA OF SPECIFIED SEVERITY:** 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.
   The condition has to be confirmed by a specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. **KIDNEY FAILURE REQUIRING REGULAR DIALYSIS:** End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner.

7. **STROKE RESULTING IN PERMANENT SYMPTOMS:** 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 attacks (TIA)
ii. Traumatic Injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. **SURGERY FOR MAJOR ORGAN /BONE MARROW TRANSPLANT:** 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.
   The following are excluded:
   i. Other stem-cell transplants
   ii. Where only islets of langerhans are transplanted

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

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

11. **MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS**
   I. The unequivocal Diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
      i. investigations including typical MRI findings which unequivocally confirm the Diagnosis to be multiple sclerosis and
      ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
   II. Neurological damage due to SLE is excluded

12. **BENIGN BRAIN TUMOR:** 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.
   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.

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

13. **BLINDNESS:** Total, permanent and irreversible loss of all vision in both eyes as a result of illness or Accident.

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.

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

14. **DEAFNESS:** Total and irreversible loss of hearing in both ears as a result of illness or Accident. This Diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.
15. **END STAGE LUNG FAILURE:** End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
    i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
    ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
    iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
    iv. Dyspnea at rest.
16. **END STAGE LIVER FAILURE:** 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
    iv. Liver failure secondary to drug or alcohol abuse is excluded.
17. **LOSS OF SPEECH:** Total and irrecoverable loss of the ability to speak as a result of Injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This Diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.
18. **LOSS OF LIMBS:** The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of Injury or disease. This will include medically necessary amputation necessitated by Injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted Injury, alcohol or drug abuse is excluded.
19. **MAJOR HEAD TRAUMA:** Accidental head Injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the Accident. This Diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The Accident must be caused solely and directly by Accidental, violent, external and visible means and independently of all other causes.
    The Accidental Head Injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

    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. Spinal cord Injury is excluded.

20. **PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION:** 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.
The NYHA Classification of Cardiac Impairment are as follows:
i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.
Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

21. **MAJOR THIRD DEGREE BURNS:** There must be third-degree burns with scarring that cover at least 40% of the body's surface area. The Diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 40% of the body surface area.

Day Care Centre: A Day Care Centre means any institution established for Day Care Treatment of illness and/or injuries or a medical setup with a Hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criterion as under-

i) has qualified nursing staff under its employment;
ii) has qualified Medical Practitioner/s in charge;
iii) has fully equipped operation theatre of its own where surgical procedures are carried out;
iv) maintains daily records of patients and will make these accessible to the Insurer's authorized personnel.

Day Care Treatment: Day Care Treatment means medical treatment, and/or *surgical procedure* which is:

i. Undertaken under General or Local Anesthesia in a *Hospital/Day Care Centre* in less than 24 hrs because of technological advancement, and
ii. which would have otherwise required Hospitalization of more than 24 hours

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

Deductible: Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of Days/hours in case of Hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Dental Treatment: Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

Disclosure to information norm: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Emergency Care: Emergency care means management for an illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a *Medical Practitioner* to prevent death or serious long term impairment of the Insured Person's health.

Grace Period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of Pre-Existing Diseases. Coverage need not be available during the period for which no premium is received. The Grace Period for payment of the premium for all types of insurance policies shall be: fifteen Days where premium payment mode is monthly and thirty Days in all other cases.

Provided the insurers shall offer coverage during the Grace Period, if the premium is paid in instalments during the policy period.

Hospital: A Hospital means any institution established for *In-Patient Care* and *Day Care Treatment* of illness and/or injuries and which has been registered as a Hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act **Or** complies with all minimum criteria as under:

i) has qualified nursing staff under its employment round the clock;

ii) has at least 10 In-Patient beds in towns having a population of less than 10,00,000 and at least 15 In-Patient beds in all other places;

iii) has qualified Medical Practitioner(s) in charge round the clock;

iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;

v) maintains daily records of patients and makes these accessible to the Insurer's authorized personnel;

Hospitalization: Hospitalization means admission in a Hospital for a minimum period of 24 consecutive *'In-Patient Care'* hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

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

(a) Acute condition - Acute condition is a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ Illness/ Injury which leads to full recovery

(b) Chronic condition - A chronic condition is defined as a disease, Illness, or Injury that has one or more of the following characteristics:

1. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

Injury: Injury means Accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

Inpatient Care: Inpatient care means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

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

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

Medical Advice: Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

Medical Expenses: Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or Medical Practitioners in the same locality would have charged for the same medical treatment.

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

Medically Necessary Treatment: Medically necessary treatment means any treatment, tests, medication, or stay in *Hospital* or part of a stay in *Hospital* which:

i) is required for the medical management of the illness or Injury suffered by the insured;

ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii) must have been prescribed by a *Medical Practitioner*;

iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for Pre-Existing Diseases and specific waiting periods from one health insurance policy to another with the same Insurer.

Network Provider: Network Provider means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

New Born Baby: Newborn baby means baby born during the Policy Period and is aged upto 90 Days.

Non-Network Provider: Non-Network means any Hospital, Day Care Centre or other provider that is not part of the network.

Notification of Claim: Notification of claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

OPD treatment: OPD treatment means the one in which the Insured visits a clinic / Hospital or associated facility like a consultation room for Diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or In-Patient.

Pre-Hospitalization Medical Expenses: Pre-Hospitalization Medical Expenses means medical expenses incurred during pre-defined number of Days preceding the Hospitalization of the Insured Person, provided that;

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

ii. The In-Patient Hospitalization claim for such Hospitalization is admissible by the Insurer

Post-Hospitalization Medical Expenses: Post-Hospitalization Medical Expenses means medical expenses incurred during pre-defined number of Days immediately after the Insured Person is discharged from the Hospital provided that:

i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and

ii. The inpatient Hospitalization claim for such Hospitalization is admissible by the Insurer.

Pre-Existing Disease: Pre-existing Disease means any condition, ailment, Injury or disease:

a) That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the Insurer
or

b) For which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

Qualified Nurse: Qualified nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

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

Room Rent: Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses

Renewal: Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the renewal continuous for the purpose of gaining credit for Pre-Existing Diseases, time-bound exclusions and for all waiting periods.

Specific waiting period means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an Accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

Surgery or Surgical Procedure: Surgery or Surgical Procedure means manual and / or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, Diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a Hospital or Day Care Centre by a *Medical Practitioner.*

Unproven/Experimental Treatment: Unproven/Experimental Treatment means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

Specific Definition

Associated Medical Expenses: Associated medical expenses means medical expenses such as Professional fees, OT charges, Procedure charges, etc., which vary based on the room category occupied by

the Insured Person whilst undergoing treatment in some of the Hospitals. If the Insured Person chooses a higher room category above the eligibility defined in policy, then proportionate deduction will apply on the Associated Medical Expenses in addition to the difference in room rent. Such associated medical expenses do not include Cost of pharmacy and consumables, Cost of implants and medical devices and Cost of diagnostics.

Age Means the completed age of the Insured Person on his / her most recent birthday as per the English calendar, regardless of the actual time of birth.

Aggregate Limit: The aggregate of admissible Hospitalisation expenses in a policy year up to which the Company is not liable.

Applicant means a person who makes a formal application for loan amount.

Certificate of Insurance means that portion of the Policy which confirms the Insured Person's cover under the Policy and sets out personal details of Insured Person, the type and plan of insurance cover in force, the Policy Period and Sum Insured etc Any annexure or endorsement to it, shall also be a part of the Policy Schedule / Certificate of Insurance.

Clinic: Clinic means a medical establishment where patients are given medical treatment or advice

Co-applicant means a person who joins in the application of a loan along with Applicant

Commencement Date means the commencement date of the coverage under this Policy as specified in the Policy Schedule / Certificate of Insurance for the respective Insured Person.

Company/We/Us/Our means Star Health and Allied Insurance Company Limited

Critical Illness means: In addition to the definitions specifically set out under Critical Illness under Standard Definitions above, the definition of the following Illnesses is provided below and these terms, wherever used in the Policy and referred to as Critical Illness, shall have the meaning as set out below:

1. **ALZHEIMER'S DISEASE** Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. 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. The Diagnosis must be supported by the clinical confirmation of a Neurologist and supported by Our appointed Medical Practitioner.
   The following conditions are however not covered:
   a. non-organic diseases such as neurosis and psychiatric Illnesses;
   b. alcohol related brain damage; and
   c. any other type of irreversible organic disorder/dementia.
2. **CREUTZFELDT-JACOB DISEASE (CJD)** Creutzfeldt-Jacob disease is an incurable brain infection that causes rapidly progressive deterioration of mental function and movement. A Medical Practitioner who is a neurologist must make a definite Diagnosis of Creutzfeldt-Jacob disease based on clinical assessment, EEG and imaging. There must be objective neurological abnormalities on exam along with severe progressive dementia.
3. **ENCEPHALITIS** Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection and resulting in permanent neurological deficit. This Diagnosis must be certified by a Medical Practitioner who is a consultant neurologist and the permanent neurological deficit must be documented for at least 6 weeks.

4. **FULMINANT HEPATITIS** A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This Diagnosis must be supported by all of the following:
   a. Rapid decreasing of liver size;
   b. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
   c. Rapid deterioration of liver function tests;
   d. Deepening jaundice; and
   e. Hepatic encephalopathy.

   Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.
5. **MUSCULAR DYSTROPHY** A group of hereditary degenerative diseases of muscle characterised by weakness and atrophy of muscle. The Diagnosis of muscular dystrophy must be unequivocal and made by a Medical Practitioner who is a consultant neurologist. The condition must result in the inability of the Life Insured to perform (whether aided or unaided) at least 3 of the 6 "Activities of Daily Living" for a continuous period of at least 6 months.

   Activities of daily living:
   i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
   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 lying position in a bed to a sitting position in an upright chair or wheel chair 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, food from a plate or bowl to the mouth once food has been prepared and made available.
   vi. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence
6. **AORTA GRAFT SURGERY** The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.

   The following are excluded from this definition-
   a. Surgery performed using only minimally invasive or intra-arterial techniques.
   b. Angioplasty and all other intra-arterial, catheter-based techniques, "keyhole" or laser procedures.
7. **SYSTEMIC LUPUS ERYTHEMATOSUS WITH LUPUS NEPHRITIS** A multi-system autoimmune disorder characterised by the development of autoantibodies directed against various self-antigens. In respect of this Policy, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V Lupus Nephritis, established by renal biopsy, and in accordance with the WHO Classification). The final Diagnosis must be confirmed by a Medical Practitioner specialising in
   Rheumatology and Immunology.
   The WHO Classification of Lupus Nephritis:
   Class I Minimal Change Lupus Glomerulonephritis
   Class II Messangial Lupus Glomerulonephritis
   Class III Focal Segmental Proliferative Lupus Glomerulonephritis

Class IV Diffuse Proliferative Lupus Glomerulonephritis
Class V Membranous Lupus Glomerulonephritis

8. **DISSECTING AORTIC ANEURYSM** A condition where the inner lining of the aorta (intima layer) is interrupted so that blood enters the wall of the aorta and separates its layers. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The Diagnosis must be made by a Medical Practitioner who is a specialist with computed tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiograph (MRA) or angiogram. Emergency surgical repair is required.
9. **INFECTIVE ENDOCARDITIS** Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:
   I. Positive result of the blood culture proving presence of the infectious organism(s);
   II. Presence of at least moderate heart valve incompetence (meaning regurgitant fraction of 20% or above) or moderate heart valve stenosis (resulting in heart valve area of 30% or less of normal value) attributable to Infective Endocarditis; and
   III. The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a Medical Practitioner who is a cardiologist.
10. **SEVERE ULCERATIVE COLITIS** Acute fulminant ulcerative colitis with life threatening electrolyte disturbances.
    All of the following criteria must be met:
    - the entire colon is affected, with severe bloody diarrhoea; and
    - the necessary treatment is total colectomy and ileostomy; and
    - the Diagnosis must be based on histopathological features and confirmed by a Medical Practitioner who is a specialist in gastroenterology.
11. **AMPUTATION OF FEET DUE TO COMPLICATIONS FROM DIABETES** Diabetic neuropathy and vasculitis resulting in the amputation of both feet at or above ankle as advised by a Medical Practitioner who is a specialist as the only means to maintain life. Amputation of toe or toes, or any other causes for amputation shall not be covered.
12. **APALLIC SYNDROME** Universal necrosis of the brain cortex with the brainstem remaining intact. The Diagnosis must be confirmed by a Neurologist acceptable to Us and the condition must be documented for at least one month.
13. **APLASTIC ANEMIA** Chronic persistent bone marrow failure which results in anemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:
    - Blood product transfusion;
    - Marrow stimulating agents;
    - Immunosuppressive agents; or
    - Bone marrow transplantation.

    The Diagnosis must be confirmed by a haematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following:
    a. Absolute neutrophil count of less than 500/mm³ or less
    b. Platelets count less than 20,000/mm³ or less
    c. Reticulocyte count of less than 20,000/mm³ or less

    Temporary or reversible Aplastic Anemia is excluded.
14. **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:

a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
b. A consultant neurologist.

Bacterial Meningitis in the presence of HIV infection is excluded.

15. **BRAIN SURGERY** The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy is performed. Keyhole surgery is included however, minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolizations, thrombolysis and stereotactic biopsy are all excluded. Brain surgery as a result of an Accident is also excluded. The procedure must be considered medically necessary by a Medical Practitioner who is a qualified specialist.
16. **CHRONIC ADRENAL INSUFFICIENCY (ADDISON'S DISEASE)** An autoimmune disorder causing a gradual destruction of the adrenal gland resulting in the need for life long glucocorticoid and mineral corticoid replacement therapy. The disorder must be confirmed by a Medical Practitioner who is a specialist in endocrinology through one of the following:
    - ACTH simulation tests;
    - insulin-induced hypoglycemia test;
    - plasma ACTH level measurement;
    - Plasma Renin Activity (PRA) level measurement.

    Only autoimmune cause of primary adrenal insufficiency is included. All other causes of adrenal insufficiency are excluded.
17. **CHRONIC RELAPSING PANCREATITIS** An unequivocal Diagnosis of Chronic Relapsing Pancreatitis, made by a Medical Practitioner who is a specialist in gastroenterology and confirmed as a continuing inflammatory disease of the pancreas characterised by irreversible morphological change and typically causing pain and/or permanent impairment of function. The condition must be confirmed by pancreatic function tests and radiographic and imaging evidence.
    Relapsing Pancreatitis caused directly or indirectly, wholly or partly, by alcohol is excluded.
18. **CROHN'S DISEASE** Crohn's Disease is a chronic, transmural inflammatory disorder of the bowel. To be considered as severe, there must be evidence of continued inflammation in spite of optimal therapy, with all of the following having occurred:
    I. Stricture formation causing intestinal obstruction requiring admission to Hospital, and
    II. Fistula formation between loops of bowel, and
    III. At least one bowel segment resection.

