NARAYANA GROUP HEALTH INSURANCE POLICY WORDING

Version 1.0

1. Preamble

This is a contract of insurance between You and Us which is subject to the payment of the full premium in advance, unless premium is agreed by both parties to be paid in instalment, and the terms, conditions, and exclusions to this Policy. This Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided by You in respect of the Insured Persons in the Proposal Form and the Customer Information Sheet.

Please inform Us immediately of any change in the address or any other changes affecting You or any Insured Person.

Note: The terms listed in Section 2 (Definitions) and used elsewhere in the Policy in Initial Capitals shall have the meaning set out against them in Section 2 wherever they appear in the Policy.

2. Definitions

For the purposes of interpretation and understanding of this Policy, We have defined herein below some of the important words used in the Policy and for the remaining language and the words they shall have the usual meaning as described in standard English language dictionaries. The words and expressions defined in the Insurance Act 1938, IRDA Act 1999, regulations notified by the IRDAI and circulars and guidelines issued by the IRDAI, as amended from time to time, shall carry the meanings explained therein.

Note: Where the context permits, the singular will be deemed to include the plural, one gender shall be deemed to include the other genders and references to any statute shall be deemed to refer to any replacement or amendment of that statute.

2.1 Standard Definitions

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

2.1.2 AYUSH Treatment refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

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

2.1.4 Associated Medical Expenses shall include Room Rent, nursing charges, Medical Practitioners' fees and operation theatre charges.

2.1.5 Cashless Facility means a facility extended by the insurer to the insured where the payments of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

2.1.6 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.

2.1.7 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 claim amount. A Co-payment does not reduce the Sum Insured.

2.1.8 Day Care Centre means any institution established for Day Care Treatment of Illness and/or Injuries or a medical set-up within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND complies with all minimum criterion as under:

a. has Qualified Nursing staff under its employment
b. has qualified Medical Practitioner(s) in charge;
c. has a fully equipped operation theatre of its own, where Surgical Procedures are carried out;
d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

2.1.9 Day Care Treatment refers to medical treatment and/or Surgical Procedure which is:

a. undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24 hours because of technological advancement, and
b. which would have otherwise required a Hospitalization of more than 24 hours.

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

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

2.1.11 Day means a continuous 24-hour period of hospitalization. The first Day commences at the exact time of admission and continues until the same time on the following calendar day (24 hours). Each subsequent Day starts immediately upon the conclusion of the previous 24-hour period and ends 24 hours later.

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

2.1.13 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:

a. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
b. the patient takes treatment at home on account of non-availability of room in a Hospital.

2.1.14 Emergency means a serious medical condition or symptom resulting from Illness or Injury which arises suddenly and unexpectedly and requires immediate care and treatment by a Medical Practitioner to prevent death or serious long-term impairment of the Insured Person's health.

Explanation: An unforeseen, sudden, and acute medical condition that arises without prior warning and requires immediate medical attention to prevent serious jeopardy to the insured person’s life, significant impairment to bodily functions, or permanent dysfunction of any body organ or part.

The condition must be of such severity that a prudent layperson with average knowledge of health and medicine would reasonably expect that failure to seek immediate care could result in:

a. Serious risk to life;
b. Permanent disability; or
c. Serious and irreversible harm to health.

Exclusions: Conditions not meeting the criteria for immediate and critical care, such as routine medical issues, elective procedures, or symptoms that are chronic, mild, or manageable through outpatient care, do not constitute an Emergency.

2.1.15 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. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

2.1.16 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 the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

a. has Qualified Nursing staff under its employment round the clock;
b. 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;
c. has qualified Medical Practitioner(s) in charge round the clock;
d. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

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

2.1.18 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.

