MAGMA
General Insurance Limited

Group Health Insurance

Policy Wordings

Magma General Insurance Limited (erstwhile Magma HDI General Insurance Company Limited) | www.magmainsurance.com | E-mail: customercare@magmainsurance.com | Toll Free: 1800 266 3202 | Registered Office: Development House, 24 Park Street, Kolkata – 700016, West Bengal. | CIN: U66000WB2009PLC136327 | IRDAI Reg. No. 149 | Group Health Insurance | Product UIN: MAGHLGP21234V022021 | For complete list of details on exclusions, risk factors, terms & conditions, please read the policy documents carefully before concluding a sale. | Trade Logo displayed above belongs to Magma Ventures Private Limited and is used by Magma General Insurance Limited under license. | Chat with MIRA on our website or say “Hi” on WhatsApp No. 7208976789 (PW.GHI.ver10.12.24)

A. Preamble

The insurance cover provided under this Policy up to the Sum Insured is and shall be subject to (a) the terms and conditions of this Policy, (b) the receipt of premium, and (c) Disclosure to information and statements which the Policyholder/ Insured person has provided in the proposal form for all persons to be insured. Please inform Us immediately of any change in the address, nature of job, state of health, or of any other changes affecting any Insured Person.

If any claim arising as a result of an Illness or Injury that occurred during the Policy Period becomes payable, then We shall pay the Benefits in accordance with the terms, conditions and exclusions of the Policy subject to availability of Sum Insured.

B. Definitions

The terms defined below have the meaning ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural, references to male include female and references to any statutory enactment include subsequent changes, replacements or amendments to the same:

i. Standard Definitions

- **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
- **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital or

b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/ Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with the following criterion:

   i. Having at least 5 in-patient beds;

   ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

   iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

   iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

AYUSH Hospitals referred above shall also obtain either pre-entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC).

- **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local

authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/ para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

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

- **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.
- **Cashless facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.
- **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon
- **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

- **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
- **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 criteria 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 Insurance company's authorized personnel.

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

  i. undertaken under General or Local Anaesthesia 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.

- **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
- **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
  i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
  ii. the patient takes treatment at home on account of non-availability of room in a hospital.
- **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** 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 insurance company's authorized personnel:
- **Hospitalisation** 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** means 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** 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** 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** 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 (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.
- **Maternity expenses** means:

  a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

  b) expenses towards lawful medical termination of pregnancy during the policy period.

- **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
- **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
- **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 setup 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 licence.
- **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** means hospitals 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** means baby born during the Policy Period and is aged up to 90 days.
- **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
- **Non-Network Provider** means any hospital, day care centre or other provider that is not part of the network.
- **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-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.
- **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:
  i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
  ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- **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 insurance company.
- **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** 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.
- **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.
- **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
- **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** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
- **Break in policy** means the period of gap that occurs at the end of the existing policy term/ installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
- **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.
- **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.
- **Complaint or Grievance** means written expression (includes communication in the form of electronic mail or voice based electronic scripts) of dissatisfaction by a complainant with respect to solicitation or sale or purchase of an insurance policy or related services by insurer and /or by distribution channel.

  Explanation: An inquiry or service request would not fall within the definition of the complaint or grievance.
- **Complainant** means a policyholder or prospect or nominee or assignee or any beneficiary of an insurance policy who has filed a complaint or grievance against an insurer and /or distribution channel.
- **Mis-selling** includes sale or solicitation of policies by the insurer or through distribution channels, directly or indirectly by

  a. exercising undue influence, use of dominant position or otherwise, or

  b. making a false or misleading statement or misrepresenting the facts or benefits, or

  c. concealing or omitting facts, features, benefits, exclusions with respect to products, or

  d. not taking reasonable care to ensure suitability of the policy to the prospects/policyholders.

- **Proposal form** means a form to be filled in by the prospect in physical or electronic form, for furnishing the information including material information, if any, as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.
- **Prospectus** means a document either in physical or electronic format issued by the insurer to sell or promote the insurance product.

ii. **Specific Definitions**

- **Act of God Perils** means and includes lightening, storm, tempest, flood, inundation, subsidence, landslide, earthquake, cyclone, tsunami, volcano and other similar calamities.
- **Adventure Sport** means any sport or activity, which is potentially dangerous to the Insured Person whether he is trained in such sport or activity or not. Such sport/activity includes without limitation stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/obstacle riding, bobsleighing/using skeletons, bouldering, boxing, canyoning, caving/pot holing, cave tubing, rock climbing/trekking/mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labour, marathon running, martial arts, micro-lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo riding, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling any type and Professional Sports (Professional sports mean Athletics, Bowling, Cycling, Football, Weightlifting, Cricket or any other sport for which a person getting compensated).
- **Age** or Aged means age as on last birthday
- **Annexure** means the document attached and marked as Annexure to this Policy
- **Cover Start Date** means the date on which the coverage under the Policy starts for respective Insured person.
- **Certificate of Insurance** means the certificate issued by Us to the insured person confirming the coverage under the Policy.
- **Diagnostic Tests:** Investigations, such as X-Ray or blood tests, to find the cause of the Insured Person's symptoms and medical condition.
- **Emergency** means a severe 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.
- **Family Floater Policy** means a policy named as a Family Floater Policy in the Policy Schedule in terms of which, two or more persons of Insured Person's family are covered as dependents to Insured Person. The definition of Family shall be as mentioned in Policy Schedule/Certificate of Insurance. For

a Floater policy, Sum Insured is available on Floater basis for the covered family members. Insurer's liability for any and all claims with respect to all family members is limited to the Sum Insured.