    The Diagnosis must be made by a Medical Practitioner who is a specialist Gastroenterologist and be proven histologically on a pathology report and/or the results of sigmoidoscopy or colonoscopy.
19. **EISENMENGER'S SYNDROME** Development of severe pulmonary hypertension and shunt reversal resulting from heart condition. The Diagnosis must be made by a Medical Practitioner who is a specialist with echocardiography and cardiac catheterisation and supported by the following criteria:
    I. Mean pulmonary artery pressure > 40 mm Hg;
    II. Pulmonary vascular resistance > 3mm/L/min (Wood units); and
    III. Normal pulmonary wedge pressure < 15 mm Hg.
20. **HEMIPLEGIA** The total and permanent loss of the use of one side of the body through paralysis caused by Illness or Injury, except when such Injury is self-inflicted.
21. **HIV DUE TO BLOOD TRANSFUSION AND OCCUPATIONALLY ACQUIRED HIV** Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:
    I. The blood transfusion was medically necessary or given as part of a medical treatment;

II. The blood transfusion was received in India after the Policy Date, Date of endorsement or Date of reinstatement, whichever is the later;
III. The source of the infection is established to be from the Institution that provided the blood transfusion and the Institution is able to trace the origin of the HIV tainted blood; and
IV. The Life Insured does not suffer from Thalassaemia Major or Haemophilia.

Infection with the Human Immunodeficiency Virus (HIV) which resulted from an Accident occurring after the Policy Date, date of endorsement or date of reinstatement, whichever is the later whilst the Life Insured was carrying out the normal professional duties of his or her occupation in India, provided that all of the following are proven to the Company's satisfaction:

I. Proof that the Accident involved a definite source of the HIV infected fluids;
II. Proof of sero-conversion from HIV negative to HIV positive occurring during the 180 Days after the documented Accident. This proof must include a negative HIV antibody test conducted within 5 Days of the Accident; and

This benefit is only payable when the occupation of the Life Insured is a Medical Practitioner, housemen, medical student, registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic in India. This benefit will not apply where a cure has become available prior to the infection. "Cure" means any treatment that renders the HIV inactive or non-infectious.

22. **LOSS OF INDEPENDENT EXISTENCE** Inability to perform at least three (3) of the "Activities of Daily Living" as defined below (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months and leading to a permanent inability to perform the same. For the purpose of this definition, the word "permanent" shall mean beyond the hope of recovery with current medical knowledge and technology.
The Diagnosis of Loss of Independent Existence must be confirmed by a Medical Practitioner.
All psychiatric related causes are excluded.
Activities of daily living:
I. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
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 lying position in a bed to a sitting position in an upright chair or wheel chair 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, food from a plate or bowl to the mouth once food has been prepared and made available.
VI. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence

23. **LOSS OF ONE LIMB AND ONE EYE** Total, permanent and irrecoverable loss of sight of one eye and loss by severance of one limb at or above the elbow or knee.
The loss of sight of one eye must be clinically confirmed by a Medical Practitioner who is an eye specialist, and must not be correctable by aides or surgical procedures.
24. **MEDULLARY CYSTIC DISEASE** Medullary Cystic Disease where the following criteria are met:

- the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
- clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and
- the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

Isolated or benign kidney cysts are specifically excluded from this benefit.

25. **MYELOFIBROSIS** A disorder which can cause fibrous tissue to replace the normal bone marrow and results in anaemia, low levels of white blood cells and platelets and enlargement of the spleen. The condition must have progressed to the point that it is permanent and the severity is such that the Life Insured requires a blood transfusion at least monthly. The Diagnosis of myelofibrosis must be supported by bone marrow biopsy and confirmed by a Medical Practitioner who is a specialist.
26. **OTHER SERIOUS CORONARY ARTERY DISEASE** Severe coronary artery disease in which at least three (3) major coronary arteries are individually occluded by a minimum of sixty percent (60%) or more, as proven by coronary angiogram only (non-invasive diagnostic procedures excluded).
    For purposes of this definition, "major coronary artery" refers to any of the left main stem artery, left anterior descending artery, circumflex artery and right coronary artery (but not including their branches).
27. **PHEOCHROMOCYTOMA** Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines requiring the actual undergoing of surgery to remove the tumour.
    The Diagnosis of Pheochromocytoma must be confirmed by a Medical Practitioner who is an endocrinologist.
28. **POLIOMYELITIS** The occurrence of Poliomyelitis where the following conditions are met:
    1. Poliovirus is identified as the cause,
    2. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.
29. **PROGRESSIVE SCLERODERMA** A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This Diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.
    The following are excluded:
    - Localised scleroderma (linear scleroderma or morphea);
    - Eosinophilic fasciitis; and CREST syndrome.
30. **PROGRESSIVE SUPRANUCLEAR PALSY** Confirmed by a Medical Practitioner who is a specialist in neurology of a definite Diagnosis of progressive supranuclear palsy. There must be permanent clinical impairment of motor function, eye movement disorder and postural instability.
31. **SEVERE RHEUMATOID ARTHRITIS** Unequivocal Diagnosis of systemic immune disorder of rheumatoid arthritis where all of the following criteria are met:
    - Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis;
    - Permanent inability to perform at least two (2) "Activities of Daily Living";
    - Widespread joint destruction and major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet; and
    - The foregoing conditions have been present for at least six (6) months.
32. **TERMINAL Illness** The conclusive Diagnosis of an Illness, which in the opinion of a Medical Practitioner who is an attending Consultant and agreed by our appointed Medical Practitioner, life expectancy is no greater than twelve (12) months from the date of notification of claim, regardless of any treatment that might be undertaken.

33. **TUBERCULOSIS MENINGITIS** caused by tubercle bacilli, resulting in permanent neurological deficit. Such a Diagnosis must be confirmed by a Medical Practitioner who is a specialist in neurology.

Day means a continuous period of 24 hours.

Dependent Child: means a child (natural or legally adopted) who is financially dependent and does not have his or her independent source of income and not over 30 years

Diagnosis: means Diagnosis by a registered Medical Practitioner, supported by clinical, radiological and histological, histo-pathological and laboratory evidence and also surgical evidence wherever applicable, acceptable to the Company.

EMI or EMI amount means and includes the amount of monthly payment required to repay the principal amount of loan and interest by the Insured Person as set forth in the amortization chart referred to in the loan agreement (or any amendments thereto) between the bank/financial Institution as the Group Administrator and the Insured Person prior to the date of occurrence of the Insured event under this Policy. For the purpose of avoidance of doubt, it is clarified that any monthly payments that are overdue and unpaid by the Insured prior to the occurrence of the Insured event will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured Person.

Expiry Date means the date on which the Insured Person's cover under the Policy expires as specified in the Certificate of Insurance.

Family: means
a. Insured Person / Beneficiary,
b. Spouse and
c. Dependent Children not exceeding 2 numbers

Grievous Injury: means emasculation, permanent privation of the sight of either eye, permanent privation of hearing of either ear, privation of any member or joint, destruction or permanent impairing of the powers of any member or joint, permanent disfiguration of head or face, fracture or dislocation of a bone or tooth.

Group Administrator / Proposer: means the person/organization who has concluded this Policy with the Company and is named in the Policy Schedule.

Hazardous Sport / Hazardous Activities: means engaging whether professionally or otherwise in any sport or activity, which is potentially dangerous to the Insured Person (whether trained, or not). Such Sport/Activity including but not limited to Winter sports, Ice hockey, Skiing, Skydiving, Parachuting, Ballooning, Scuba Diving, Bungee Jumping, Mountain Climbing, Riding or Driving in Races or Rallies, caving or pot holing, hunting or equestrian activities, diving or under-water activity, rafting or canoeing involving rapid waters, yachting or boating outside coastal waters, jockeys, horseback, Polo, Circus personnel, army/navy/air force personnel and policemen whilst on duty, persons working in underground mines, explosives, magazines, workers whilst involved in electrical installation with high-tension supply, nuclear installations, handling hazardous chemicals.

Instalment: means frequency of Premium amount paid through Monthly/Quarterly/Half-yearly mode by the Policy Holder / Insured Person.

Insured Person/Beneficiary means the name/s of persons shown in the Policy Schedule / to whom a Certificate of Insurance has been issued, who is/are covered under this Policy, and in respect of whom the appropriate premium has been received.

In-Patient: means an Insured Person who is admitted to Hospital and stays there for a minimum period of 24 hours for the sole purpose of receiving treatment.

Major Surgery means list of surgery as stated in the Policy Schedule / Certificate of Insurance.

Necessary and Reasonable Medical Expenses: means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved.

Nuclear, Chemical Or Biological Attack shall mean the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent during the period of this insurance by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear. "Chemical" agent shall mean any compound which, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants or material property. "Biological" agent shall mean any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause Illness and/or death in humans, animals or plants.

Permanent Partial Disablement: means Medical Practitioner certified total loss or loss of use of specific body part as detailed under "Permanent Partial Disablement - Benefit 3 " following Accidental Injury to the Insured Person

Permanent Total Disablement: means the Insured Person, following Accidental injuries is unable to engage in each and every occupation or employment for compensation or profit for which he is reasonably qualified by education, training or experience for the rest of his life. If at the time of loss the Insured Person is unemployed, Permanent Total Disablement shall mean the total and permanent inability to perform all of the usual and customary duties and activities of a person of like age and sex even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication

Policy: means the Policy Wordings in this document, the proposal form/member enrolment form of the respective Insured Person, Policy Schedule/Certificate of Insurance for the respective Insured Person, optional/add-on benefits (if applicable) which form a part of the Policy including endorsements, as amended from time to time which form a part of the Policy and shall be read together. No change in this Policy shall be valid until approved by Our authorized officer and such approval is endorsed hereon.

Policy Period means the period specified in the Policy Schedule.

Period of Insurance means the period between the Commencement Date and Expiry Date as specified in the Certificate of Insurance during which cover is available for the respective Insured Person(s).

Policy Schedule means the schedule attached to and forming part of this Policy mentioning the details of the group, the period and the limits to which benefits under the Policy are subject to, including any endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Policy Year means a period of 12 consecutive months from the Commencement Date

Proposal Form / Declaration Form: means any initial or subsequent declaration made by Policy Holder / Insured

Risk Group : Risk Group I- Persons engaged primarily in administrative functions Risk Group II - Persons engaged in manual work other than what is specifically provided for under Group III Risk Group III – Persons working in explosives industry, mine and /or Magazine workers, high tension electric supply, horse racing including jockeys, athletes and occupations of similar hazard.

Single Standard A/C room: Single Standard A/C room means a single occupancy air-conditioned room with attached wash room and a couch for the attendant. The room may have a television and /or a telephone. Such room must be the most economical of all accommodations available in that Hospital as single occupancy. This does not include Deluxe room or a suite

Standard type aircraft/Sea Craft: Standard type aircraft/Sea Craft means an aircraft/sea-craft duly licensed to carry passengers (for hire or otherwise) by appropriate authority irrespective of whether such an aircraft is privately owned or charted or operated by a regular airline.

Sum Insured means the amount shown in the Policy Schedule / Certificate of Insurance against each plan, which shall be the Company's maximum total and cumulative liability for each Insured Person for any and all claims made under any or all benefits under such plan covered under this Policy during the Period of Insurance.

Temporary Total Disablement: Temporary Total Disablement means the Insured Person is totally disabled from engaging in any occupation or business for a temporary period following a Grievous Injury arising solely and directly from an Accident

Waiting Period: Waiting period refers to the period during which the Company shall not be liable to make any payment for any claim which occurs or where the signs and/ or the symptoms of Illness/ condition for the claim has occurred. This is not applicable if caused directly due to an Accident during the Period of Insurance.

C. COVERAGE

The following covers are available, in consideration of the premium paid and shown in the Certificate of Insurance / Policy Schedule and such coverage/s is/are subject to the terms, conditions, exclusions and definitions contained herein the Company agrees as under.

Plan A – Critical Illness

Critical Illness: If during the Period of Insurance the Insured Person shall contract the below mentioned **Critical Illness** as a first incidence, then Company will pay the Sum Insured stated in the Policy Schedule / Certificate of Insurance as lump-sum amount.

S.No.	Group 1 3 Critical Illnesses
1	Cancer of Specified Severity
2	Myocardial Infarction
3	Kidney Failure Requiring Regular Dialysis
S.No.	**Group 2** **6 Critical Illnesses**
1	Cancer of Specified Severity
2	Myocardial Infarction
3	Kidney Failure Requiring Regular Dialysis
4	Open Chest CABG
5	Permanent Paralysis of Limbs
6	Stroke Resulting in Permanent Symptoms
S.No.	**Group 3** **9 Critical Illnesses**
1	Cancer of Specified Severity

2	Myocardial Infarction
3	Kidney Failure Requiring Regular Dialysis
4	Open Chest CABG
5	Permanent Paralysis of Limbs
6	Stroke Resulting in Permanent Symptoms
7	Surgery for Major Organ /Bone Marrow Transplant
8	Benign Brain Tumor
9	Blindness
S.No.	**Group 4**
	15 Critical Illnesses
1	Cancer of Specified Severity
2	Myocardial Infarction
3	Kidney Failure Requiring Regular Dialysis
4	Open Chest CABG
5	Permanent Paralysis of Limbs
6	Stroke Resulting in Permanent Symptoms
7	Surgery for Major Organ /Bone Marrow Transplant
8	Benign Brain Tumor
9	Blindness
10	Deafness
11	HIV Due to Blood Transfusion and Occupationally Acquired HIV
12	End Stage Lung Failure
13	End Stage Liver Failure
14	Major Third degree Burns
15	Coma of Specified Severity
S.No.	**Group 5**
	21 Critical Illnesses
1	Cancer of Specified Severity
2	Myocardial Infarction
3	Kidney Failure Requiring Regular Dialysis
4	Open Chest CABG
5	Permanent Paralysis of Limbs
6	Stroke Resulting in Permanent Symptoms
7	Surgery for Major Organ /Bone Marrow Transplant
8	Benign Brain Tumor
9	Blindness
10	Deafness
11	HIV Due to Blood Transfusion and Occupationally Acquired HIV
12	End Stage Lung Failure
13	End Stage Liver Failure
14	Major Third degree Burns
15	Coma of Specified Severity
16	Repair /Replacement of Heart Valves

17	Motor Neuron Disease with Permanent Symptoms
18	Multiple Sclerosis with Persisting Symptoms
19	Aorta Graft Surgery
20	Severe Rheumatoid Arthritis
21	Alzheimer's Disease
S.No.	**Group 6**
	32 Critical Illnesses
1	Cancer of Specified Severity
2	Myocardial Infarction
3	Kidney Failure Requiring Regular Dialysis
4	Open Chest CABG
5	Permanent Paralysis of Limbs
6	Stroke Resulting in Permanent Symptoms
7	Surgery for Major Organ /Bone Marrow Transplant
8	Benign Brain Tumor
9	Blindness
10	Deafness
11	HIV Due to Blood Transfusion and Occupationally Acquired HIV
12	End Stage Lung Failure
13	End Stage Liver Failure
14	Major Third degree Burns
15	Coma of Specified Severity
16	Repair /Replacement of Heart Valves
17	Motor Neuron Disease with Permanent Symptoms
18	Multiple Sclerosis with Persisting Symptoms
19	Aorta Graft Surgery
20	Severe Rheumatoid Arthritis
21	Alzheimer's Disease
22	Primary (Idiopathic) Pulmonary Hypertension
23	Loss of Limbs
24	Terminal Illness
25	Tuberculosis Meningitis
26	Apallic Syndrome
27	Brain Surgery
28	Major Head Trauma
29	Crohn's Disease
30	Infective Endocarditis
31	Creutzfeldt-Jacob Disease (CJD)
32	Medullary Cystic Disease
S.No.	**Group 7**
	54 Critical Illnesses
1	Cancer of Specified Severity
2	Myocardial Infarction