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

a. Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
b. Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
ii. it needs ongoing or long-term control or relief of symptoms
iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
iv. it continues indefinitely
v. it recurs or is likely to recur

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

2.1.21 Intensive / Critical 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.

2.1.22 In-Patient Care means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

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

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

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

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

a. is required for the medical management of the Illness or Injury suffered by the insured
b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity
c. must have been prescribed by a Medical Practitioner
d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

2.1.27 Migration means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

2.1.28 Network Provider means Hospital enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a Cashless Facility. This list includes list of Preferred Network Provider and list of Other Network Providers for which the benefits shall apply as illustrated in the Policy Schedule and following sections in this document.

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

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

2.1.31 Pre-existing Disease means any condition, ailment, injury, or disease:

a. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement or;
b. Which are declared by the Insured Person or found during the pre-policy health check-up or;
c. For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement.

2.1.32 Pre-hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b. The In-Patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.1.33 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:

a. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and
b. The In-Patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.1.34 Portability means the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

2.1.35 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.

2.1.36 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.

2.1.37 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.

2.1.38 Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the Associated Medical Expenses.

2.1.39 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 or prolongation of life, performed in a Hospital or Day Care Center by a Medical Practitioner. For clarification, Surgery or Surgical Procedures are defined by the following criteria:

a. They are always performed by "surgeons" recognised and legally permitted to conduct surgery, based on their training and education, by the National Medical Commission.
b. The procedure always involves giving an incision on the skin and / or deeper underlying tissue (depending on the type of surgery) of the human body mainly by cutting and stitching using surgical instruments including minimal access equipment like laparoscope and surgical robotic equipment with a purpose of removing a diseased organ (partially or fully) for diagnostic or treatment purpose, repairing an organ, removing infected or cancerous tissue, creating alternate channels when the main organs are diseased, implanting artificial implants or any other specified indication.
c. The procedure always involves giving some form of anaesthesia (local, regional or general).
d. The procedures are always done in a specified and designated sterile area called an operation theatre or room using specialized equipment. Rarely, surgical procedures might be carried out in an emergency or a ward in cases of extreme life-threatening situations.

Non-Surgery or Non-Surgical Procedures are:

a. Procedures performed in settings such as catheterization laboratories, endoscopy suites, interventional radiology suites areas including but not limited to procedures like Transcatheter Aortic Valve Implantation (TAVI), interventional radiology (IR), and neuro-interventional techniques.
b. Any procedure conducted by a physician, radiologist, or surgeon that involves the placement of catheters, stents, beads, wires, balloons, implants, devices, scopes, sclerosing agents, or laser treatments.
c. All other medical treatments, including intensive care unit (ICU) care, are considered Non-Surgical and are considered as medical management and Non-Surgical Procedures.
d. During the course of medical management in the ICU, all other medical interventions, including diagnostic and therapeutic bronchoscopic / endoscopic procedures, percutaneous image-guided procedures and intensive care unit (ICU) care procedures such as ECMO, are classified as medical management and are not considered Surgical Procedures.

2.1.40 Commencement Date means the date of commencement of insurance coverage under the Policy as specified in the Policy Schedule.

2.1.41 Disclosure of information norm means the Certificate of Insurance shall be void and all premium paid by the Insured Person(s) hereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

2.1.42 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:

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

2.2 Specific Definitions

2.2.1 Age means completed years on last birthday as on Commencement Date.

2.2.2 Base Premium means the premium excluding taxes and cess, for the Base Benefits mentioned under Section 3.

2.2.3 Base Sum Insured means the amount stated in the Certificate of Insurance / Policy Schedule.

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

2.2.5 Diagnostic Tests means investigations, such as X-Ray or blood tests, to determine the cause of symptoms and/or medical conditions.

2.2.6 Diagnostic Services means a broad range of Diagnostic Tests and exploratory or therapeutic procedures essential for detection, identification and treatment of medical condition.

2.2.7 Evidence Based Clinical Practice means process of making clinical decisions for In-Patient Care using current best evidence in conjunction with clinical expertise.