- **Hospital** Only for the purposes of any claim or treatment permitted to be made or taken outside India Hospital (outside India) means an institution (including nursing homes) established outside India for indoor medical care and treatment of Illness and/or Injuries which has been registered and licensed as such with the appropriate local or other authorities in the relevant area, wherever applicable, and is under the constant supervision of a medical practitioner. The term Hospital shall not include a clinic, rest home, or convalescent home for the addicted, detoxification centre, sanatorium, and old age home.
- **IRDAI** means the Insurance Regulatory and Development Authority of India.
- **Insured Person** means the person(s) named in the Policy Schedule/ Certificate of Insurance who are covered under this Policy and in respect of whom the appropriate premium has been received.
- **Policy** means this Policy document, any annexures thereto and the Policy Schedule including endorsements, if any, Your statements in the proposal form and the Information Summary Sheet as applicable.
- **Policy Start Date** means the start date of the Policy as specified in the Policy Schedule.
- **Policy Expiry Date** means the date on which the Policy expires as specified in the Policy Schedule.
- **Policy Period** means the period between the Policy Start Date and the Policy Expiry Date as shown in the Policy Schedule.
- **Policy Year** means a period of twelve consecutive months commencing from the Policy Start Date as specified in the Policy Schedule or any anniversary thereof.
- **Policyholder** means the person named in the Policy Schedule as the policyholder and who has concluded this Policy with Us.
- **Primary Insured** member means Policyholder's employee or a member of covered group who satisfies and continues to satisfy the eligibility criteria as specified in Policy Schedule and Certificate of Insurance.
- **Rehabilitation** includes treatment aimed at restoring health or mobility, or to allow a person to live an independent life, such as after a stroke.
- **Policy Schedule** means the schedule issued by Us along with this Policy mentioning the details of the Policyholder and Insured person, period of Policy and other details. Any changes made to it shall be issued as Endorsement Schedule and shall be considered a part of this Policy.
- **Shared Accommodation** means a Hospital room with two or more patient beds
- **Sum Insured means**:

  i. For an Individual Policy, the sum shown in the Policy Schedule/ Product Benefits Table against an Insured Person which represents Our maximum, total and cumulative liability for any and all claims under the Policy during a Policy Year in respect of that Insured Person.

  ii. For a Family Floater Policy, the sum shown in the Policy Schedule/ Product Benefits Table which represents Our maximum, total and cumulative liability for any and all claims under the Policy during a Policy Year in respect of any and all Insured Persons.

- **Terrorism/ Terrorist** Activity means an act, including, but not limited to, the use of force or violence and/or the threat thereof, of 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.
- **TPA or Third Party Administrator** means a company registered with the Authority, and engaged by an insurer, for a fee, by whatever name called and as may be mentioned in the agreement, for providing health services.
- **We/Our/Us** means MAGMA General Insurance Limited.
- **You/Your/Policyholder** means the employer or legally constituted group named in the Schedule who has concluded this Policy with Us.

C. Benefits covered under the policy

Base Covers:

The Benefits under this Policy are subject always to the Sum Insured, any subsidiary limit specified in the Policy Schedule/ Certificate of Insurance, the terms, conditions, limitations and exclusions mentioned in the Policy and eligibility as per the insurance plan opted for or as shown in the Policy Schedule/Certificate of Insurance.

Following covers are available as Base covers under the policy. Following Base covers are applicable to your Policy as mentioned in Policy Schedule/ Certificate of Insurance.

Our maximum liability under each of the opted Base Covers will be a part of and up to Sum Insured as specified in Policy Schedule/Certificate of Insurance for these covers.

- **Inpatient Care**

We shall cover the Reasonable and Customary Charges for the following Medical Expenses incurred by Insured Person if during the Policy Period, he/she requires Hospitalization on the written Medical Advice of a Medical Practitioner, for any Illness or Injury which is contracted or sustained during the Policy Period and is covered under this Policy:

a) Medical Practitioners' fees

b) Room Rent and other boarding charges

c) ICU Charges

d) Operation theatre charges

e) Diagnostic procedures' charges

f) Medicines, drugs and other consumables as prescribed by the Medical Practitioner

g) Qualified Nurses' charges

h) Intravenous fluids, blood transfusion, injection administration charges

i) Anaesthesia, Blood, Oxygen, operation theatre charges, surgical appliances

j) The cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure

- **Day Care Treatment**

Under this section, We will also cover the Medical Expenses incurred for Day Care Treatment on the written medical advice of a Medical Practitioner following an Illness or Injury which occurs during the Policy Period, up to the limits specified in the Policy Schedule/Certificate of Insurance. Any OPD treatment undertaken in a Hospital/Day Care Centre will not be covered under this Benefit. Please refer to Annexure for list of Day Care Treatments.

- **Hospital Cash**

If an Insured Person is Hospitalized during the Policy Period then We shall pay the daily cash amount specified in the Policy Schedule /Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalization provided that:

a. We shall not make any payment under this Benefit to You for more than the number of days of Hospitalisation as specified in Policy Schedule /Certificate of Insurance

b. A deductible in terms of number of days per Hospitalization event will be applicable if and as specified in Policy Schedule /Certificate of Insurance

c. We shall not make any payment under this Benefit for any diagnosis or treatment arising from or related to pregnancy (whether uterine or extra uterine), childbirth including caesarean section, medical termination of pregnancy and/or any treatment related to pre and post-natal care of the New Born Baby.