3	Kidney Failure Requiring Regular Dialysis
4	Open Chest CABG
5	Permanent Paralysis of Limbs
6	Stroke Resulting in Permanent Symptoms
7	Surgery for Major Organ /Bone Marrow Transplant
8	Benign Brain Tumor
9	Blindness
10	Deafness
11	HIV Due to Blood Transfusion and Occupationally Acquired HIV
12	End Stage Lung Failure
13	End Stage Liver Failure
14	Major Third degree Burns
15	Coma of Specified Severity
16	Repair /Replacement of Heart Valves
17	Motor Neuron Disease with Permanent Symptoms
18	Multiple Sclerosis with Persisting Symptoms
19	Aorta Graft Surgery
20	Severe Rheumatoid Arthritis
21	Alzheimer's Disease
22	Primary (Idiopathic) Pulmonary Hypertension
23	Loss of Limbs
24	Terminal Illness
25	Tuberculosis Meningitis
26	Apallic Syndrome
27	Brain Surgery
28	Major Head Trauma
29	Crohn's Disease
30	Infective Endocarditis
31	Creutzfeldt-Jacob Disease (CJD)
32	Medullary Cystic Disease
33	Loss of Speech
34	Encephalitis
35	Fulminant Hepatitis
36	Muscular Dystrophy
37	Systemic Lupus Erythematosus with Lupus Nephritis
38	Dissecting Aortic Aneurysm
39	Severe Ulcerative Colitis
40	Amputation of Feet due to Complications from Diabetes
41	Aplastic Anemia
42	Bacterial Meningitis
43	Chronic Adrenal Insufficiency (Addison's Disease)
44	Chronic Relapsing Pancreatitis
45	Eisenmenger's Syndrome

46	Hemiplegia
47	Loss of Independent Existence
48	Loss of One Limb and One Eye
49	Myelofibrosis
50	Other Serious Coronary Artery Disease
51	Pheochromocytoma
52	Poliomyelitis
53	Progressive Scleroderma
54	Progressive Supranuclear Palsy

Provided however that, the Insured Person subjects himself/herself to examination by the empanelled Medical Practitioner of the Company and the incidence of such Critical Illness is confirmed by the empanelled Medical Practitioner and must be supported by treating Medical Practitioner's certificate regarding duration and etiology of the Critical Illness, clinical radiological histological, pathological, histo-pathological and laboratory evidence acceptable to the Company

Waiting Period: An initial Waiting Period of 30 Days is applicable from the date of commencement of the Period of Insurance as specified in the Policy Schedule / Certificate of Insurance. The Waiting Period is not applicable for Accidental claims.

Important Note:

1. Insurance under this Policy shall cease upon payment of lump-sum on occurrence of any Critical Illness and no further payment will be made for any consequent / subsequent / dependent Illness.
2. Only one lump sum payment shall be provided regardless of the number of Critical Illness suffered by the Insured Person.
3. The Customer has an option to choose sets of above critical Illness viz., 3, 6, 9, 15, 21, 32 & 54 as stated in the Policy schedule
4. This cover is available on individual Sum Insured basis.

Plan B – Hospital Cash

I. **Mandatory Cover:** Section 1 and / or Section 2 are mandatory:

Section 1: Sickness Hospital Cash:

If during the Period of Insurance stated in the Policy Schedule / Certificate of Insurance, the Insured Person shall suffer from any Illness/diseases and if such Illness/diseases shall, upon the advice of a duly qualified Medical Practitioner, require admission of the Insured Person/Beneficiary as an In-Patient in any Hospital in India for the purpose of medical /surgical treatment, then the Company will pay, Hospital Cash amount stated in the Policy Schedule / Certificate of Insurance for every 24 hours of Hospitalisation subject to maximum number of Days stated in the Policy Schedule / Certificate of Insurance.

Section 2: Accident Hospital Cash:

If during the Period of Insurance stated in the Policy Schedule / Certificate of Insurance, the Insured Person shall sustain bodily Injury due to Accident and if such Accident shall, upon the advice of a duly qualified Medical Practitioner, require admission of the Insured Person/Beneficiary as an In-Patient in any Hospital in India for the purpose of medical /surgical treatment, then the Company will pay, Hospital Cash amount stated in the Certificate of Insurance for every 24 hours of Hospitalisation subject to maximum number of Days stated in the Policy Schedule / Certificate of Insurance.

II. **Optional Covers: (Available on payment of additional premium and only if specifically opted and shown in the Policy Schedule / Certificate of insurance)**

1) **Day Care Hospital Cash**: If during the Period of Insurance stated in the Policy Schedule / Certificate of Insurance, the Insured Person/Beneficiary undergoes a Day Care Procedure, the Company will pay the Hospital Cash amount stated in the Policy Schedule / Certificate of Insurance.
   This benefit is available only for 5 times in a Policy Year.
2) **ICU Hospital Cash due to Sickness**: **(Applicable if Section 1 is opted)**
   If during the Period of Insurance stated in the Policy Schedule / Certificate of Insurance, the Insured Person shall suffer from any Illness/diseases and if such Illness/diseases shall, upon the advice of a duly qualified Medical Practitioner, require admission in ICU for the purpose of treatment of Illness /diseases, then the Company will pay 200% of the Section 1 limit, ICU Hospital Cash due to Sickness stated in the Policy Schedule / Certificate of Insurance for every 24 hours of treatment in ICU, provided there is an admissible claim under Section 1. Hospital Cash amount under section 1 cover will not be payable for the period the Insured Person was in ICU.
3) **ICU Hospital cash due to Accident:** (Applicable if Section 2 is opted) If during the Period of Insurance stated in the Policy Schedule / Certificate of Insurance, the Insured Person shall sustain bodily Injury due to Accident and if such Accident shall, upon the advice of a duly qualified Medical Practitioner, require admission in ICU for the purpose of treatment of Accident/Injury, then the Company will pay 200% of the Section 2 limit, as ICU Hospital Cash due to Accident stated in the Policy Schedule / Certificate of Insurance for every 24 hours of treatment in ICU, provided there is an admissible claim under Section 2.
   Hospital Cash amount under Section 2 will not be payable for the period for which the Insured Person was admitted in ICU.
4) **Convalescence Benefit Hospital Cash:** If during the Period of Insurance stated in the Policy Schedule / Certificate of Insurance the Insured Person/Beneficiary shall suffer from any Illness or sustain bodily Injury through Accident and if such disease / Injury or Accident shall, upon the advice of a duly qualified Medical Practitioner, require admission of the Insured Person/Beneficiary as an In-Patient in any Hospital in India for the purpose of medical /surgical treatment for more than consecutive Days as stated in the Policy Schedule / Certificate of Insurance, then the Company will pay a lump sum amount equal to one Day limit as mentioned in the Policy Schedule / Certificate of Insurance in addition to the admissible claim payable under Section 1 or Section 2.
   The options available are:
   a. Lump Sum benefit paid on completion of 5 whole Days of stay at the Hospital.
   b. Lump Sum benefit paid on completion of 7 whole Days of stay at the Hospital.
   c. Lump Sum benefit paid on completion of 10 whole Days of stay at the Hospital.
5) **Child Birth Benefit Hospital Cash**: If during the Period of Insurance stated in the Policy Schedule / Certificate of Insurance the Insured Person/Beneficiary shall, upon the advice of a duly qualified Medical Practitioner, require admission of the Insured Person/Beneficiary as an In-Patient in any Hospital in India for the purpose of Child Delivery, then the Company will pay Hospital Cash Amount stated in the Policy Schedule / Certificate of Insurance subject to maximum number of Days stated in the Policy Schedule / Certificate of Insurance.
   Special Condition:
   1. Where a claim under this benefit (5) is admissible, claim under Section 1 and/or Section 2 will not be payable
   2. The coverage under this benefit is subject to a Waiting Period of 9 months from the first commencement date of this Policy. However this Waiting Period can be waived on payment of additional premium.
   3. Only female Insured Persons/Beneficiary are eligible for this benefit

6) **Worldwide Hospital Cash**: If during the Period of Insurance stated in the Policy Schedule / Certificate of Insurance, the Insured Person/Beneficiary shall suffer from any Illness or sustain bodily Injury through Accident and if such disease / Illness / Injury or Accident shall, upon the advice of a duly qualified Medical Practitioner, require admission of the Insured Person/Beneficiary as an In-Patient in any Hospital outside India for the purpose of medical /surgical treatment, then the Company will pay Hospital Cash Amount mentioned in the Policy Schedule / Certificate of Insurance for every 24 hours of Hospitalization subject to maximum number of Days stated in the Policy Schedule / Certificate of Insurance.

7) **Joint Hospitalisation Hospital Cash:** If during the Period of Insurance stated in the Policy Schedule / Certificate of Insurance, if the two or more Insured Person / Beneficiary of the same family are jointly Hospitalised as an In-Patient, then the Company will pay Joint Hospitalisation amount as stated in the Policy Schedule / Certificate of Insurance, provided there is an admissible claim under Section 1 or Section 2.
   - This benefit is available once during the Policy Period.
   - This benefit is applicable on an individual Sum Insured basis

8) **Surgery Benefit Hospital Cash**: If during the Period of Insurance stated in the Policy Schedule / Certificate of Insurance, the Insured Person/Beneficiary undergoes Major surgery as per the list given below, then the Company will pay a Surgery Benefit amount as stated in the Policy Schedule / Certificate of Insurance, provided there is an admissible claim under Section 1 or Section 2
   - Hernia
   - Hysterectomy
   - Cardiac Surgeries
   - Brain Tumour Surgeries
   - Pace Maker implantation for sick sinus syndrome
   - Cancer Surgeries
   - Hip, Knee, Joint Replacement Surgery
   - Organ Transplant.
     - This benefit is available once per Policy Year for each Insured Person.
     - This benefit is applicable on an individual Sum Insured basis
     - The payment under this benefit is in addition to the section 1 and/or section 2 benefits specified.

9) **30 Days Waiting Period Waiver:** Waiting Period (Code Excl 03) stands waived off.

10) **First 24 months Waiting Period Waiver**: Waiting Period (Code Excl 02) Stands waived off (or) waiting period shall be reduced from 24 month to 12 months as stated in the Policy Schedule / Certificate of Insurance.

11) **Pre existing Disease Waiting Period Waiver:** Waiting Period (Code Excl 01)stands waived off (or) Waiting Period shall be reduced from 36 months **to** 24 months **(or)** 12 months as stated in the Policy Schedule / Certificate of Insurance.

Plan C – Equal Monthly Instalment (EMI) Protect

If during the Period of Insurance stated in the Policy Schedule / Certificate of Insurance, the Insured Person shall suffer from any Illness/diseases/Injury and if such Illness/diseases/Injury shall, upon the advice of a duly qualified Medical Practitioner, require admission of the Insured Person/ Beneficiary as an In-Patient in any Hospital in India for the purpose of medical /surgical treatment, then the Company will pay the number of EMIs/EMI amount as specified in the Policy Schedule/ Certificate of Insurance for every completed continuous Hospitalization period of 24 hours.

Hospitalisation in Days	Number of EMIs payable
3-5 Days	1
6-8 Days	2
9-11 Days	3
12-14 Days	4
15 Days and above	5

Optional Cover

Hospitalisation in Days	Number of EMIs payable
2-5 Days	1

Note:

1. Irrespective of number of Days of Hospitalization, the maximum number of EMIs that will be paid shall not exceed 5 in a Policy year.
2. This cover is available on Individual Sum Insured basis only.

Plan D – Personal Accident

Geographical Scope: The Personal Accident insurance cover applies Worldwide unless otherwise stated
Important: Benefit 1 and / or Benefit 2 are mandatory:-

Accidental Death - Benefit 1

The Company will pay as hereinafter mentioned:
If at any time during the Period of Insurance, the Insured Person shall sustain any bodily Injury resulting solely and directly from Accident, and such Accident causes death of the Insured Person within 12 calendar months from the date of Accident, then the Company will pay an amount as provided in "Benefit 1" under "Schedule of Benefits"

Permanent Total Disablement - Benefit 2

If following an Accident which caused permanent total impairment of the Insured Person's physical capabilities, then the Company will pay the benefits as provided in "Benefit 2" under "Schedule of Benefits" depending upon the degree of disablement provided that:

a) The disablement occurs within 12 Calendar months from the date of the Accident.
b) The disablement is confirmed and claimed for, prior to the expiry of a period of 60 Days since occurrence of the disablement.

Provided always that the Policy will not pay under more than one of the Benefits stated under "Schedule of Benefits" in respect of the same Accident.

OPTIONAL COVERS (Available only if specifically opted and shown in the Policy Schedule / Certificate of Insurance)

1. **Permanent Partial Disablement (Benefit 3):** If following an Accident which caused permanent partial impairment of the Insured Person's physical capabilities, then the Company will pay the benefits as provided in "Benefit 3" under "Schedule of Benefits", depending upon the degree of disablement provided that:
   a) The disablement occurs within 12 calendar months from the date of the Accident.
   b) The disablement is confirmed and claimed for, prior to the expiry of a period of 60 Days since occurrence of the disablement.

Provided always that the Policy will not pay under more than one of the Benefits stated under "Schedule of Benefits" in respect of the same Accident In case of multiple disability from the same Accident, the Policy will pay the highest of the either two compensation.

2. **Temporary Total Disablement (Weekly Compensation) (Benefit 4):** If at any time during the Period of Insurance the Insured Person/s shall sustain Grievous Injury arising solely and directly from an Accident and resulting in admission in a Hospital / Nursing Home as an In-Patient, then the Insured Person will be paid a sum calculated at 1% of the Sum Insured under Benefit 4 per completed week but not exceeding the amount stated in the Policy Schedule / Certificate of Insurance per completed week, in all, under all Personal Accident policies, if such Injury be the sole and direct cause of Temporary Total Disablement.
This benefit is subject to a maximum period of 100 weeks or the number of weeks stated in the Certificate of insurance whichever is less from the date of such Temporary Total Disablement.
In no case shall the compensation exceed the Sum Insured for this benefit.
The payment shall be made only after the termination of such disablement.
All the benefit under this section is subject to exclusions, as mentioned in 'General Exclusions' of this Policy.