2.2.8 Family Floater Policy means a Policy described as such in the Policy Schedule where the family members (two or more) named in the Policy Schedule are insured under this Policy. Only the following family members can be covered under a Family Floater Policy:

a. Insured Person; and/or
b. Insured Person's legally married spouse (for as long as they continue to be married); and/or
c. Insured Person's parent(s) or parent(s)-in-law, and/or
d. Insured Person's dependent children who are more than 3 months and less than 25 years of Age on the commencement of the Policy Period

2.2.9 First Policy means the Policy Schedule issued to the Policyholder at the time of inception of the Policy mentioned in the Policy Schedule with Us.

2.2.10 Customer Information Sheet means the summary of information provided to You by Us about Policy Terms and Conditions as prescribed by IRDAI.

2.2.11 Insured Person(s) means person(s) named as insured in the Certificate of Insurance / Policy Schedule.

2.2.12 IRDAI means the Insurance Regulatory and Development Authority of India.

2.2.13 Medical Devices are devices intended for internal or external use in the diagnosis, treatment, mitigation or prevention of disease or disorder.

2.2.14 Medical Record means the collection of information as submitted in claim documentation concerning an Insured Person's Illness or Injury that is created and maintained in the regular course of management, made by a Medical Practitioners who has knowledge of the acts, events, opinions or diagnoses relating to the Insured Person's Illness or Injury, and made at or around the time indicated in the documentation.

2.2.15 Out-Patient Consultation means the one in which the Insured Person visits a clinic / Hospital, or associated facility like a consultation room, for the advice of a Medical Practitioner.

2.2.16 Policy means these terms and conditions, the Certificate of Insurance / Policy Schedule, as amended from time to time, Your statements in the Proposal and the Information Summary Sheet and any endorsements attached by Us to the Policy from time to time.

2.2.17 Policy Period is the period between the inception date and the expiry date of the Policy as specified in the Certificate of

Insurance / Policy Schedule or the date of cancellation of this Policy, whichever is earlier.

2.2.18 Policy Year means a period of twelve months beginning from the Commencement Date and ending on the last day of such twelve-month period. For the purpose of subsequent years, Policy Year shall mean a period of twelve months commencing from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Expiry Date, as specified in the Certificate of Insurance / Policy Schedule.

2.2.19 Policy Schedule means a certificate issued by Us, and, if more than one, then the latest in time. The Policy Schedule contains details of the Policyholder, Insured Persons and the Benefits applicable under the Policy.

2.2.20 Prescription Medicine means a drug that can only be sold or dispensed to a patient with a valid prescription from a registered medical practitioner (RMP).

2.2.21 Primary Insured Person means the Policyholder or the beneficiary if he/she is covered under the Policy as an Insured Person. In case the Policyholder is not an Insured Person, then Primary Insured Person will be the eldest Insured Person covered under the Policy.

2.2.22 Private Room means the basic version of single occupancy room as determined or specified by the relevant hospital and is not a General Ward or a Semi-Private room. Basic version here means the one in this room category with the lowest Room Rent.

2.2.23 Semi-Private Room means the basic version of double occupancy room as determined or specified by the relevant hospital and is not a General Ward or a Private room. Basic version here means the one in this room category with the lowest Room Rent.

2.2.24 Reimbursement means settlement of claims paid directly by Us to the concerned Beneficiary.

2.2.25 Service Provider means any person, organization, institution that has been engaged by Us to provide services specified under the benefits to the Insured Person.

2.2.26 Specialist Doctor refers to a medical professional who has received advanced education, training, and qualifications in a specific area of medicine beyond the basic medical degree (MBBS). This qualification is often recognized through the completion of a postgraduate degree or diploma (e.g., MD, MS, DM, MCh, DNB) in a specialized field such as but not limited to cardiology, neurology, oncology, endocrinology, or orthopaedics.

2.2.27 Standby Services are services of another Medical Practitioner requested by treating Medical Practitioner and involving prolonged attendance without direct (face-to-face) patient contact or involvement.

2.2.28 Sum Insured means the aggregate limit of indemnity consisting of the Base Sum Insured, Revive, AccumulatePlus, (provided that these optional covers are in force for the Insured Person), which represents the maximum, total and cumulative liability of the Company for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year. In case of Family Floater Policy, Sum Insured means the Sum Insured is shared amongst the primary insured and his/her family members who are covered under the policy. This means that the family together is eligible for claim up to the Sum Insured only in a year.