- **Outpatient Cover**

We will cover the Reasonable and Customary Charges incurred for availing following services on an out-patient basis to assess Insured Person's health condition for any Illness or injury as specified in Policy Schedule/Certificate of Insurance

- medically necessary consultations with a Medical Practitioner

- undergoing any Diagnostic Tests prescribed by the Medical Practitioner

- medicines purchased under and supported with a Medical Practitioner's prescription.

- Non surgical and minor surgical procedures which are neither in-patient nor day care procedures

The waiting periods as defined in Section III of this Policy will not be applicable for this Cover.

The amount payable under this Benefit shall be up to the limit shown in the Policy Schedule/Certificate of Insurance.

- **Critical Illness Cover**

We shall pay the amount as specified in the Policy Schedule/Certificate of Insurance against this Benefit as a lump sum amount, provided that:

i. The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period, and

ii. The Insured Person survives for at least the number of days as defined in "Survival clause" under this benefit in Policy Schedule/certificate of Insurance following such diagnosis.

We will not make any payment under this Benefit if the Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the inception of coverage of Insured Person under this Policy.

This Benefit can be availed by the Insured Person only once during his/her lifetime. A waiting period of 48 months will be applicable for claim under this Benefit in case claim is for any of the Critical Illnesses which is a consequence of or arises out of any Pre-Existing Disease.

If a claim becomes admissible under this Cover, it shall not be available for that Insured Person at the time of Renewal.

The waiting periods and as defined in Section III of this Policy will not be applicable for this Cover.

For the purpose of this Benefit, covered Critical Illness means:

1. Cancer of specified severity;
2. Kidney failure requiring regular dialysis;
3. Multiple Sclerosis with persistent symptoms
4. Major Organ/Bone marrow Transplant
5. Open Heart Replacement or Repair of Heart Valves
6. Open Chest CABG (Coronary Artery Bypass Graft)
7. Stroke resulting in permanent symptoms
8. Permanent Paralysis of Limbs
9. Myocardial Infarction (First Heart Attack of specified severity)
10. Coma of specified severity
11. Parkinson's Disease
12. Benign Brain Tumor
13. Alzheimer's Disease
14. End Stage Liver failure
15. Surgery of Aorta
16. Deafness
17. Loss of Speech
18. Third Degree Burns
19. Motor Neuron Disease with Permanent Symptoms

20. Primary Pulmonary Hypertension
21. Pulmonary Artery Graft Surgery
22. Muscular Dystrophy
23. Systemic Lupus Erythematosis with Lupus Nephritis
24. Pneumonectomy
25. Medullary Cystic Disease
26. Angioplasty
27. Blindness
28. End Stage lung failure
29. Major Head Trauma
30. Cardiomyopathies
31. Terminal illness
32. Fulminant Hepatitis
33. Coronary Artery disease
34. Bacterial Meningitis
35. Multiple system Atrophy

Critical Illnesses as per below grid will be covered as per the plan option in the Policy:

S. No.	Name of Critical Illness	Option A	Option B	Option C	Option D	Option E	Option F
1	Cancer of specified severity	Yes	Yes	Yes	Yes	Yes	Yes
2	Kidney failure requiring regular dialysis	Yes	Yes	Yes	Yes	Yes	Yes
3	Multiple Sclerosis with persistent symptoms	Yes	Yes	Yes	Yes	Yes	Yes
4	Major Organ Transplant	Yes	Yes	Yes	Yes	Yes	Yes
5	Heart Valve Replacement	Yes	Yes	Yes	Yes	Yes	Yes
6	Coronary Artery Bypass Graft	Yes	Yes	Yes	Yes	Yes	Yes
7	Stroke resulting in permanent symptoms	Yes	Yes	Yes	Yes	Yes	Yes

8	Permanent Paralysis of Limbs	Yes	Yes	Yes	Yes	Yes	Yes
9	Myocardial Infarction (First Heart Attack of specified severity)	Yes	Yes	Yes	Yes	Yes	Yes
10	Coma of specified severity	-	Yes	Yes	Yes	Yes	Yes
11	Parkinson's Disease	-	Yes	Yes	Yes	Yes	Yes
12	Benign Brain Tumor	-	Yes	Yes	Yes	Yes	Yes
13	Alzheimer's Disease	-	-	Yes	Yes	Yes	Yes
14	End Stage Liver failure	-	-	Yes	Yes	Yes	Yes
15	Surgery of Aorta	-	-	Yes	Yes	Yes	Yes
16	Deafness	-	-	-	Yes	Yes	Yes
17	Loss of Speech	-	-	-	Yes	Yes	Yes
18	Third Degree Burns	-	-	-	Yes	Yes	Yes
19	Motor Neuron Disease with Permanent Symptoms	-	-	-	-	Yes	Yes
20	Primary Pulmonary Hypertension	-	-	-	-	Yes	Yes
21	Pulmonary Artery Graft Surgery	-	-	-	-	Yes	Yes
22	Muscular Dystrophy	-	-	-	-	Yes	Yes
23	Systemic Lupus Erythematosis with Lupus Nephritis	-	-	-	-	Yes	Yes
24	Pneumonectomy	-	-	-	-	Yes	Yes
25	Medullary Cystic Disease	-	-	-	-	Yes	Yes
26	Angioplasty	-	-	-	-	-	Yes
27	Blindness	-	-	-	-	-	Yes
28	End Stage lung failure	-	-	-	-	-	Yes
29	Major Head Trauma	-	-	-	-	-	Yes
30	Cardiomyopathies	-	-	-	-	-	Yes
31	Terminal illness	-	-	-	-	-	Yes
32	Fulminant Hepatitis	-	-	-	-	-	Yes
33	Coronary Artery disease	-	-	-	-	-	Yes
34	Bacterial Meningitis	-	-	-	-	-	Yes
35	Multiple system Atrophy	-	-	-	-	-	Yes

Definition of Critical Illnesses:

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 –

- All tumors which are histologically described as carcinoma-in-situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- 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
- All thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- Chronic lymphocytic leukemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below with mitotic count of less than or equal to 5/50 HPFs
- All tumors in the presence of HIV infection.