Special Conditions (applicable for Benefit 1, Benefit 2, Benefit 3 and Benefit 4)

1. If the Accident affects any physical function, which was already impaired prior to the Accident, a deduction as per "Table – B1" will be made in respect of this prior disablement.
2. If the Accident impairs a number of physical functions, the degree of disablement given in the Schedule of Benefits will be added together, but liability in any case shall not exceed 100% of the Sum Insured.
3. Where a claim for 100% of the Sum Insured is admitted / admissible the coverage under the Policy ceases for such relevant person.
4. Where a claim for less than 100% of the Sum Insured is admitted / admissible, the coverage under the Policy will continue until expiry for the balance Sum Insured and Company would exclude such disability on renewal in respect of such relevant person if the group Policy is renewed
5. In the event of Permanent Disablement, the Insured Person will be under obligation:
   a) To have himself/herself examined by Medical Practitioners appointed by the Company/ and the Company will pay the costs involved thereof.
   b) To authorize Medical Practitioners providing treatments or giving expert opinion and any other authority to supply the Company any information that may be required. If the obligations are not met with due to whatsoever reason, the Company may be relieved of its liability to pay. Provided however the Insured Person shall be deemed to have discharged his duties/obligations if he authorizes / gives consent to the treating Medical Practitioner/s or the experts who gave opinion. Any subsequent failure on the part of the treating Medical Practitioner/experts who gave opinion / Hospital will not be held up against the Insured Person.

Exclusions (applicable to all Benefits)

(a) Any payment in case of more than one claim under the Policy during the Period of Insurance by which the maximum liability of the Company in that Policy Period would exceed the Sum Insured.
(b) Any other claim after a claim has been admitted by the Company and becomes payable for Death or 100% Permanent Total Disablement.
(c) Any claim arising out of pregnancy or childbirth, infirmity, whether directly or indirectly.

3. **Ambulance Charges / Transportation Expenses of Mortal Remains**

Following will be considered towards an admissible claim under the Policy due to an Accident outside the place of the Insured Person's residence, the Company shall pay up to limits mentioned in the Certificate of Insurance during the Period of Insurance either

a) Towards ambulance charges for emergency treatment to go to the Hospital in case of Injury
Or
in case of Death
b) Towards transportation of the mortal remains of the Insured Person (including the cost of embalming and coffin charges) to the residence of the Insured Person,

This lump sum amount is payable in addition to the Sum Insured

4. **Travel Expenses for One Relative:** Following an admissible claim under the Policy towards Death of the Insured Person due to an Accident, outside the place of his/her residence, the Company will pay up to the limits mentioned in the Certificate of Insurance for the transport expenses to one relative of the Insured Person.
This amount is payable in addition to the Sum Insured
5. **Purchase of Blood:** The Company will pay up to the limits mentioned in the Certificate of Insurance towards the expenses incurred in purchasing blood through a Hospital or Government approved blood bank for the purpose of the Insured Person's medical or surgical treatment provided there is an admissible claim under this Policy.
This amount is payable in addition to the Sum Insured
6. **Transportation of Imported Medicines:** The Company will pay up to the limits mentioned in the Certificate of Insurance towards the expenses incurred on freight charges for importing medicines to India, provided that:
   a. There is an admissible claim under the Policy.
   b. The medicines, formulations or alternatives of the imported medicines are not available in India, and
   c. The medicines are necessary for the medical/surgical treatment of the Insured Person in a Hospital following the Accident.
   d. The medicines which are imported should be permissible under Government Regulation
   e. The medicines shall not include any drugs under clinical trial or medicines, formulations or molecules of unproven efficacy.
   f. Prescription of the treating Medical Practitioner with confirmation that the medicine is not available in India

   This amount is payable in addition to the Sum Insured
7. **Medical Expenses following an Admissible Personal Accident Claim:** This insurance is extended to pay any necessary and reasonable medical expenses incurred and expended by the Insured Person arising solely and directly as a result of Accident up to the limits mentioned in the Certificate of Insurance subject to exclusions mentioned in the General Exclusion of this Policy.
   Sufficient proof for the treatment taken to be submitted to the Company
   This amount is payable in addition to the Sum Insured
   The benefits under this extension is optional and is effective only if
   1. There is an admissible claim under Accidental Death - Benefit 1 / Permanent Total Disablement - Benefit 2 / Permanent Partial Disablement - Benefit 3 /Temporary Total Disablement (Weekly Compensation) - Benefit 4
   2. Medical expenses incurred / expended during the Period of Insurance and are payable only if the Policy is in force.
   3. Treatment availed is not an Unproven / Experimental Treatment
   4. Treatment is taken in a Clinic / Nursing Home or Hospital (except for physiotherapy done at home)
8. **Medical Expenses Irrespective of an Admissible Personal Accident Claim:** This insurance is extended to pay any necessary and reasonable medical expenses incurred and expended by the Insured Person arising solely and directly as a result of Accident up to the limits mentioned in the Policy Schedule

/ Certificate of Insurance subject to exclusions mentioned in the General Exclusion of this Policy. Sufficient proof for the treatment taken to be submitted to the Company
This amount is payable in addition to the Sum Insured
The benefits under this extension is optional and is effective only if

1. Medical expenses incurred / expended during the Policy tenure and are payable only if the Policy is in force.
2. Treatment availed is not an Unproven / Experimental Treatment
3. Treatment is taken in a Clinic / Nursing Home or Hospital (except for physiotherapy done at home).

9. **Home Convalescence:** Following an admissible claim for Permanent Total Disability / Permanent Partial disability under the Policy, the Company will pay the cost of engaging one attendant at residence immediately after discharge from the Hospital provided the same is recommended by the attending Medical Practitioner. Such expenses are payable up-to the limits mentioned in Certificate of Insurance. No payment will be made for the first day.
This benefit is payable in addition to the Sum Insured
10. **Hospital Cash Benefit:** Following an admissible claim under the Policy the Company will pay up to the limits mentioned in the Certificate of Insurance for each completed Day of Hospitalization. This benefit is subject to a time excess of 24hours.
No claim under this head shall lie with the Company where the admission is for physiotherapy and/or any epidemic.
This benefit is payable in addition to the Sum Insured
11. **Vehicle and/or Residence Modification:** The Company will pay upto 10% of the Sum Insured subject to the limits mentioned in the Certificate of Insurance towards the expenses incurred to modify the Insured Person's residential accommodation or vehicle as long as the modification have been carried out in India and certified by a Medical Practitioner to be necessary and directly required as a result of the Accident for which there is an admissible claim under Permanent Total Disablement - Benefit 2 under this Certificate of Insurance
This amount is payable in addition to the Sum Insured
12. **External Support to the Insured Person:** This insurance is extended to pay for the cost of crutches / walkers / artificial limbs / wheelchair incurred by the Insured Person arising solely and directly as a result of Accident up to the limits mentioned in the Certificate of Insurance subject to exclusions mentioned in the General Exclusion of this Policy. Sufficient proof of Accident with respective bills, invoices, payment receipts and such other documents should be submitted to the Company.
The benefits under this extension is optional and is effective only if there is an admissible claim under the Policy for Permanent Total Disablement - Benefit 2
13. **Funeral Expenses:** Following an admissible claim towards death of the Insured Person due to an Accident, the Company shall pay up to the limits mentioned in the Certificate of Insurance towards funeral expenses of the Insured Person. Sufficient bills, invoices, payment receipts and such other documents should be submitted to the Company
14. **Educational Benefit in Case of Accidental Death / Permanent Total Disability of the Insured Person:** Following an admissible claim under the Policy towards Accidental Death - Benefit 1 / Permanent Total Disablement - Benefit 2 of the Insured Person, the Company will pay Educational Benefit for a maximum of two dependent children of the Insured Person, as mentioned below:
    - If the Insured Person has dependent child/children below the age of 23 years, an amount as stated in the Certificate of Insurance is payable.
15. **Out Patient Medical Expenses Due to Grievous Injury:** This insurance is extended to pay necessary and reasonable Out Patient Medical Expenses incurred and expended by the Insured Person arising

solely and directly as a result of Accident resulting in Grievous Injury up to the limits mentioned in the Certificate of Insurance subject to exclusions mentioned in the General Exclusion of this Policy. Sufficient proof for the treatment taken to be submitted to the Company.
This amount is payable in addition to the Sum Insured
Note: Medical expenses incurred / expended are during the Period of Insurance and are payable only if the Policy is in force.

Plan E – Group Health

That if during the Period of Insurance stated in the Policy Schedule / Certificate of Insurance the Insured Person shall suffer from any Illness or sustain bodily Injury through Accident and if such disease or Injury shall require the Insured Person/s, upon the advice of a duly qualified Medical Practitioner or of duly Qualified Surgeon to incur Hospitalization expenses for medical/surgical treatment at any Nursing Home / Hospital in India as an In-Patient, the Company will pay to the **Insured Person/s** the amount of such expenses as are reasonably and necessarily incurred up-to the limits mentioned in the Certificate of Insurance but not exceeding the Sum Insured stated in the Certificate of Insurance hereto.

a. Room, boarding, nursing expenses as provided by the Hospital / Nursing Home up to the limits mentioned in the table below:

Sum Insured Rs.	Limit Rs.
2,00,000	Up to 2,000/- per day
3,00,000 and 4,00,000	Up to 5,000/- per day
5,00,000 to 25,00,000	Single Standard A/C Room

b. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist fees.

c. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, diagnostic materials and X-ray, diagnostic imaging modalities, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent and similar expenses

d. Emergency ambulance charges up to the limits mentioned in the Policy Schedule / Certificate of Insurance for transportation of the Insured Person by private ambulance service when this is needed for medical reasons to go to Hospital for treatment, provided however there is an admissible claim under the Policy.

e. Relevant Pre-Hospitalization and Post–Hospitalization medical expenses up to the limits mentioned in the Policy Schedule / Certificate of Insurance.

f. **AYUSH Treatment**: Expenses incurred on treatment under Ayurveda, Unani, Sidha and Homeopathy systems of medicines in a Government Hospital or in any institute recognized by the government and/or accredited by the Quality Council of India/National Accreditation Board on Health is payable up to the limits given below:

Sum Insured Rs.	Limit per Period of Insurance Rs.
Up to 4,00,000/-	Up to 10,000
5,00,000/- to 15,00,000/-	Up to 15,000
20,00,000/- and 25,00,000/	Up to 20,000

Note: Payment under this benefit forms part of the Sum Insured.

g. **Automatic Restoration of Sum Insured**: There shall be automatic restoration of the Sum Insured immediately upon exhaustion of the Sum Insured, which has been defined, during the Period of Insurance

up to 25% of the Sum Insured. Automatic Restoration will operate only after the exhaustion of the Sum Insured.

It is made clear that such restored Sum Insured can be utilized only for Illness / disease unrelated to the Illness / diseases for which claim/s was / were made. The unutilized restored Sum Insured cannot be carried forward.

Note: Automatic Restoration of Sum Insured is available only for Sum Insured options of Rs.3,00,000/- and above. Not applicable for Sum Insured of Rs.2,00,000/-.

h. **Organ Donor Expenses** for organ transplantation where the Insured Person is the recipient are payable provided the claim for transplantation is payable and subject to the availability of the Sum Insured .Donor screening expenses and post-donation complications of the donor are not payable. This cover is subject to a limit of 10% of the Sum Insured or Rs. 1 lakh whichever is less

i. **Cost of Health Checkup**: Expenses incurred towards cost of health check-up up to the limits mentioned in the table given below for every claim free year provided the health checkup is done at Network Hospitals and the Policy is in force. Payment under this benefit does not form part of the Sum Insured.

If a claim is made by any of the Insured Persons, the health check up benefits will not be available under the Policy for the other covered members of the family of that Insured Person who has made a claim.

Note: Payment of expenses towards cost of health check up will not prejudice the Company's right to deal with a claim in case of non disclosure of material fact and / or Pre-Existing Diseases in terms of the Policy.

Sum Insured Rs.	Limit Per Period of Insurance (Rs.)
2,00,000/-	Not Eligible
3,00,000/-	Up to 750/-
4,00,000/-	Up to 1,000/-
5,00,000/-	Up to 1,500/-
7,00,000/-	Up to 1,750/-
10,00,000/-	Up to 2,000/-
15,00,000/-	Up to 2,500/-
20,00,000/-	Up to 3,000/-
25,00,000/-	Up to 3,500/-

j. **Expenses incurred on treatment of Cataract** is subject to the limit as per the following table

Sum Insured Rs.	Limit per eye Rs.	Limit per Period of Insurance Rs.
2,00,000/-	Up to 12,000/-per eye, per Policy period	
3,00,000/-	Up to 25,000/-	Up to 35,000/-
4,00,000/-	Up to 30,000/-	Up to 45,000/-
5,00,000/- & 7,00,000/-	Up to 40,000/-	Up to 60,000/-
10,00,000/- to 25,00,000/-	Up to 50,000/-	Up to 75,000/-

k. **Coverage for Modern Treatments:** The expenses payable during the entire Period of Insurance for the following Treatment / Procedures (either as a Day Care or as an In-Patient exceeding 24hrs of admission in the Hospital) is limited to the amount mentioned in table below

Sum Insured Options Disease	Uterine artery Embolization and HIFU	Balloon Sinuplasty	Deep Brain Stimulation	Oral* Chemotheraphy	Immunotheraphy-Monoclonal Antibody to be given as injection
	Limit per person, per Period of Insurance for each Treatment / Procedures Rs.				
Rs.2,00,000/-	25,000	10,000	50,000	25,000	50,000
Rs.3,00,000/-	37,500	15,000	75,000	37,500	75,000
Rs.4,00,000/-	1,00,000	40,000	2,00,000	1,00,000	2,00,000
Rs.5,00,000/-	1,25,000	50,000	2,50,000	1,25,000	2,50,000
Rs.7,00,000/	1,25,000	50,000	2,50,000	1,25,000	2,75,000
Rs.10,00,000/	1,50,000	1,00,000	3,00,000	2,00,000	4,00,000
Rs.15,00,000/-	1,75,000	1,25,000	4,00,000	2,50,000	5,00,000
Rs.20,00,000/-	2,00,000	1,50,000	4,50,000	2,75,000	5,50,000
Rs.25,00,000/-	2,00,000	1,50,000	5,00,000	3,00,000	6,00,000

Sum Insured Options Diseases	Intra Vitreal injections	Robotic surgeries	Stereotactic radio surgeries	Bronchical Thermoplasty	Vaporisation of the prostate (Green laser treatment or holmium laser treatment)	IONM-(Intra Operative Neuro Monitoring)	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions
	Limit per person, per Period of Insurance for each Treatment / Procedures Rs.						
Rs.2,00,000/-	10,000	50,000	50,000	Up to Sum Insured			50,000
Rs.3,00,000/-	15,000	75,000	75,000				75,000
Rs.4,00,000/-	40,000	2,00,000	1,75,000				2,00,000
Rs.5,00,000/-	50,000	2,50,000	2,00,000				2,50,000
Rs.7,00,000/	60,000	2,75,000	2,25,000				2,75,000
Rs.10,00,000/	75,000	3,00,000	2,50,000				3,00,000
Rs.15,00,000/-	1,00,000	4,00,000	2,75,000				5,00,000
Rs.20,00,000/-	1,25,000	4,50,000	2,75,000				5,50,000
Rs.25,00,000/-	1,50,000	5,00,000	3,00,000				6,00,000

*Sublimits are all inclusive with or without Hospitalization where ever Hospitalization includes Pre and Post Hospitalization.

I. **Air Ambulance charges up to 10% of the Sum Insured, provided that**

1. It is for life threatening emergency health condition/s of the Insured Person which requires immediate and rapid ambulance transportation to the Hospital/Clinic that ground transportation cannot provide.