2.2.29 Daily Deductible means a Per Day Deductible under a health insurance policy that provides that the Insured Person shall pay a specified rupee amount per Day of admission in case of indemnity policies You will be liable to pay that amount, which will apply before any benefits are payable by Us. A Daily Deductible does not reduce the Base Sum Insured.

2.2.30 Aggregate Deductible is a cost-sharing requirement under a health insurance policy that provides that the Company will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the Company. An Aggregate deductible does not reduce the Sum Insured. The deductible is applicable in aggregate towards hospitalization expenses incurred (across multiple claims) which are admissible under this Policy (and not excluded) during the policy year by insured person (individual Sum Insured policy) or insured family (in case of floater sum insured policy).

2.2.31 Waiting Period means a time-bound exclusion period related to condition(s) specified in the Policy Schedule or the Policy which shall be served before a claim related to such condition(s) becomes admissible.

2.2.32 Standby Services are services of another Medical Practitioner requested by treating Medical Practitioner and involving

prolonged attendance without direct (face-to-face) patient contact or involvement.

2.2.33 We/Our/Us means Narayana Health Insurance Limited (The "Company").

2.2.34 You / Your / Policyholder / Insured Person means the person named in the Certificate of Insurance who has concluded this Policy with Us. Insured Person means the person mentioned in the Certificate of Insurance who shall be the actual beneficiary of this Policy, Policyholder means the Group Administrator who has concluded this Policy with Us.

2.3 Critical Illness Standard Definitions

2.3.1 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.

2.3.2 Stroke resulting in Permanent Symptoms

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

The following are excluded:
a. Transient ischemic attacks (TIA)
b. Traumatic Injury of the brain
c. Vascular disease affecting only

2.3.3 Open Chest CABG (Coronary Artery By-pass Graft) Surgery

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

2.3.4 Cancer of Specified Severity

A malignant tumour 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 leukaemia, lymphoma and sarcoma.

The following are excluded:
a. All tumours 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.
b. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
c. Malignant melanoma that has not caused invasion beyond the epidermis;
d. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
e. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
f. Chronic lymphocytic leukaemia less than RAI stage 3
g. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
h. All Gastro-Intestinal Stromal Tumours histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2.3.5 Encephalitis (Viral)

Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection and resulting in permanent neurological deficit. This diagnosis must be certified by a Registered Medical practitioner who is a consultant neurologist and the permanent neurological deficit must be documented for at least 6 weeks.

2.3.6 Brain Surgery

The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy is performed. Keyhole surgery is included however, minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolization, thrombolysis and stereotactic biopsy are all excluded. Brain surgery as a result of an Accident is also excluded. The procedure must be considered medically necessary by a Registered Medical practitioner who is a qualified specialist.

2.3.7 Total Replacement of Joints

Surgical replacement of a joint with an artificial prosthesis performed under general or regional anaesthesia in a Hospital by an orthopaedic surgeon.

2.3.8 Cirrhosis of Liver

a. Cirrhosis is a late stage of scarring (fibrosis) of the liver caused by many forms of liver diseases and conditions, such as hepatitis.
b. Characterized by at least three of the following conditions:
    - Jaundice
    - Ascites
    - Bleeding from oesophageal varices
c. Should be certified by a hepatologist and supported by an MRI and Ultrasound and elevated Bilirubin levels.
d. Drug or alcohol abuse leading to liver cirrhosis is excluded.