2. 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.

3. Multiple Sclerosis with persisting symptoms

The unequivocal diagnosis of definite Multiple Sclerosis confirmed and evidenced by all of the following:

- Investigations including typical MRI findings, which unequivocally confirm the diagnosis to be multiple sclerosis and
- There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

4. Major Organ/ Bone Marrow Transplant

The actual undergoing of a transplant of:

- One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- Human bone marrow using hematopoietic stem cells

The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

a) Other stem-cell transplants

b) Where only islets of Langerhans are transplanted

5. Open Heart Replacement or Repair of Heart Valves

The actual undergoing of open-heart valve surgery to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s).

The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

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

6. Open Chest CABG (Coronary Artery Bypass Graft)

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 breastbone) 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:

a) Angioplasty and/or any other intra-arterial procedures

7. Stroke resulting in Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and embolization from an extra cranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

i. Transient Ischemic Attacks (TIA)

ii. Traumatic injury of the brain

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

8. 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.

9. First Heart Attack of Specified Severity (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 should be evidenced by all of the following criteria:

- A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain).
- New characteristic electrocardiogram changes
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

- Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponins I or T
- Other acute Coronary Syndromes
- Any type of Angina Pectoris
- A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

10. 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:

- No response to external stimuli continuously for at least 96 hours;
- Life support measures are necessary to sustain life.
- 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.

11. Parkinson's Disease

The occurrence of Parkinson's Disease where there is an associated Neurological Deficit that results in Permanent Inability to perform independently at least three of the activities of daily living as defined below.

i. Transferring: The ability to move from bed to an upright chair or wheelchair and vice versa;

ii. Mobility: The ability to move indoors from room to room on level surfaces;

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

iv. Bathing/Washing: The ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash satisfactorily by other means

v. Feeding: The ability to feed oneself once food has been prepared and made available

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

Parkinson's disease secondary to drug and/or alcohol abuse is excluded

12. Benign Brain Tumor

1. 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.
2. The 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.

3. The following are **excluded**:

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

13. Alzheimer's Disease

Clinically established diagnosis of Alzheimer's Disease (presenile dementia) resulting in a permanent inability to perform independently three or more activities of daily living – bathing, dressing/undressing, getting to and using the toilet, transferring from bed to chair or chair to bed, continence, eating/drinking and taking medication – or resulting in need of supervision and permanent presence of care staff due to the disease. These conditions have to be medically documented for at least 3 months.

14. End Stage Liver Failure

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

a) permanent jaundice, and

b) ascites, and

c) Hepatic encephalopathy

II. Liver failure secondary to alcohol or drug misuse is excluded.

15. Surgery of Aorta

The actual undergoing of medically necessary surgery for a disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches. Traumatic injury of the aorta is excluded.

16. Deafness

Total and irreversible loss of hearing in both ears as a result of Illness or Accident. The diagnosis must be supported by pure tone audiogram test and certified by an ear, nose and throat specialist (ENT specialist). Total means "the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing" in both ears.

17. Loss of Speech

Total and irreversible loss of the ability to speak as a result of injury or disease to the vocal chords. The inability to speak must be established for a continuous period of 12 months. The diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

All psychiatric related causes are excluded.

18. Major Burns (Third Degree Burns)

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

19. 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.

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:

a. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

b. 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. Pulmonary Artery Graft Surgery

The undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

22. Muscular Dystrophy

A group of hereditary degenerative diseases of muscle characterized by weakness and atrophy of muscle. The diagnosis of muscular dystrophy must be unequivocal and made by a Registered Doctor 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:

- 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.
- Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
- Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheelchair and vice versa.
- Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.
- Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
- Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence

23. Systemic Lupus Erythematosus

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 Registered Doctor 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

24. Pneumonectomy

The undergoing of surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic injury suffered by the life assured.

The following conditions are excluded:

- Removal of a lobe of the lungs (lobectomy)
- Lung resection or incision

25. Medullary Cystic Disease

Medullary Cystic Disease where the following criteria are met:

a. the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis.

b. clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and

c. the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

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

26. Angioplasty

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

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

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

27. Blindness

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

II. The Blindness is evidenced by:

i. corrected visual acuity being 3/60 or less in both eyes or;

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

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

28. 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.

29. 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.

II. 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.

III. 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.

IV. The following are excluded:

i. Spinal cord injury.

30. Cardiomyopathies

A diagnosis of cardiomyopathy by a Specialist Medical Practitioner (Cardiologist). There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities for a minimum period of 30 days to at least Class 3 of the New York Heart Association classifications of functional capacity (heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain) and LVEF of 40% or less.

The following conditions are excluded:

• Cardiomyopathy secondary to alcohol or drug abuse.

• All other forms of heart disease, heart enlargement and myocarditis

31. Terminal illness

The conclusive diagnosis of an illness that is expected to result in the death of the Insured Person within 6 months. This diagnosis must be supported by a specialist and confirmed by the Company's appointed Doctor. The Company reserves the right for independent assessment.