2. Necessary medical treatment not being available at the location where the Insured Person is situated at the time of emergency
3. It is prescribed by a Medical Practitioner and is Medically Necessary;
4. The Insured Person is in India and the treatment is in India only
5. Such Air ambulance should have been duly licensed to operate as such by Competent Authorities of the Government/s

Note: This benefit is available for Sum Insured options of Rs.5,00,000/- and above only.

Important:

a) Claims will be settled by in-house claims team

b) Expenses on Hospitalization are payable provided the Hospitalization is for minimum period of 24 hours. However this time limit will not apply for the Day Care Treatments / procedures taken in the Hospital / Nursing Home where the Insured Person is discharged on the same day. All Day Care Treatments are covered. The company's liability for specified ailment / surgical procedure is up to the limits mentioned in the Policy Schedule / Certificate of Insurance.

c) Expenses relating to Hospitalization will be considered in proportion to the eligible room category stated in the Policy Schedule / Certificate of Insurance or actual whichever is less.

PLAN F: Group Health TOP UP

In consideration of the premium paid, subject to the terms, conditions, exclusions and definitions contained herein the Company agrees as under.

Silver Plan

That if during the Period of Insurance stated in the Policy Schedule / Certificate of Insurance the Insured Person shall suffer from any Illness or sustain bodily Injury through Accident and if such disease, Illness or Injury shall require the Insured Person/s, upon the advice of a duly qualified Medical Practitioner or of duly Qualified Surgeon to incur Hospitalization expenses for medical/surgical treatment at any Nursing Home / Hospital in India as an In-Patient, the Company will pay to the Insured Person/s the amount of such expenses in excess of the deductible per Hospitalization mentioned in the Policy Schedule / Certificate of Insurance as are reasonably and necessarily incurred under the following heads but not exceeding the Sum Insured in aggregate in any one period stated in the Policy Schedule / Certificate of Insurance hereto

Gold Plan

that if during the Period of Insurance stated in the Policy Schedule / Certificate of Insurance the Insured Person shall suffer from any Illness or sustain bodily Injury through Accident and if such disease, Illness or Injury shall require the Insured Person/s, upon the advice of a duly qualified Medical Practitioner or of duly Qualified Surgeon to incur Hospitalization expenses for medical/surgical treatment at any Nursing Home / Hospital in India as an In-Patient, the Company will pay to the Insured Person/s the amount of such expenses in excess of the aggregate limit but not exceeding the Sum Insured in aggregate in any one period stated in the Policy Schedule / Certificate of Insurance hereto

1. **Coverage Applicable for Silver and Gold Plan**
   a. Room, boarding, nursing expenses as provided by the Hospital / Nursing Home up to Rs.5,000/- per day
   b. Surgeon, Anesthetist, Medical Practitioner, Consultants, specialist fees.
   c. Anesthesia, blood, oxygen, operation theatre charges, ICU Charges, surgical appliances, medicines and drugs, diagnostic materials and X-ray, diagnostic imaging modalities, dialysis, chemotherapy, radiotherapy, cost of pacemaker, stent and similar expenses
   d. Emergency ambulance charges up to the limits mentioned in the Policy Schedule / Certificate of Insurance for transportation of the Insured Person by private ambulance service when this is needed

for medical reasons to go to Hospital for treatment, provided however there is an admissible claim under the Policy.

e. Relevant Pre-Hospitalization and Post–Hospitalization medical expenses up to the limits mentioned in the Policy Schedule / Certificate of Insurance.

f. **AYUSH Treatment**: Expenses incurred on treatment under Ayurveda, Unani, Sidha and Homeopathy systems of medicines in a Government Hospital or in any institute recognized by the government and/or accredited by the Quality Council of India/National Accreditation Board on Health up to the amount stated in the Policy Schedule / Certificate of Insurance per Policy Period.

g. **Coverage for Modern Treatments:** The expenses payable during the Period of Insurance for the following treatment / procedures (either as a day care or as an In-Patient exceeding 24hrs of admission in the Hospital) is limited to the amount mentioned in table below

Sum Insured Rs.	Uterine artery Embolization and HIFU	Balloon Sinuplasty	Deep Brain Stimulation	Oral Chemotheraphy (Sublimits including pre & Post Hospitalization)	Immunotherapy- Monoclonal Antibody to be given as injection	Intra Vitreal injections
	Limit per person, per Period of Insurance for each diseases / Condition Rs.					
From Rs.5,00,000/- to Rs.7,50,000/-	125000	50000	250000	125000	275000	60000
From Rs.7,50,001/- to Rs.10,00,000/-	150000	100000	300000	200000	400000	75000
From Rs.10,00,001/- to Rs.15,00,000/-	175000	125000	400000	250000	500000	100000
From Rs.15,00,001/- to Rs.20,00,000/-	200000	150000	450000	275000	550000	125000
From Rs.20,00,001/- to Rs.25,00,000/-	200000	150000	500000	300000	600000	150000

Sum Insured Rs.	Robotic Surgeries	Stereotactic radiosurgery	Bronchical Thermoplasty, Vaporisation of the prostate(Green laser treatment or holmium laser treatment),IONM-(Intra Operative Neuro Monitoring)	Stem cell theraphy: Hematopoietic stem cells for bone marrow transplant for haematological conditions
	Limit per person, per Period of Insurance for each diseases / Condition Rs.			
From Rs.5,00,000/- to Rs.7,50,000/-	275000	275000	Up to Sum Insured	275000
From Rs.7,50,001/- to Rs.10,00,000/-	300000	225000		400000
From Rs.10,00,001/- to Rs.15,00,000/-	400000	250000		500000

From Rs.15,00,001/- to Rs.20,00,000/-	450000	275000		550000
From Rs.20,00,001/- to Rs.25,00,000/-	500000	300000		600000

Expenses on Hospitalization are payable provided the Hospitalization is for minimum period of 24 hours. However, this time limit will not apply for the Day Care Treatments / procedures taken in the Hospital / Nursing Home where the Insured Person is discharged on the same day. The company's liability for specified ailment / surgical procedure is up to the limits mentioned in the Policy Schedule / Certificate of Insurance.

Expenses relating to Hospitalization will be considered in proportion to the room rent limit stated in the Policy Schedule/Certificate of Insurance or actual whichever is less. Proportionate deductions 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.

Important Note:

Applicable for Silver Plan

1. The Company is liable only for the amount in excess of the Deductible.
2. Deductible is applied for each Hospitalization

Applicable for Gold Plan

1. The Company's liability will begin only when the aggregate of the Hospitalization expenses admissible under this Policy during this Period of Insurance exceed the aggregate limit.
2. The amount payable shall be the amount in excess of the aggregate limit, however not exceeding the Sum Insured for the Policy Period.

D. WAITING PERIOD

The Company shall not be liable under this Policy if the Hospitalization is for,

1. Pre-Existing Diseases - Code Excl 01

I. **Applicable for Plan B and Plan C:** Pre Existing Diseases as defined in the Policy until 36 consecutive months of continuous coverage have elapsed under this Policy since Commencement Date of the first Policy with the Company.

Note for Plan B: In the event of this Insurance Policy not being renewed or when the Insured Member cancels his/her cover under the Policy, such Insured Member has the option to migrate to retail Hospital Cash Insurance Policy offered by the Company. In such an event the continuity of benefits with respect to waiting periods 1, 2, and 3 will be given in the individual health insurance Policy according to the number of years covered continuously under this Policy.

In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

II. **Applicable for Plan E:** Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the Commencement Date of the first Policy with insurer.

In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

Coverage under the Policy after the expiry of 36 months for any Pre-Existing Disease is subject to the same being declared at the time of application and accepted by Insurer.

III. **Applicable for Plan F:** Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the Commencement Date of the first Policy with insurer.

In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

Coverage under the Policy after the expiry of 36 months for any Pre-Existing Disease is subject to the same being declared at the time of application and accepted by Insurer.

2. Specified disease/procedure waiting period – Code Excl 02

1. **Applicable for Plan B and Plan C:** The following specified ailments / Illness / diseases for 24 consecutive months from the Commencement Date under the Policy.
   a. Treatment of Cataract and diseases of the anterior and posterior chamber of the Eye, Diseases of ENT, Diseases related to Thyroid, Benign diseases of the breast.
   b. Subcutaneous Benign Lumps, Sebaceous cyst, Dermoid cyst, Mucous cyst lip / cheek, Carpal Tunnel Syndrome, Trigger Finger, Lipoma , Neurofibroma, Fibroadenoma, Ganglion and similar pathology
   c. All treatments (Conservative, Operative treatment) and all types of intervention for Diseases related to Tendon, Ligament, Fascia, Bones and Joint Including Arthroscopy and Arthroplasty / Joint Replacement [other than caused by Accident].
   d. All types of treatment for Degenerative disc and Vertebral diseases including Replacement of bones and joints and Degenerative diseases of the Musculo-skeletal system, Prolapse of Intervertebral Disc (other than caused by Accident),
   e. All treatments (conservative, interventional, laparoscopic and open) related to Hepato-pancreato-biliary diseases including Gall bladder and Pancreatic calculi. All types of management for Kidney and Genitourinary tract calculi.
   f. All types of Hernia,
   g. Desmoid Tumor, Umbilical Granuloma, Umbilical Sinus, Umbilical Fistula,
   h. All treatments (conservative, interventional, laparoscopic and open) related to all Diseases of Cervix, Uterus, Fallopian tubes, Ovaries, Uterine Bleeding, Pelvic Inflammatory Diseases
   i. All Diseases of Prostate, Stricture Urethra, all Obstructive Uropathies,
   j. Benign Tumours of Epididymis, Spermatocele, Varicocele, Hydrocele,
   k. Fistula, Fissure in Ano, Hemorrhoids, Pilonidal Sinus and Fistula, Rectal Prolapse, Stress Incontinence
   l. Varicose veins and Varicose ulcers
   m. All types of transplant and related surgeries (Other than bone marrow transplant for acute hematological malignancies and acute medical emergencies when indicated)
   n. Congenital Internal disease / defects / anomalies

   Note: If these are pre-existing at the time of proposal, they will be covered subject to exclusion number 3 mentioned below

   In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

2. **Applicable for Plan E**
   a. Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage after the Commencement Date of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident.
   b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
   c. If any of the specified disease/procedure falls under the Waiting Period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.

d. The Waiting Period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

e. List of specific diseases/procedures

1. The expenses on treatments (conservative, interventional, laparoscopic and open) related to Hepato-pancreato-biliary diseases including Gall bladder and Pancreatic calculi, all types of management for kidney and genitourinary tract calculi., all Diseases of Prostate, all types of Hernia,, Hydrocele, Congenital Internal disease/defect anomalies (Except to the extent covered under Newborn Baby Cover if specifically opted) Pilonidal sinus and Fistula / Fissure in ano, Piles, Sinusitis and related disorders.
2. Cataract and diseases of the anterior and posterior chamber of the Eye, Diseases of ENT, Diseases related to Thyroid, Prolapse of intervertebral disc (other than caused by Accident),Varicose veins and Varicose ulcers, all Stricture Urethra, all Obstructive Uropathies, Epididymal Cyst, Benign Tumours of Epididymis, Spermatocele, Varicocele, Hemorrhoids, Rectal Prolapse, Stress Incontinence.
3. Desmoid tumour of anterior abdominal wall.
4. All treatments (conservative, interventional, laparoscopic and open) related to all Diseases of Uterus, Fallopian tubes, Cervix and Ovaries, Uterine bleeding, Pelvic Inflammatory Diseases, Benign breast diseases, Umbilical sinus, Umbilical fistula.
5. Conservative, operative treatment and all types of intervention for Diseases related to Tendon, Ligament, Fascia, Bones and Joint Including Arthroscopy and Arthroplasty [other than caused by Accident]
6. Degenerative disc and Vertebral diseases including Replacement of bones and joints and Degenerative diseases of the Musculo-skeletal system
7. Subcutaneous Benign lumps, Sebaceous cyst, Dermoid cyst, Mucous cyst lip / cheek, Carpal tunnel syndrome, Trigger finger, Lipoma, Neurofibroma, Fibroadenoma, Ganglion and similar pathology
8. Any transplant and related surgery

3. **Applicable for Plan F**

1. Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage after the Commencement Date of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident.
   List of specific diseases/procedures:
   a) Hepato-pancreato-biliary diseases including Gall bladder and Pancreatic calculi
   b) All types of management for kidney and genitourinary tract calculi
   c) All Diseases of Prostate
   d) All types of Hernia
   e) Hydrocele
   f) Congenital Internal disease/defect anomalies (Except to the extent covered under Newborn Baby Cover if specifically opted)
   g) Pilonidal sinus and Fistula / Fissure in ano,
   h) Piles
   i) Sinusitis and related disorders
2. Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the Commencement Date of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident.
   List of specific diseases/procedures

a) Cataract and diseases of the anterior and posterior chamber of the Eye, Diseases of ENT, Diseases related to Thyroid, Prolapse of intervertebral disc (other than caused by Accident), Varicose veins and Varicose ulcers, all Stricture Urethra, all Obstructive Uropathies, Epididymal Cyst, Benign Tumours of Epididymis, Spermatocele, Varicocele, Hemorrhoids, Rectal Prolapse, Stress Incontinence.
b) Desmoid tumour of anterior abdominal wall.
c) All treatments (conservative, interventional, laparoscopic and open) related to all Diseases of Uterus, Fallopian tubes, Cervix and Ovaries, Uterine bleeding, Pelvic Inflammatory Diseases, Benign breast diseases, Umbilical sinus, Umbilical fistula.
d) Conservative, operative treatment and all types of intervention for Diseases related to Tendon, Ligament, Fascia, Bones and Joint Including Arthroscopy and Arthroplasty [other than caused by Accident]
e) Degenerative disc and Vertebral diseases including Replacement of bones and joints and Degenerative diseases of the Musculo-skeletal system
f) Subcutaneous Benign lumps, Sebaceous cyst, Dermoid cyst, Mucous cyst lip / cheek, Carpal tunnel syndrome, Trigger finger, Lipoma, Neurofibroma, Fibroadenoma, Ganglion and similar pathology
g) Any transplant and related surgery

3. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
4. If any of the specified disease/procedure falls under the Waiting Period specified for Pre-Existing Diseases, then the longer of the two Waiting Periods shall apply.
5. The Waiting Period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

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3. 30-Day Waiting Period – Code Excl 03: (Applicable for Plan A, B, C, E and F)

a. Expenses related to the treatment of any Illness within 30 Days from the first Policy Commencement Date shall be excluded except claims arising due to an Accident, provided the same are covered.
b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.
c. The within referred Waiting Period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

E. EXCLUSIONS

Applicable for Plan A: Critical Illness

The Company shall not be liable to make any payment under this Policy towards a covered Critical Illness, caused by, based on, arising out of or howsoever attributable to any of the following:

1. Any Illness, sickness or disease other than those specified as Critical Illnesses under this Policy.

2. Any claim with respect to any Critical Illness contracted, diagnosed or manifested prior to Commencement date of this Policy

3. Pre-existing Disease means any condition, aliment, Injury or disease / critical Illness / disability:

a. That is/are diagnosed by a physician within 36 months prior to the effective date of the Policy issued by the insurer or its reinstatement; or

b. For which medical advice or treatment was recommended by, or received from, a Physician within 36 months Prior to the effective date of the Policy issued by the insurer or its reinstatement.