Terminal illness due to AIDS is excluded.

32. 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:

1) Rapid decreasing of liver size;

2) Necrosis involving entire lobules, leaving only a collapsed reticular framework;

3) Rapid deterioration of liver function tests;

4) Deepening jaundice; and

5). Hepatic encephalopathy.

Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

33. Coronary Artery Diseases

The narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, as proven by coronary arteriography, regardless of whether or not any form of coronary

artery Surgery has been performed. Coronary arteries herein refer to left main stem, left anterior descending circumflex and right coronary artery.

34. Bacterial Meningitis

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit lasting for a minimum period of 30 days. It should result in a permanent inability to perform at least three of the 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.

Permanent Neurological Deficit means Symptoms of dysfunction in the nervous system that is present on clinical examination and expected to last throughout the insured person's life. Symptoms that are covered include numbness, increased sensitivity, paralysis, localized weakness, difficulty with speech, inability to speak, difficulty in swallowing, visual impairment, difficulty in walking, lack of coordination, tremor, seizures, lethargy, dementia, delirium and coma.

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.

35. Multiple System Atrophy

A diagnosis of multiple system atrophy by a Specialist Medical Practitioner (Neurologist). There must be evidence of permanent clinical impairment for a minimum period of 30 days of either:

• motor function with associated rigidity of movement; or

• The ability to coordinate muscle movement; or

• Bladder control and postural hypotension.

- **Corona Protection Cover:**

We shall pay the amount as specified in the Policy Schedule/Certificate of Insurance against this Benefit as a lump sum amount, provided that:

i. The Insured Person is first diagnosed as suffering from a Covid-19 during the Policy Period, and

ii. The diagnosis of Covid-19 is done at a Diagnostic centre which is authorized by the Government of India

We will not make any payment under this Benefit if the Insured Person is first diagnosed as suffering from Covid-19 prior to the inception of coverage of Insured Person under this Policy. The initial waiting period as mentioned in the Policy Schedule/Certificate of Insurance will be applicable. Other waiting periods and as defined in Section III of this Policy will not be applicable for this Cover.

We shall not make any payment for home or institutional quarantine for suspected Covid-19 disease. Positive diagnosis of Insured person for Covid-19 is mandatory for claim admissibility.

COVID-19 here means, Corona virus disease as defined by the World Health Organization (WHO) and caused by the virus SARS-CoV2.

Extension covers:

Following extension covers are applicable to each insured person under this Policy. The coverage limits are specified in the Policy Schedule/ Certificate of Insurance. The limits for these covers are applicable for each Insured Person and are included within the Sum Insured limit, unless specified otherwise. All the waiting periods and Exclusions are applicable to these Extension Covers as well unless specified otherwise.

<Extension Covers wordings as applicable>

D. Exclusions

i. Standard Exclusions

Waiting Periods: Following waiting periods will be applicable to each Insured Person under this Policy.

- **First Thirty Days Waiting Period (Code- Excl03)**

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

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

- **Specific Diseases Waiting Period (Code- Excl02):**

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage, as may be the case after the date of inception of the first policy with the Insurer. This exclusion shall not be applicable for claims arising due to an accident.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

List of these diseases is:

1. Cataract
2. Stones in biliary and urinary systems
3. Hernia / Hydrocele
4. Hysterectomy for any benign disorder
5. Lumps / cysts / nodules / polyps / internal tumours
6. Gastric and Duodenal Ulcers
7. Surgery on tonsils / adenoids
8. Osteoarthrosis / Arthritis / Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse
9. Fissure / Fistula / Haemorrhoid
10. Sinusitis / Deviated Nasal Septum / Tympanoplasty / Chronic Suppurative Otitis Media
11. Benign Prostatic Hypertrophy
12. Knee/Hip Joint replacement
13. Dilatation and Curettage
14. Varicose veins
15. Dysfunctional Uterine Bleeding / Fibroids / Prolapse Uterus / Endometriosis
16. Chronic Renal Failure or end stage Renal Failure
17. Internal congenital anomalies/diseases/defects
18. HIV , AIDS

- **Pre-Existing disease (Code- Excl01):**

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of above defined months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

We will not be liable to make any payment under this Policy under any circumstances, for any claim in respect of any Insured Person, directly or indirectly for, caused by or arising from or in any way attributable to any of the following permanent exclusions. In case extension covers are opted, respective permanent exclusion(s) stand deleted to the extent of coverage as per terms and conditions of that Extension cover.

- Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**.
- **Hazardous or Adventure sports: (Code- Excl09):** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
- **Obesity/ Weight Control: Code- Excl06**

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

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

- **Cosmetic or Plastic Surgery (Code Excl08)**

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

- **Refractive Error (Code Excl15)**
- Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.
- **Treatment** received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code- Excl13**
- **Sterility and Infertility (Code Excl17)**

  Expenses related to sterility and infertility. This includes:

  (i) Any type of contraception, sterilization

(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy

(iv) (iv) Reversal of sterilization

- **Maternity expenses (Code Excl18)**

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

- **Change of Gender treatment (Code Excl07):**

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

- **Excluded Providers (Code Excl11):**

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

LIST of these have been provided on our website.

- **Investigation & Evaluation (Code Excl04):**

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

- **Rest Cure, Rehabilitation and respite Care (Code Excl05)**

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.

- **Breach of Law (Code Excl10)**

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

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

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

ii. Specific Exclusions

- Treatment provided by a Medical Practitioner who is not recognized by the Medical Council of India.
- Treatment of any sexual problem including impotence (irrespective of the cause) or erectile dysfunction.
- Treatment for any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
- Treatment for sleep apnoea, snoring, or any other sleep-related breathing problem.
- Any treatment received outside India.
- Treatment provided by anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family.
- X-Ray or laboratory examinations or other diagnostic studies, not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, whether or not requiring Hospitalization.
- Treatment for, or arising from, an Injury that is intentionally self-inflicted, including attempted suicide.
- Any treatment arising from and/or taken for Crohn's Disease, Ulcerative colitis, Cystic kidneys, Neurofibromatosis, Factor V Leiden Thrombophilia, Familial Hypercholesterolemia, Haemophilia, Hereditary Fructose Intolerance, Hereditary Hemochromatosis, Hereditary Spherocytosis.
- Private nursing/attendant's charges incurred during pre-hospitalization or post-hospitalization.
- Drugs or treatment not supported by prescription.
- Issue of fitness certificate and fitness examinations
- External and/ or durable medical/non-medical equipment of any kind used for diagnosis and/ or treatment, CPAP, CAPD, infusion pump.
- Ambulatory devices, walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and also any medical equipment which is subsequently used at home.
- OPD treatment is not covered. However, this exclusion does not apply for Outpatient Cover.
- All preventive care, vaccination including inoculation and immunizations, except if it is certified and recommended by the attending Medical Practitioner as part of in-patient treatment. However, this exclusion does not apply for Outpatient Cover.
- Dental Treatment including Surgical Procedures for the treatment of bone disease when related to gum disease or damage, or treatment for, or treatment arising from, disorders of the temporomandibular joint. This exclusion does not apply for Outpatient Cover

EXCEPTION: We will pay for a Surgical Procedure wherein the Insured Person Hospitalized as a result of an Accident and which is undertaken for Inpatient Care in a Hospital and carried out by a Medical Practitioner.

- Any expenses for OPD treatment, or any expenses for drugs or dressings not prescribed for Insured Person's intake within hospitalization period, except as included in Post-hospitalization Medical Expenses Extension cover. This exclusion does not apply to Outpatient Cover.
- We will not pay for routine eye examinations, contact lenses spectacles, hearing aids, dentures and artificial teeth. This exclusion does not apply for Outpatient Cover.
- Any treatment modality other than Allopathic Treatment
- Charges related to a Hospital stay not expressly mentioned as being covered. Service charges levied by the Hospital under whatever head. Complete list of these excluded expenses is mentioned in Annexure II of this Policy. The list is available on our website www.magmainsurance.com
- Artificial life maintenance, including life support machine used to sustain a person, incurred after confirmation by the treating doctor that the patient is in vegetative state.
- Any charges incurred to procure any medical certificate, medical records, treatment or Illness/Injury related documents pertaining to any period of Hospitalization/Day Care Treatment undertaken for any Illness or Injury.
- Circumcision unless necessary for the treatment of an Illness or disease or necessitated by an Accident.
- Treatment for any Illness or Injury resulting from nuclear or chemical contamination, war, participation in riot, revolution, acts of terrorism or any similar event (other than natural disaster or calamity)
- Treatment for any External Congenital Anomaly.

E. General Terms and clauses

i. Standard General Terms and Conditions

- **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.

- **Claim Settlement (Provision for penal interest)**

(i) The Company shall settle or reject a claim, as may be the case, within 15 days.

(iii) In case of delay beyond stipulated 15 days, the Company shall be liable to pay interest to the Policyholder at a rate 2% above the bank rate.

(Explanation: "Bank rate" means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due.)

- **Material change**

It is a Condition Precedent to the Our liability under the Policy that the Policyholder/ Insured Person shall immediately notify Us in writing of any material change in the risk on account of change in the nature of occupation or business at his/her own expense. We may, in Our discretion, adjust the scope of cover and/or the premium payable, accordingly, in line with our board approved underwriting policy. The Policyholder/Insured Person must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, endorsement or reinstatement of the Policy. The Policy terms and conditions may be altered accordingly.

- **Multiple Policies**

In case of multiple policies which provide fixed benefits, on the occurrence of insured event in accordance with the terms & conditions of the policies, each insurer shall make the claim payment independent of payment received under similar health policies.

1. 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.

2. 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.

3. If the amount to be claimed exceeds the sum insured under a single policy, the Insured Person shall have the right to choose insurers from whom he/she wants to claim the balance amount.

4. 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.

- **Free Look Provision**

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

The insured shall be allowed a free look provision of thirty (30) days from date of receipt of the Policy document to review the terms and conditions of the Policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or

ii. where the risk has already commenced and the option of return of the Policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

In case of any delay in refund, the insurer shall refund such amounts along with interest at the bank rate plus 2 percent on the refundable amount, from the date of receipt of the request for free look cancellation till the date of refund. Such interest shall be paid suo moto by the insurer.

- **Cancellation/ Termination (other than Free Look cancellation)**

a. The Policyholder may cancel this Policy by giving 7 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period on prorate basis.

   Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any Benefit has been availed by the Insured person under the Policy.

b. 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 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

- **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/doctor/any other party acting on behalf of the insured person with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

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

- **Renewal of Policy**

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

a) The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

b) Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years.

c) Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.

d) 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 with Break in Policy. Coverage is not available during the grace period.

e) No loading shall apply on renewals based on individual claim experience.

- **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.