In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

Coverage under the Policy after the expiry of 36 months for any Pre-Existing Disease is subject to the same being declared at the time of application and accepted by Insurer.

4. Any Critical Illness caused due to treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.
5. Narcotics used by the Insured Person unless taken as prescribed by a registered Medical Practitioner.
6. Any Critical Illness caused due to intentional self-Injury, suicide or attempted suicide, whether the person is medically sane or insane.
7. Any Critical Illness, caused by or arising from or attributable to a foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
8. Any Critical Illness caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of Nuclear Fuel, Nuclear, Chemical or Biological Attack.
9. Congenital External Anomalies, inherited disorders or any complications or conditions arising there from including any developmental conditions of the Insured.
10. Any Critical Illness caused by any treatment necessitated due to participation as a professional in hazardous or adventure sport, 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 and selfie Accident.
11. Participation by the Insured Person in any flying activity, except as a bona fide, fare paying passenger of a recognized airline on regular routes and on a scheduled timetable.
12. Any Critical Illness caused by medical treatment traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy. Any Critical Illness due to miscarriages (unless due to an Accident) and lawful medical termination of pregnancy during the Period of Insurance.
13. Any Critical Illness, caused by any Unproven/ Experimental Treatment, service and supplies for or in connection with any treatment. Unproven/ Experimental Treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
14. Any Critical Illness based on certification/Diagnosis/treatment from persons not registered as Medical Practitioners, or from a Medical Practitioner who is practicing outside the discipline that he/ she is licensed for.
15. Any Critical Illness, caused due to any treatment, including surgical management, to change characteristics of the body to those of opposite sex.
16. Any Critical Illness, caused due to cosmetic or plastic surgery or any treatment to change the 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 Person. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
17. Any Critical Illness, caused due to surgical treatment of obesity that does not fulfil all the below conditions:
    a. Surgery to be conducted is upon the advice of the Doctor

b. The Surgery / Procedure conducted should be supported by clinical protocols
c. The member has to be 18 years of age or older and
d. Body Mass Index (BMI):
   - greater than or equal to 40 or
   - greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:
     i. Obesity related cardiomyopathy
     ii. Coronary heart disease
     iii. Severe Sleep Apnea
     iv. Uncontrolled Type 2 Diabetes despite optimal therapy

17. Any Critical Illness, caused due to treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reason.

18. Any Critical Illness, caused by treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

19. In the event of the death of the Insured Person within the stipulated survival period as set out above.

20. Any Critical Illness, caused by sterility and infertility. This includes:
a. Any type of contraception, sterilization
b. Assisted Reproductive services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

Applicable for Plan B: Hospital Cash and Plan C: Equal Monthly Instalment (EMI) Protect

The Company shall not be liable for this Policy if the Hospitalization is for

1. Circumcision (unless necessary for treatment of a disease not excluded under this Policy or necessitated due to an Accident), Preputioplasty, Frenuloplasty, Preputial Dilatation and Removal of SMEGMA **-Code- Excl 19**

2. Congenital External Condition / Defects / Anomalies **- Code- Excl 20**

3. Convalescence, general debility, run-down condition, Nutritional deficiency states **- Code- Excl 21**

4. Intentional self -Injury**-Code- Excl 22**

5. Injury/disease caused by or arising from or attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not) **-Code- Excl 24**

6. Injury or disease caused by or contributed to by nuclear weapons/ materials **-Code- Excl 25**

7. Expenses incurred on Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Hyperbaric Oxygen Therapy, Rotational Field Quantum Magnetic Resonance Therapy, VAX-D, Low level laser therapy, Photodynamic therapy and such other therapies similar to those mentioned herein under this exclusion **-Code- Excl 26.**

8. Unconventional, Untested, Experimental therapies**-Code- Excl 27**

9. Autologous derived Stromal vascular fraction, Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular injection therapy **-Code- Excl 28**

10. Inoculation or Vaccination (except for post–bite treatment and for medical treatment for therapeutic reasons) **-Code- Excl 31**

11. Any Hospitalization which are not medically necessary / does not warrant Hospitalization **-Code-Excl 36**

Applicable for Plan D – Personal Accident

GENERAL EXCLUSIONS (APPLICABLE TO ALL BENEFITS AND OPTIONAL COVERS OF THIS PLAN):

The Company shall not be liable to make any payments in respect of:

1. Any claim relating to events occurring before the commencement of the cover or otherwise outside the Period of Insurance.
2. Any claim in respect of Pre-existing conditions.
   Note: "Where the Proximate cause is Accident, then the benefit will become payable as per Policy"
3. Any claim if the Insured Person acts against the advice of a physician.
4. Any claim arising out of Accidents that the Insured Person has caused a. intentionally or by committing
   a. crime
      or
   b. as a result of drunkenness or addiction (drugs, alcohol).
      or
   c. self-endangerment unless in self-defense or to save human life.
5. Insured Person engaging in Air Travel unless he/she flies as a fare-paying passenger on a Standard type aircraft properly licensed to carry passengers. For the purpose of this exclusion Air Travel means being in or on or boarding an aircraft for the purpose of flying therein or alighting there from.
6. Accidents that are results of war and warlike occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power, seizure capture arrest restraints detainments of all kings princes and people of whatever nation, condition or quality whatsoever.
7. Participation of the Insured Person in riots, confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.
8. Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from:
   a) Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self sustaining process of nuclear fission) of nuclear fuel.
   b) Nuclear weapons material
   c) The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
   d) Nuclear, Chemical, Biological Attack
9. Any claim arising out of sporting activities in so far as they involve the training or participation in competitions of professional or semi-professional sports persons.
10. Participation in Hazardous Sport / Hazardous Activities

Applicable for PLAN E – Group Health and **PLAN F – Group Top up**

The Company shall not be liable to make any payments under this Policy in respect of any expenses what so ever incurred by the Insured Person in connection with or in respect of:

Standard Exclusions

1. **Investigation & Evaluation – Code Excl 04**
   b. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded

c. Any diagnostic expenses which are not related or not incidental to the current Diagnosis and treatment are excluded

2. **Rest Cure, rehabilitation and respite care – Code Excl 05:** Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs

3. **Obesity / Weight Control – Code Excl 06:** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions;
   A. Surgery to be conducted is upon the advice of the Doctor
   B. The surgery/Procedure conducted should be supported by clinical protocols
   C. The member has to be 18 years of age or older and
   D. Body Mass Index (BMI);
      1. greater than or equal to 40 or
      2. 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:
         a. Obesity-related cardiomyopathy
         b. Coronary heart disease
         c. Severe Sleep Apnea
         d. Uncontrolled Type2 Diabetes

4. **Change-of-Gender treatments – Code Excl 07:** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

5. **Cosmetic or plastic Surgery – Code Excl 08:** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

6. **Hazardous or Adventure sports – Code Excl 09:** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7. **Breach of law – Code Excl 10:** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

8. **Excluded Providers – Code Excl 11:** 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.

9. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof **– Code Excl 12**

10. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons **– Code Excl 13**

11. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure **– Code Excl 14**
12. **Refractive Error – Code Excl 15:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
13. **Unproven Treatments – Code Excl 16:** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
14. **Sterility and Infertility – Code Excl 17:** Expenses related to sterility and infertility. This includes;
    a. Any type of contraception, sterilization
    b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    c. Gestational Surrogacy
    d. Reversal of sterilization
15. **Maternity – Code Excl 18**
    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.

Specific Exclusions

16. Circumcision unless necessary for treatment of a disease not excluded under this Policy or necessitated due to an Accident, Preputioplasty, Frenuloplasty, Preputial Dilatation and Removal of SMEGMA. **- Code Excl 19.**
17. Congenital External diseases/condition defects or anomalies - **Code Excl 20**.
18. Convalescence, general debility, run-down condition, Nutritional deficiency states - **Code Excl 21**.
19. Intentional self Injury - **Code Excl 22**.
20. Injury/disease caused by or arising from or attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not) - **Code Excl 24**.
21. Injury or disease caused by or contributed to by nuclear weapons/materials. - **Code Excl 25**.
22. Expenses incurred on Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Hyperbaric Oxygen Therapy, Rotational Field Quantum Magnetic Resonance Therapy, VAX-D, Low level laser therapy, Photodynamic therapy and such other similar therapies. - **Code Excl 26**.
23. Unconventional, untested, experimental therapies. - **Code Excl 27**.
24. Autologous derived Stromal vascular fraction, Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular injection therapy. Immunotherapy without proper indication. - **Code Excl 28**.
25. Biologicals, except when administered as an In-Patient, when clinically indicated and Hospitalization warranted. - **Code Excl 29**.
26. Inoculation or Vaccination (except for post–bite treatment and for medical treatment other than for prevention of diseases). - **Code Excl 31**.
27. Hospital registration charges, admission charges, record charges, telephone charges and such other charges - **Code Excl 34**.

28. Cost of spectacles and contact lens, hearing aids, Cochlear implants and procedures, walkers and crutches, wheel chairs, CPAP, BIPAP, Continuous Ambulatory Peritoneal Dialysis, infusion pump and such other similar aids. - **Code Excl 35**.
29. Any Hospitalizations which are not Medically Necessary - **Code Excl 36**.
30. Other Excluded Expenses as detailed in the website " www.starheath.in" **Code- Excl 37**
31. Existing disease/s, disclosed by the insured and mentioned in the Policy Schedule under Permanent Exclusion (based on insured's consent). - **Code Excl 38**.
32. Naturopathy Treatment. - **Code Excl 40**.

General Exclusions
Applicable for all plans (Plan A, B, C, D, E and F)

1. Out-patient treatment except for Accidental injuries
2. 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;
3. Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants unless prescribed by a Medical Practitioner;
4. 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;
5. Hormone Replacement Therapy;
6. Genetic tests undertaken to establish whether or not the Insured Person may be genetically disposed to the development of a medical condition in the future unless requires for current medical treatment;

F. CONDITIONS

Conditions (Applicable for Plan A, Plan B, Plan C, Plan D, Plan E and Plan F)
Standard Conditions

1. **Disclosure of Information:** The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the Insured Person.
2. **Multiple Policies:**
   i) Insured Person having multiple policies shall also have the right to prefer claims under this Policy for the amounts disallowed under any other Policy / Policies even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this Policy.
   ii) In case of multiple Policies taken by an Insured Person during a period from one or more Insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her Policies. In all such cases the Insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.
   iii) If the amount to be claimed exceeds the Sum Insured under a single Policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.
   iv) Where an Insured Person has Policies from more than one Insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen Policy.

v) In case of Benefit based policies, on occurrence of the insured event, the Insured person can claim from all insurers under policies applicable.

3. **Complete Discharge:** Any payment to the Insured Person, Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

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

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

   For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the Hospital/Medical Practitioner/any other party acting on behalf of the Insured Person, with intent to deceive the insurer or to induce the Insurer to issue an insurance Policy:

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

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

5. **Cancellation**

   Applicable for Plan E & Plan F

   i. The Policy Holder may cancel his Policy anytime during the term by giving 7 days written notice. In such an event, The Company shall

   a. refund proportionate premium for unexpired Policy period, for policy term upto one year and there is no claim (s) made during the Policy period.

   b. refund premium for the unexpired Policy period, in respect of policies with policy term more than 1 year and risk coverage for such Policy years has not commenced.

   ii. The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person by giving 15 Days written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

   Note: In case of long term policies the refund will be given after adjusting the long term discount availed by the insured/ policyholder.

   Applicable for Plan A, Plan B, Plan C, Plan D-

   i. Where policy term is less than 1 year- **no refunds will be given on cancellation where the chosen term is less than 1 year.**

ii. Where the policy term is 1 year or more, the Insured may cancel the policy by providing a notice of 7 days, and in such an event, the **Company shall refund the premium for the unexpired policy period as per the rates provided under the below tables showing cancellation charges. No refund on cancellation for policies which are on monthly instalment option.**

iii. The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person by giving 15 Days written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

Policy Term : 1 Year		
Without Instalment		
Risk period up to (months)	Retention	Refund
1	17.5%	82.5%
3	32.5%	67.5%
6	55.0%	45.0%
9	77.5%	22.5%

Policy Term : 1 Year		
Half-yearly Instalment		
Risk period up to (months)	Retention	Refund
1	35.0%	65.0%
4	80.0%	20.0%
7	62.5%	37.5%
10	85.0%	15.0%

Policy Term : 1 Year		
Quarterly Instalment		
Risk period up to (months)	Retention	Refund
1	70.0%	30.0%
4	80.0%	20.0%
7	82.5%	17.5%
10	85.0%	15.0%

Policy Term : 2 Year		
Without Instalment		
Risk period up to (months)	Retention	Refund
1	15.0%	85.0%
3	22.5%	77.5%
6	32.5%	67.5%
9	45.0%	55.0%
12	55.0%	45.0%
15	67.5%	32.5%
18	77.5%	22.5%
21	87.5%	12.5%

Policy Term : 2 Year		
Half-yearly Instalment		
Risk period up to (months)	Retention	Refund
1	35.0%	65.0%
4	80.0%	20.0%
7	62.5%	37.5%
10	85.0%	15.0%
15	87.5%	12.5%
21	87.5%	12.5%

Policy Term : 2 Year		
Quarterly Instalment		
Risk period up to (months)	Retention	Refund
1	70.0%	30.0%
4	80.0%	20.0%
7	82.5%	17.5%
10	85.0%	15.0%
13	95.0%	5.0%
16	92.5%	7.5%
19	92.5%	7.5%
22	92.5%	7.5%

Policy Term : 3 Year

Policy Term : 3 Year

Policy Term : 3 Year

Without Instalment		
Risk period up to (months)	Retention	Refund
1	12.5%	87.5%
3	17.5%	82.5%
6	25.0%	75.0%
9	32.5%	67.5%
12	40.0%	60.0%
15	47.5%	52.5%
18	55.0%	45.0%
21	62.5%	37.5%
24	70.0%	30.0%
27	77.5%	22.5%
30	85.0%	15.0%
33	92.5%	7.5%

Half-yearly Instalment		
Risk period up to (months)	Retention	Refund
1	35.0%	65.0%
4	80.0%	20.0%
7	62.5%	37.5%
10	85.0%	15.0%
15	87.5%	12.5%
21	87.5%	12.5%
27	92.5%	7.5%
33	92.5%	7.5%

Quarterly Instalment		
Risk period up to (months)	Retention	Refund
1	70.0%	30.0%
4	80.0%	20.0%
7	82.5%	17.5%
10	85.0%	15.0%
13	95.0%	5.0%
16	92.5%	7.5%
19	92.5%	7.5%
22	92.5%	7.5%
25	97.5%	2.5%
28	95.0%	5.0%
31	95.0%	5.0%
34	95.0%	5.0%