- **Redressal of Grievance**

In case of any grievance, the insured person may contact the Company through

Website: www.magmainsurance.com
Toll free: 1800 266 3202
E –mail: gro@magmainsurance.com
Fax: 91 033 4401 7471
Courier: Any of Our branch offices or corporate office during business hours

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:

Grievance Redressal Officer at the address:
Magma General Insurance Limited
Equinox Business Park, Tower 3, 2nd Floor,

Unit Number 1B & 2B, LBS Marg, Kurla (West),
Mumbai – 400070, Maharashtra.

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

If Insured Person is not satisfied with the redressal of grievance through above methods, 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. The contact details of the Insurance Ombudsman offices have been provided as Annexure-I. Detailed process along with list of Ombudsman offices are available at council of Insurance Ombudsman https://www.cioins.co.in/

Grievance may also be lodged at IRDAI Integrated Grievance management System:
https://bimabharosa.irdai.gov.in .

- **Complete Discharge**

Any payment to the 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.

- **Nomination**

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

- **Possibility of Revision of Terms of the Policy Including the Premium Rates**

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

- **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.

- **Migration**

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration.

- **Portability**

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the due date for policy renewal date as per IRDAI Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/ Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

- **Premium payment in Instalments:**

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

i. 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.

ii. During such grace period, coverage will not be available from the due date of instalment premium payment till the date of receipt of premium by Company.

iii. The insured person will get the accrued continuity benefits in respect of the “Waiting Periods”, “Specific Waiting Periods” 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 right to recover and deduct all the pending instalments from the claim amount due under the policy.

ii. Specific Terms and clauses

- **Endorsements:**

Insured Person/the Policyholder should request for any endorsement in writing. Any endorsement that is accepted by Us shall be effective from the date of the request as received from Insured Person /the Policyholder, or the date of receipt of premium, whichever is later.

We reserve the rights to do underwriting in case of any such endorsement requests which has a bearing on the premium and/or material risk.

- **Communications & Notices**

Any communication or notice or instruction under this Policy shall be in writing and will be sent to:

a. To Us, at the address as specified in Policy Schedule and Certificate of Insurance

b. The Policyholder's, at the address as specified in Policy Schedule OR to the Insured Person, at the address as specified in Certificate of Insurance

c. No insurance agents, brokers, other person or entity is authorized to receive any notice on behalf of Us unless explicitly stated in writing by Us

d. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

e.

- **Limitation of Liability**

If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding or arbitration, as the case may be, within twelve months from the date of such rejection or settlement the claim shall be deemed to have been abandoned and Our liability shall be extinguished and shall not be recoverable thereafter.

- **Records to be maintained**

The Policyholder or the Insured Person, as the case may be, shall keep an accurate record containing all relevant and accurate medical records like in-patient records, Discharge summary, medical certificates, medical prescriptions, diagnostic reports and reports confirming the need for treatment (if any) and shall allow Us or our representative(s) to inspect such records. The Policyholder or the Insured Person as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Period or until final adjustment (if any) and resolution of all claims under this Policy.

- **Geographical Scope**

The geographical scope of this Policy applies to events within India unless specified otherwise for any of the Base and/or Extension Covers.

- **Policy Disputes**

Any and all disputes or differences under or in relation to this Policy herein shall be determined by Indian law and shall be subject to the jurisdiction of the Indian Courts.

- **Assignment**

The payment due under any Benefit under this Policy can be assigned in accordance with provisions of applicable law.

- **Alteration to the Policy**

This Policy constitutes the complete contract of insurance. Subject to the provisions of applicable law, no change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement signed and stamped by Us. No one except Us can change or vary this Policy.

- **No Constructive Notice**

Any knowledge or information of any circumstances or condition in relation to the Policyholder/Insured Person which is in Our possession and not specifically informed by the Policyholder/ Insured Person shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

- **Claim Procedure**

Provided that due adherence/observance and fulfilment of the terms and conditions of this Policy (conditions and all endorsements, Annexures hereon are to be read as part of this Policy) shall so far as they relate to anything to be done or not to be done by You and / or any Insured Person be a Condition Precedent to admission of Our liability under this Policy.

On the occurrence or the discovery of any Illness or Injury that may give rise to a claim under this Policy, then as a Condition Precedent to Our liability under the Policy, the following procedure shall be complied with:

1. For Availing Cashless Facility (Procedure for Domestic Claims)

Cashless facility can be availed only at Our Network Providers. The complete list of Network Providers is available on Our website and can also be obtained by contacting Us over the telephone. The updated list of TPA containing complete details is available on Our website www.magmainsurance.com .

Cashless facility will be availed through the TPA. The TPA will be contacted on its helpline and must be provided with the membership number, Policy Number and the name of the Insured Person at least 72 hours before admission to the Hospital for planned Hospitalization and within 24 hours of admission to the Hospital in case of Emergency Hospitalization. The TPA will also, by fax or e-mail, be provided with details of Hospitalization like diagnosis, name of the Hospital, duration of stay in the Hospital, estimated expenses of Hospitalization etc. in the prescribed form available with the insurance help desk at the Hospital. Any additional information as may be required by the medical panel of the TPA must also be furnished. After establishing the admissibility of the claim under the Policy, the TPA shall provide a pre-authorisation to the Hospital guaranteeing payment of the Hospitalization expenses subject to the Sum Insured, terms conditions and limitations of the Policy. The authorization shall be issued to the Network Provider within 24 hours of receiving the complete information.

2. **For admission in Non-Network Provider or into Network Provider if Cashless facility is not availed (Re-imbursement Claims)**

a. **Intimation of claim:** Preliminary intimation of claim with particulars relating to Policy Number, name of the Insured Person in respect of whom claim is made, nature of Illness/Injury and name and address of the attending Hospital, must be provided to Us at least 72 hours before admission to the Hospital in case of planned Hospitalization, and within 24 hours of admission in the Hospital, in case of Emergency Hospitalization.