Policy Term : 4 Year Without Instalment		
Risk period up to (months)	Retention	Refund
1	12.5%	87.5%
3	17.5%	82.5%
6	22.5%	77.5%
9	27.5%	72.5%
12	32.5%	67.5%
15	40.0%	60.0%
18	45.0%	55.0%
21	50.0%	50.0%

Policy Term : 4 Year Half-yearly Instalment		
Risk period up to (months)	Retention	Refund
1	35.0%	65.0%
4	80.0%	20.0%
7	62.5%	37.5%
10	85.0%	15.0%
15	87.5%	12.5%
21	87.5%	12.5%
27	92.5%	7.5%
33	92.5%	7.5%

Policy Term : 4 Year Quarterly Instalment		
Risk period up to (months)	Retention	Refund
1	70.0%	30.0%
4	80.0%	20.0%
7	82.5%	17.5%
10	85.0%	15.0%
13	95.0%	5.0%
16	92.5%	7.5%
19	92.5%	7.5%
22	92.5%	7.5%

24	55.0%	45.0%
27	62.5%	37.5%
30	67.5%	32.5%
33	72.5%	27.5%
36	77.5%	22.5%
39	85.0%	15.0%
42	90.0%	10.0%
45	95.0%	5.0%

39	95.0%	5.0%
45	95.0%	5.0%

25	97.5%	2.5%
28	95.0%	5.0%
31	95.0%	5.0%
34	95.0%	5.0%
37	97.5%	2.5%
40	97.5%	2.5%
43	97.5%	2.5%
46	97.5%	2.5%

Policy Term : 5 Year		
Without Instalment		
Risk period up to (months)	**Retention**	**Refund**
1	12.5%	87.5%
3	15.0%	85.0%
6	20.0%	80.0%
9	25.0%	75.0%
12	30.0%	70.0%
15	32.5%	67.5%
18	37.5%	62.5%
21	42.5%	57.5%
24	47.5%	52.5%
27	52.5%	47.5%
30	55.0%	45.0%
33	60.0%	40.0%
36	65.0%	35.0%

Policy Term : 5 Year		
Half-yearly Instalment		
Risk period up to (months)	**Retention**	**Refund**
1	35.0%	65.0%
4	80.0%	20.0%
7	62.5%	37.5%
10	85.0%	15.0%
15	87.5%	12.5%
21	87.5%	12.5%
27	92.5%	7.5%
33	92.5%	7.5%
39	95.0%	5.0%
45	95.0%	5.0%
51	95.0%	5.0%
57	95.0%	5.0%

Policy Term : 5 Year		
Quarterly Instalment		
Risk period up to (months)	**Retention**	**Refund**
1	70.0%	30.0%
4	80.0%	20.0%
7	82.5%	17.5%
10	85.0%	15.0%
13	95.0%	5.0%
16	92.5%	7.5%
19	92.5%	7.5%
22	92.5%	7.5%
25	97.5%	2.5%
28	95.0%	5.0%
31	95.0%	5.0%
34	95.0%	5.0%
37	97.5%	2.5%

39	70.0%	30.0%
42	75.0%	25.0%
45	77.5%	22.5%
48	82.5%	17.5%
51	87.5%	12.5%
54	92.5%	7.5%
57	97.5%	2.5%

40	97.5%	2.5%
43	97.5%	2.5%
46	97.5%	2.5%
49	97.5%	2.5%
52	97.5%	2.5%
55	97.5%	2.5%
58	97.5%	2.5%

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

7. **Redressal of Grievance:** In case of any grievance the Insured Person may contact the Company through

   Website : www.starhealth.in

   E-mail : grievances@starhealth.in, gro@starhealth.in

   Ph. No. : 044-69006900 | Toll Free No. 1800 425 2255
   Senior Citizens may call at 044-69007500

   Courier/ Post: Star Health and Allied Insurance Company Limited 4th Floor, Balaji Complex, No.15, Whites Lane, Whites Road, Royapettah, Chennai- 600014

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

   If Insured person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at 044-43664600.

   For updated details of grievance officer, kindly refer the link
   https://www.starhealth.in/grievance-redressal

   If Insured person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017, as amended from time to time.

   Grievance may also be lodged at IRDAI integrated Grievance Management System - https://bimabharosa.irdai.gov.in/

8. **Claim Settlement**

I. Condition Precedent to Admission of Liability (Applicable for Plan A, Plan B, Plan C, and Plan D): The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

II. Notification of Claim (Applicable for Plan A, Plan B, Plan C, and Plan D): Upon the happening of any event, which may give rise to a valid claim under this Policy, notice with full particulars shall be sent to the Company within 15 Days from the date of occurrence of the event / Diagnosis of Critical Illness
Note: Any Medical Practitioner authorized by the Company shall be allowed to examine the Insured Person/s in case of any alleged Injury or diseases requiring Hospitalization when and as often as the same may reasonably be required on behalf of the Company at the Company's cost.

III. **Submission of Documents**

a. **Applicable for Plan A:** The Insured Person or person(s) claiming on behalf of the Insured Person shall submit within 15 Days of notification of claim, the filled and signed claim form and all relevant documents, information medical records and any other information/ documents the Company may request, to establish the Claim made
The company may examine and relax the time limits depending upon the merits of the Case
Such documents include but not limited to the following:-
- Claim form duly completed and signed
- Medical Certificate confirming the Diagnosis / treatment of critical Illness from the treating Medical Practitioner in letter head.
- All Diagnostic test results / Imaging confirming positive existence of critical Illness
- Discharge summary / in case papers / complete treatment records (wherever applicable)
- Treating Medical Practitioner's certificate regarding the duration & etiology of the Critical Illness in letter head.
- Any other document specific to the treatment / Illness
- Copy of PAN Card
- Copy of Aadhar Card
- KYC (Identity proof with Address) of the proposer, as per AML Guidelines

b. Applicable for Plan B & C :
Claim must be filed within 15 Days from the date of discharge from the Hospital.
Note: Conditions 2 & 3 are precedent to admission of liability under the Policy. However the Company may examine and relax the time limit mentioned in these conditions depending upon the merits of the case
The Insured Person/s shall submit to the Company:-
a. Duly completed claim form, and
b. Discharge Summary from the Hospital
c. Hospital Main bill with breakup details.
d. KYC (Identity proof with Address) of the proposer, as per AML Guidelines

c. Applicable for Plan D :
Documents to be submitted for claims:
Duly completed claim form, copy of PAN Card and Aadhar Card of the Insured Person Nominee / Legal Heir as the case may be
and
For Death Claims:-
- Death Certificate
- Post-mortem Certificate, if conducted

- FIR (wherever required)
- Police Investigation report / Panchanama (wherever required)
- Viscera Sample Report / Chemical analysis report (wherever required)
- Forensic Laboratory Report (wherever required)
- Legal Heir Certificate (wherever required)
- Succession Certificate (wherever required)

For Permanent Total Disablement - Benefit 2 and Permanent Partial Disablement - Benefit 3

- Certificate from Government doctor not below the rank of Civil Surgeon, confirming the disability and its %.

Note: The Company authorized doctor may examine the Insured Person/s if required

For Temporary Total Disablement (Weekly Compensation) - Benefit 4

- Certificate from the employer confirming leave of absence from duty (applicable for employer – employee group)
- Certificate from the treating doctor that the claimant is fit to resume duty (fitness certificate)

Travel expenses for one relative

- Proof of expenses incurred (original)

Vehicle and/or residence modification

- Certificate from the Medical Practitioner confirming the Disability and the requirement of modification
- Estimate from Workshop
- Invoice and Cash receipt for having carried the modification
- Estimate from civil engineer
- Invoice / Cash receipt for completion of the civil work modification

Purchase of blood:

- Original receipt for purchase of blood (wherever applicable)

Transportation of imported medicines:

- Prescription of the treating Medical Practitioner with confirmation that the medicine is not available in India.
- Original receipt for the freight incurred for import of the medicine, along with a copy of invoice

Ambulance charges / transportation expenses of mortal remains

- Death Certificate or
- Proof of Hospitalisation
- Proof of utilized services of either Ambulance or Mortuary Van (Original Receipt)

Medical expenses due to Accident:

- Original Discharge Summary (wherever applicable)
- Original Medical Reports
- Original Invoices/Bills,
- Original Payment Receipts

Hospital Cash and Home Convalescence

- Discharge Summary (Where original is required for other purposes, a certified copy may be submitted)
- Recommendation by the treating Medical Practitioner for appointing an attendant at home for continuation of treatment.
- Cash receipt for payment made to the attendant

Educational Benefit

- Death certificate of Parent/s or Guardian
- Age proof of the student
- Proof of education.

Note: The Company reserves the right to call for additional documents wherever required.

Out Patient Medical Expenses due to Grievous Injury

- Original Prescription
- Original Invoices/Bills,
- Original Payment Receipts

Note

1. For assistance call 24 hours help-line 044-69006900 or Toll Free No. 1800 425 2255, Senior Citizens may call at 044-40020888
2. KYC (Identity proof with Address) of the proposer, as per AML Guidelines

9. **Renewal of Policy (Applicable for Plan B, Plan C and Plan D):** The Policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person.
   i). Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding Policy years.
   ii). Request for renewal along with requisite premium shall be received by the Company before the end of the Policy period.
   iii). At the end of the Policy period, the Policy shall terminate and can be renewed within the Grace Period of 30 Days to maintain continuity of benefits without break in Policy.
   iv). Coverage is not available during the Grace Period.
10. **Premium Payment in Instalments (Applicable for Plan A, Plan B, Plan C and Plan D):** If the insured person has opted for Payment of Premium on an installment basis i.e. Half Yearly or Quarterly or Monthly or as mentioned in the Policy Schedule/Certificate of Insurance, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

    i. For monthly instalment option: Grace Period of 15 days would be given to pay the instalment premium due for the policy.

    ii. For Quarterly and Half yearly instalment option: Grace Period of 30 days would be given to pay the instalment premium due for the policy.

    iii. The insured person will get the accrued continuity benefit in respect of the (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) in the event of payment of premium within the stipulated grace Period

    iv. No interest will be charged If the instalment premium is not paid on due date.

    v. In case of instalment premium due not received within the grace period, the policy will get cancelled.

    vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

    vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

    viii. For premium paid in instalments during the policy period, coverage is available during the grace period also

11. **Possibility of Revision of Terms of the Policy including the Premium Rates (Applicable for Plan A, Plan B, Plan C and Plan D):** The Company, may revise or modify the terms of the Policy including the

premium rates as per the extant Guidelines. The Insured Person shall be notified thirty days before the changes are effected.

Specific Conditions (Applicable for Plan A, Plan B, Plan C, Plan D, Plan E, Plan F)

12. The premium payable under this Policy shall be payable in advance. No receipt of premium shall be valid except when acknowledged on the official form of the Company signed by a duly authorized official of the Company. The due payment of premium and the observance of fulfillment of the terms, provision, conditions and endorsements of this policy by the Insured Person/s, in so far as they relate to anything to be done or complied with by the Insured Person/s, shall be a condition precedent to admission any liability of the Company to make any payment under this Policy. No waiver of any terms, provisions, conditions, and endorsements of this Policy shall be valid unless made in writing and signed by an authorized official of the Company.
13. **Territorial Limit:** All medical /surgical treatments under this Policy shall have to be taken in India. This condition will not apply if optional cover II (6) – Worldwide Hospital Cash is opted.
14. All claims under this Policy shall be payable in Indian currency.
15. **Notices:** Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or email to Star Health and Allied Insurance Company Limited, No.1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai 600034. Customer Care No. 044-69006900 or Toll Free No. 1800 425 2255, e-mail: support@starhealth.in. Notice and instructions will be deemed served 7 Days after posting or immediately upon receipt in the case of hand delivery or e-mail
16. **Customer Service:** If at any time the Insured Person requires any clarification or assistance, the Insured Person may contact "Balaji Complex, No.15, Whites Lane, Whites Road, Royapettah, Chennai- 600014", during normal business hours.
17. **Excluded Hospitals (providers):** Insured can refer the company website using the following link to the list of excluded Hospitals. https://www.starhealth.in/lookup/Hospital/#excluded-Hospital

Specific Conditions (Applicable for Plan A, Plan B, Plan C and Plan D)

18. **Addition and deletion of Insured Persons / Beneficiary**
Addition of persons into this Group Policy can be made only on payment of additional premium.
Refund of premium for deletion of persons from the Group can be made on pro-rata basis subject to there being “No claim” in respect of such persons.
19. **Automatic Expiry**: The insurance under this Policy with respect to each relevant Insured Person shall expire immediately on the earlier of the following events:
    - ✓ Upon the death of the Insured Person.
    - ✓ Upon exhaustion of the Hospital Cash Amount chosen.
    - ✓ Upon exhaustion of the Maximum number Hospital Cash Days per year chosen.
    - ✓ Upon Payment of a claim under Plan A
    - ✓ Upon Payment of 100% Sum Insured under Plan D
    - ✓ At the expiry of the Period of Insurance for which the premium has been paid or on the expiry date shown in the Policy Schedule/Certificate of Insurance whichever is earlier.
20. **Automatic Termination of Individual Certificate of Insurance**. The Certificate of Insurance will terminate on the earliest of the following dates:
    1. The date of expiry of certificate of insurance or
    2. The date the Insured Person is no longer eligible to be within the classification of Insured Person(s) described in the Policy Schedule / Certificate of Insurance or

3. The Insured Person ceases to be a resident of India or
4. From the date the Certificate of Insurance is cancelled either by the Group Administrator or by the Company
5. From the date on which the premium when due, is not received (applicable only if payment is agreed to be received in instalment)

21. Material change: The Group Administrator shall immediately notify the Company in writing of any change in his business or occupation or physical defect or infirmity with which the Insured Person/s has become affected.

22. Role of Group Administrator / Proposer: The Group Administrator / Proposer shall play a facilitative role between the Insurer and the Insured Person. Such role includes

1) Furnishing to the Company detailed list of Insured Person/s for preparation of Certificate of Insurance.
2) Distributing Certificate of Insurance received from the Company. (However, where the Company / Certificate of Insurance in electronic form directly to the Insured Person/s this will not apply).
3) Facilitating Insured Person / s in availing all insurance related services
4) To make payment of premium on or before the stipulated time.
5) Immediately notify the Company of any change in business or occupation of the proposer or Insured entity or any physical defect or infirmity of the Insured Person with which the Insured Person becomes affected.
6) If an Insured Person leaves the group as per group rules, Group Administrator should facilitate to provide option to migrate to another Policy at premium as applicable for such individual insurance. In such event:-
   a. Insured Person who have been covered continuously for a period of one year under this Policy with the Company, 30 Days Waiting Period shall be waived.
   b. Insured Person who have been covered continuously for a period of two years under this Policy with the Company, 30 Days Waiting Period and First two year Waiting Period shall be waived.
   c. In respect of Insured Person who have been covered continuously for a period a threeyears or more under this Policy with the Company, 30 Days Waiting Period, First two year waiting period, 36 months Waiting Period with reference to Pre Existing Diseases shall be waived.

23. Duties of the Group Administrator / Proposer / Insured Person on occurrence of loss

On the occurrence of any loss, within the scope of cover under the Policy the Insured Person shall:

i) Forthwith file/submit a Claim Form in accordance with 'Obligation of the Insured Person' Clause as provided in General Conditions.
ii) If the Insured Person does not comply with the provisions of this Clause or other obligations cast upon the Insured Person under this Policy, in terms of the other clauses referred to herein or in terms of the other clauses in any of the Policy documents, all benefits under the Policy shall be forfeited, at the option of the Company.

24. Fraudulent claims: If any claim is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Group Administrator / Proposer / Insured Person or anyone acting on his behalf to obtain any benefit under this Policy, shall be forfeited and the Policy will be cancelled without any refund of premium

25. Important Note:

1. The Policy Schedule, Certificate of Insurance and any Endorsement are to be read together and any word or such meaning wherever it appears shall have the meaning as stated in the Act / Indian Laws

2. The terms conditions and exceptions that appear in the Policy Schedule, Certificate of Insurance or in any Endorsement are part of the contract, must be complied with and applies to each relevant Insured Person. Failure to comply with may result in the claim being denied.
3. The attention of the Policy Holder/Insured Person is drawn to the website www.starhealth.in for anti fraud Policy of the company for necessary compliance by all stake holders.

26. Policy disputes: Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured Person and the Company to be subject to Indian Law.

CONDITIONS (Applicable for Plan E and Plan F)

Standard Conditions (Applicable for Plan E and Plan F)

1. Claim Settlement

A. Condition Precedent to Admission of Liability: The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

B. Documents for Cashless Treatment:

a. For assistance call 24 hours help-line 044-69006900 or Toll Free No. 1800 425 2255, Senior Citizens may call at 044-40020888
b. Inform the ID number for easy reference
c. On admission in the Hospital, produce the ID Card issued by the Company at the Hospital Helpdesk
d. Obtain the Pre-authorisation Form from the Hospital Help Desk, complete the Patient Information and resubmit to the Hospital Help Desk.
e. The Treating Medical Practitioner will complete the Hospitalisation/ treatment information and the Hospital will fill up expected cost of treatment. This form is submitted to the Company
f. The Company will process the request and call for additional documents / clarifications if the information furnished is inadequate.
g. Once all the details are furnished, the Company will process the request as per the terms and conditions as well as the exclusions therein and either approve or reject the request based on the merits.
h. In case of emergency Hospitalization information to be given within 24 hours after Hospitalization
i. Cashless facility can be availed only in Networked Hospitals. For details of Networked Hospitals, the Insured Person may visit www.starhealth.in or contact the nearest branch.
j. KYC (Identity proof with Address) of the proposer, as per AML Guidelines

In non-network Hospitals payment must be made up-front and then reimbursement will be effected on submission of documents.

Note: The Company reserves the right to call for additional documents wherever required.

Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person can go ahead with the treatment, settle the Hospital bills and submit the claim for a possible reimbursement.

C. For Reimbursement claims : Time limit for submission of

Sl.no.	Type of Claim	Prescribed time limit
1	Reimbursement of Hospitalization, day care and pre Hospitalization expenses	Claim must be filed within 15 Days from the date of discharge from the Hospital.

2	Reimbursement of Post Hospitalization	within 15 Days after date of discharge from Hospital

D. Notification of Claim: Upon the happening of the event, notice with full particulars shall be sent to the Company within 24 hours from the date of occurrence of the event irrespective of whether the event is likely to give rise to a claim under the Policy or not.

Note: Conditions C and D are precedent to admission of liability under the Policy. However the Company will examine and relax the time limit mentioned in these conditions depending upon the merits of the case.

E. Documents to be submitted for Reimbursement: The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

a. Duly completed claim form, and
b. Pre Admission investigations and treatment papers.
c. Discharge Summary from the Hospital
d. Cash receipts from Hospital, chemists
e. Cash receipts and reports for tests done
f. Receipts from Medical Practitioner, surgeons, anesthetist
g. Certificate from the attending Medical Practitioner regarding the Diagnosis.
h. Copy of PAN card
i. Organ transplant on the Insured Person shall satisfy the requirements of the Transplantation of Human Organs Act of 1994 and any amendments thereto.
j. KYC (Identity proof with Address) of the proposer, as per AML Guidelines
k. NEFT documents viz., Customer name, Bank Account No., Name of the Bank, IFSC code
l. CKYC No. of the proposer

Note: For assistance call 24 hours help-line 044-69006900 or Toll Free No. 1800 425 2255, Senior Citizens may call at 044-40020888

2. Migration: (Applicable for Plan B, Plan C, Plan E and Plan F) In case of migration of one policy to another with the same insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.

3. Renewal of Policy: The Policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person.

1. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding Policy years.
2. Request for renewal along with requisite premium shall be received by the Company before the end of the Period of Insurance.
3. At the end of the Period of Insurance, the Policy shall terminate and can be renewed within the Grace Period of 30 Days to maintain continuity of benefits without break in Policy.
4. Coverage is not available during the Grace Period.
5. In the event of the group Policy being discontinued or not renewed or when the Insured Person of the group leave the group on account of resignation/retirement/termination or otherwise, the following provision shall apply.
   a. The Insured Person/s covered under this group Policy will be granted cover under Indemnity based Individual Health Policy. In respect of Insured Persons who have been covered

continuously for a period of one year under this group Policy with the Company, exclusion Code Excl – 03 shall be waived.

b. In respect of Insured Persons who have been covered continuously for a period of two years under this group Policy with the Company, exclusions Code Excl-03 and Code Excl-02 shall be waived

c. In respect of Insured Persons who have been covered continuously for a period of three years under this group Policy with the Company, exclusions Code Excl-03, Code Excl-02 and Code Excl-01 shall be waived.

4. **Arbitration:** The parties to the contract may mutually agree and enter into a separate Arbitration Agreement to settle any and all disputes in relation to this Policy. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996."

5. **Withdrawal of Policy**
   i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 Days prior to expiry of the Policy.
   ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of Waiting Period as per IRDAI guidelines, provided the Policy has been maintained without a break.

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

Specific Conditions (Applicable for Plan E and Plan F)

7. The Insured Person shall obtain and furnish the Company with all original bills, receipts and other documents upon which a claim is based and shall also give the Company such additional information and assistance as the Company may require in dealing with the claim

8. Any Medical Practitioner authorized by the Company shall be allowed to examine the Insured Person/s in case of any alleged Injury or diseases requiring Hospitalization when and as often as the same may reasonably be required on behalf of the Company at the Company's cost.

9. **Addition / Deletion:** Addition: Enrolment of new Insured Persons / Beneficiary will be made during the Period of Insurance stated in the master Policy Schedule / Certificate of Insurance. The Period of Insurance for such newly enrolled Insured Person / Beneficiary will be for a period of one year as stated in the Policy Schedule / Certificate of Insurance issued to the Insured Person / Beneficiary. Such new enrolment of Insured Persons/Beneficiary will be on mutual agreed terms at the Commencement Date of the Policy.

   Deletion of Insured Persons / Beneficiary from the Group can be made and refund will be effected on pro-rata basis from the date of request for deletion of the Insured Person(s) / Beneficiary subject to NO claim being made in respect of that Insured Person(s) / Beneficiary or his/her family member(s).

10. **Automatic Termination**: The insurance under this Policy with respect to each relevant Insured Person, Beneficiary / family shall terminate immediately on the earlier of the following events:

1. Upon the death of the Insured Person. This also means that in case of family floater Policy, cover for the other surviving members of the family will continue, subject to other terms of the Policy.
2. Upon exhaustion of the Sum Insured.

11. Policy disputes: Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law.

12. Automatic Termination of Individual Certificate of Insurance. The Certificate of Insurance will terminate on the earliest of the following dates:

1. The date of expiry of Certificate of Insurance or
2. The date the Insured Person / Beneficiary is no longer eligible to be within the classification of Insured Person(s) described in the Policy Schedule or
3. The Insured Person / Beneficiary ceases to be a resident of India or
4. From the date the Certificate of Insurance is cancelled either by the Company

13. All claims under this Policy shall be payable in Indian currency. All medical /surgical treatments under this Policy shall have to be taken in India. This condition will not apply if optional cover II (6) Worldwide Hospital Cash is opted.

14. Important Note:

a. Where the Policy is on floater basis, the Sum Insured and sub-limits float amongst family members covered.

b. The Policy Schedule, Certificate of Insurance and Endorsement are to be read together and any word or such meaning wherever it appears shall have the meaning as stated in the Act / Indian Laws. The Special Conditions if any stated in the Policy Schedule / Certificate of Insurance supersede these Policy Wordings.

c. The terms conditions and exceptions that appear in the Policy or in any Endorsement are part of the contract, must be complied with. Failure to comply may result in the claim being denied.

d. The attention of the Policy holder / Insured Person is drawn to our website www.starhealth.in for anti fraud Policy of the company for necessary compliance by all stake holders

15. Role of Group Administrator / Proposer

The Group Administrator / Proposer shall play a facilitative role between the Insurer and the Insured Person. Such role includes.

1) Furnishing to the Company detailed list of Insured Person/s for preparation of Policy Schedule / Certificate of Insurance and ID cards.

2) Distributing Certificate of Insurance and ID cards received from the Company. (However, where the Company issues ID card / Certificates of Insurance in electronic form directly to the Insured Person/s this will not apply).

3) Facilitating Insured Person / s in availing all insurance related services including cashless facility wherever required.

4) If a Insured Person leaves the group as per group rules, Group Administrator should facilitate to provide option to migrate to another Policy at premium as applicable for such individual insurance. In such event:-

   a. Insured Person who have been covered continuously for a period of one year under this Policy with the Company, 30 Days Waiting Period Code Excl 03 and First year exclusions **Code Excl 02** (For Plan E – 12 months and for Plan F – 12 months) shall be waived.

b. Insured Person who have been covered continuously for a period of two years under this Policy with the Company, 30 Days Waiting Period **Code Excl 03**, First year exclusions **Code Excl 02** (For Plan E – 12 months and for Plan F – 12 months) and First two year exclusions **Code Excl 02** (For Plan F – 24months) shall be waived.

c. In respect of Insured Person who have been covered continuously for a period a three years under this Policy with the Company, 30 Days waiting period **Code Excl 03**, First year exclusions, First two year exclusions **Code Excl 02** (For Plan E – 12 months and for Plan F – 12 months) and First two year exclusions **Code Excl 02** (For Plan F – 24months), Pre Existing Disease Exclusion **Code Excl 01** (For Plan E – 36 months and for Plan F -36 months) shall be waived.

List of Ombudsman

Office Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet,	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).

Office Details	Jurisdiction of Office (Union Territory, District)
CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
KOCHI Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp.to Maharaja's College, M. G. Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363/2740798	Rajasthan.

Office Details	Jurisdiction of Office (Union Territory, District)
Email: bimalokpal.jaipur@cioins.co.in	
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 – 4002082/ 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022-69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj,

Office Details	Jurisdiction of Office (Union Territory, District)
	Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).
Kindly refer to the link below, for future updates in Ombudsman address: https://cioins.co.in/Ombudsman	

List I — Items for which coverage is not available in the policy (Applicable for Plan E and F)

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES

15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED
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
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

Items that are to be subsumed into Room Charges (Applicable for Plan E and F)

Sl No	ITEM
1	BABY CHARGES (UNLESS SPECIFIED / INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH

14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET / WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

Items that are to be subsumed into Procedure Charges (Applicable for Plan E and F)

Sl No.	ITEM
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (FOR SITE PREPARATIONS)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES

7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

Items that are to be subsumed into costs of treatment (Applicable for Plan E and F)

Sl No.	ITEM
1	ADMISSION / REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION / DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP / CAPD EQUIPMENTS
7	INFUSION PUMP — COST
8	HYDROGEN PEROXIDE / SPIRIT / DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH

12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABS
16	SCRUB SOLUTION / STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Schedule of Benefits	
Benefit	**Percentage of the Sum Insured**
Accidental Death – Benefit 1	100%
Permanent Total Disablement – Benefit 2	
a. Sight of both eyes	100%
b. Physical separation of two entire hands	100%
c. Physical separation of two entire foot	100%
d. One entire hand and one entire foot	100%
e. Sight of one eye and loss of one hand	100%
f. Sight of one eye and loss of one entire foot	100%
g. Use of two hands	100%
h. Use of two foot	100%
i. Use of one hand and one foot	100%
j. Sight of one eye and use of one hand	100%
k. Sight of one eye and use of one foot	100%
l. Sight of one eye	50%
m. Physical separation of one entire hand	50%
n. Physical separation of one entire foot	50%
o. Use of one hand without physical separation	50%
p. Use of one foot without physical separation	50%
Loss of Foot/hand means total severance through or above the ankle/wrist joints respectively. Loss of Eye means entire and irrevocable loss of sight.	

Permanent Partial Disablement – Benefit 3	
a. Loss of toes all	20%
b. Loss of Great toe (Both Phalanges)	5%
c. Loss of Great toe (One Phalanx)	2%
d. Other than Great, if more than One toe lost, for each toe	1%
e. Loss of hearing both ears	75%
f. Loss of hearing one ear	30%
g. Loss of four fingers and thumbs of One hand	40%
h. Loss of four fingers	35%
i. Loss of thumb both phalanges (Both Phalanges)	25%
j. Loss of thumb both phalanges (One phalanx)	10%
k. Loss of index finger three phalanges	10%
l. Loss of index finger two phalanges	8%
m. Loss of index finger One phalanx	4%
n. Loss of middle finger three phalanges	6%
o. Loss of middle finger Two phalanges	4%
p. Loss of middle finger One phalanx	2%
q. Loss of ring finger Three Phalanges	5%
r. Loss of ring finger Two Phalanges	4%
s. Loss of ring finger One Phalanx	2%
t. Loss of little finger Three phalanges	4%
u. Loss of little finger Two phalanges	3%
v. Loss of little finger One phalanx	2%
w. Loss of metacarpals	3%
x. Additional (Third, fourth or fifth)	2%
y. Any other Permanent partial disablement	Percentage as assessed by the Medical Board or by the government Medical Practitioner
Loss of Thumb or index finger means actual severance through or above the joint that meets the hand at the palm.	

Table – B1			
Physical function already impaired prior to Accident			**Percentage Of Sum Insured Deducted**
1	Loss of toes all	All	20
	Loss of Great toe	both phalanges	5
	Loss of Great toe	one phalanx	2
	Other than Great, if more than		
	One toe lost, for each toe	For each toe	1
2	Loss of hearing both ears	Both ears	75
	Loss of hearing one ear	One ear	30
3	Loss of four fingers and thumbs of One hand		40
4	Loss of four fingers		35
	Loss of thumb both phalanges	Both phalanges	25
		One phalanx	10
5	Loss of index finger three phalanges	Three phalanges	10
	Two phalanges	Two phalanges	8
	One phalanx	One phalanx	4
6	Loss of middle finger	Three phalanges	6
		Two phalanges	4
		One phalanx	2
7	Loss of ring finger	Three phalanges	5
		Two phalanges	4
		One phalanx	2
8	Loss of little finger	Three phalanges Two phalanges One phalanx	4 3 2
9	Loss of metacarpals	First or second	3
		Additional (third fourth or fifth)	2
10	Any other Permanent partial disablement		Percentage as assessed by the Medical Board or by the government Medical Practitioner