3. **Submission of claim:** The claim form along with the attending Medical Practitioner's certificate duly filled and signed in all respects with the following claim documents will be submitted to Us not later than 30 days from the date of discharge from the Hospital.

Mandatory documents

a) Duly completed claim form.

b) Test reports and prescriptions relating to first / previous consultations for the same or related illness.

c) Case history / admission-discharge summary describing the nature of the complaints and its duration, treatment given, advice on discharge etc. issued by the Hospital.

d) Death summary in case of death of the Insured Person at the Hospital.

e) Post Mortem Report, if applicable & if conducted.

f) Hospital receipts / bills / cash memos in original (including advance and final Hospital settlement receipts).

g) All test reports for X-rays, ECG, Scan, MRI, Pathology etc., including the Medical Practitioner's prescription advising such tests/investigations (CDs of angiogram, surgery etc. need not be sent unless specifically sought).

h) Medical Practitioner's prescriptions with cash bills for medicines purchased from outside the Hospital.

i) F.I.R/MLC. in the case of Accidental Injury and English translation of the same, if in any other language.

j) Legal heir certificate in the absence of nomination under the Policy, in case of death of the Insured Person. In the absence of legal heir certificate, evidence establishing legal heirship may be provided as required by Us.

k) For a) maternity claims, discharge summary mentioning LMP, EDD & Gravida b) Cataract claims - IOL sticker c) PTCA claims - Stent sticker.

l) Copies of health insurance policies held with any other insurer covering the Insured Person(s).

m) If a claim is partially settled by any other insurer, a certificate from the other insurer confirming the final claim amount settled by them and that original claim documents are retained at their end.

Documents to be submitted if specifically sought:

a. Copy of indoor case records (including Qualified Nurse's notes, OT notes and anaesthetists' notes, vitals chart).

b. Copy of extract of inpatient register.

c. Attendance records of employer/educational institution.

d. Complete medical records (including indoor case records and OP records) of past Hospitalization/treatment, if any.

e. Attending Medical Practitioner's certificate clarifying.

   i. reason for Hospitalization and duration of Hospitalization

   ii. history of any self-inflicted Injury

   iii. history of alcoholism, smoking

   iv. history of associated medical conditions, if any

f. Previous master health check-up records/pre-employment medical records, if any.

g. Any other document necessary in support of the claim on case-to-case basis.

For AYUSH Claims:

a. AYUSH claims would be payable as per the guidelines determined by Ministry of AYUSH, Government of India or any such committee of experts constituted to determine in-patient admissibility of claims, treatment modalities and corresponding treatment cost for providing AYUSH Coverage as defined from time to time.

b. In patient admissibility of AYUSH claims would be determined in line with reasonable admissibility and its reasonable claim cost, as under allopathy or modern medicine for the same ailment or medical condition.

The claim documents should be sent to:

Any of Our branch offices or corporate office

Payment of Claim

- No liability under the Policy will be admitted, if the claim is fraudulent or supported by fraudulent means.
- The Insured Person or any person acting on behalf of the Insured Person, as the case may be, must provide at his/her expense, all the information asked by Us in relation to the claim and he/she must provide all reasonable cooperation and assistance to Us as may be required.
- If required, the Insured Person or any person acting on behalf of the Insured Person, as the case may be, must give consent to obtain medical reports from the Medical Practitioner at Our expense.
- If requested by Us, the Insured Person must agree to be examined by a Medical Practitioner of Our choice and at Our expense.
- All claims under this Policy shall be payable in Indian Currency.
- Claims under this Policy shall be settled or rejected, as the case may be, within 15 days.

Annexure

Office of the Ombudsman	Contact Details	JURISDICTION
AHMEDABAD	Shri. Collu Vikas Rao Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU	Mr. Vipin Anand Insurance Ombudsman 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	Shri. R. M. Singh Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir,Arera Hills Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 / 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh and Chhattisgarh.
BHUBANESWAR	Shri. Manoj Kumar Parida Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455/2596429/2596003 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
CHANDIGARH	Mr. Atul Jerath Insurance Ombudsman Office of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh

CHENNAI	Shri. Somnath Ghosh Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)
DELHI	Ms. Sunita Sharma Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992/23213504/23232481 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh
GUWAHATI	Shri. Somnath Ghosh Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Near Pan Bazar, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Shri. N. Sankaran Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai Showroom, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR	Shri. Rajiv Dutt Sharma Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
KOCHI	Shri. G. Radhakrishnan Insurance Ombudsman	Kerala, Lakshadweep, Mahe-a part of Union

	Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G. Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Territory of Puducherry
KOLKATA	Ms. Kiran Sahdev Insurance Ombudsman 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	Shri. Atul Sahai Insurance Ombudsman 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	Mr. Vipin Anand Insurance Ombudsman 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	Shri. Bimbadhar Pradhan	State of Uttarakhand and

	Insurance Ombudsman 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	the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA	Ms. Susmita Mukherjee Insurance Ombudsman 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	Shri. Sunil Jain Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. Nos. 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)

For updated list visit- https://www.cioins.co.in/Ombudsman

Annexure

List I – Item for which coverage in not available in the policy

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

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

List II – Items that are to be subsumed into Room Charges

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

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

List III – Items that are to be subsumed into Procedure Charges

Sl No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT

15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into costs of treatment

Sl No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer & Strips
18	URINE BAG