2.3.9 Third Degree Burns

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

3. Base Coverage (Hospitalization)

The Benefits available under this Policy are described below.

a. The Policy covers Reasonable and Customary Charges incurred towards medical treatment or consultation taken by the Insured Person during the Policy Period for an Illness, Injury or conditions as described in the sections below, provided such Illness, Injury or conditions contracted or sustained by an Insured Person during the Policy Period. The Benefits listed in the sections below will be payable subject to the terms, conditions and exclusions of this Policy and the availability of the Sum Insured and always subject to any sub-limits in respect of that Benefit as specified in the Policy Schedule for the Insured Person.

b. All the Benefits (including Optional Coverage (Hospitalization) and Optional Base Covers) under the product have been summarized in the Schedule of Benefits as illustrated in Annexure 1.

c. All claims for any benefits under the Policy must be made in accordance with the process defined under Section 10 (Claim Procedure)

d. All claims paid under any benefit except for those paid under Section 4.11 (Annual Health Check-up) and Section 5 (Optional Base Covers) shall reduce the Sum Insured for that Policy Year in which the claim has been incurred, unless otherwise specified in the respective section and only the balance Sum Insured after payment of claim amounts admitted shall be available for all future claims arising in that Policy Year.

3.1 In-Patient Care

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period, provided that:

a. Hospitalization is Medically Necessary and advised by Medical Practitioner and the treatment follows Evidence Based Clinical Practices and Standard Treatment Guidelines.

b. The Medical Expenses incurred are Reasonable and Customary Charges for one or more of the following:
   i. Room Rent for Room Type as specified in Certificate of Insurance / Schedule of Benefits
   ii. Nursing charges for nursing services under Hospitalization through a qualified nursing staff as an In-Patient;
   iii. Medical Practitioners' fees, excluding any charges or fees for Standby Services;
   iv. Physiotherapy, investigation and diagnostics procedures directly related to the current event which lead to Hospitalization;
   v. Medicines, drugs as prescribed by the treating Medical Practitioner related to the current event that lead to Hospitalization and not otherwise;
   vi. Intravenous fluids, blood transfusion, injection administration charges, consumables and/or enteral feedings;
   vii. Operation theatre charges;
   viii. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
   ix. Intensive / Critical Care Unit Charges;
   x. Ancillary hospital charges;
   xi. Implants as per hospital policy or clinical conditions.

c. If the Insured Person chooses to get admitted in higher category room other than the eligible Room Type for eligible cases of admissions, We shall be liable to pay only a pro-rated portion of the total Associated Medical Expenses (including surcharges or taxes thereon) in the proportion of the difference between the Room Rent for the eligible category as specified in the Certificate of Insurance / Policy Schedule and the availed category of room.

d. We shall not be liable to pay the visiting fees or consultation charges for any Medical Practitioner visiting the Insured Person unless such:
   i. Medical Practitioner's treatment or advice has been sought by the Hospital; and
   ii. Visiting fees or consultation charges are included in the Hospital's bill

3.2 Pre-hospitalization Medical Expenses

We will indemnify the Insured Person's Pre-hospitalization Medical Expenses incurred following an Illness or Injury at Network Providers as listed out in Annexure 2 and updated on our website from time to time, that occurs during the Policy Period provided that:

a. We have accepted a claim under Section 3.1 (In-Patient Care) or Section 3.4 (Day Care Treatment) or Section 3.5 (Living Organ Donor Transplant) or Section 3.7 (Alternative Treatments) or Section 3.8 (Technological Advancements and Treatments) and Pre-hospitalization Medical Expenses are incurred for the same condition for which We have accepted the In-Patient Care or Day Care Treatment or Alternative Treatments or Technological Advancements & Treatments or Living Organ Donor Transplant claim.

b. We will not be liable to pay Pre-hospitalization Medical Expenses beyond the period specified in the Certificate of Insurance / Policy Schedule immediately preceding the Insured Person's admission for In-Patient Care / Day Care Treatment / Alternative Treatments/ Technological Advancement and Treatments / Living Organ Donor Transplant or such expenses incurred prior to inception of the First Policy with Us.

c. Pre-hospitalization Medical Expenses can be claimed under the Policy on a Reimbursement basis only.

d. Pre-hospitalization Medical Expenses incurred on Physiotherapy will also be payable provided that such Physiotherapy is Medically Necessary and advised by the Medical Practitioner and such Physiotherapy is directly related to the current event that led to Hospitalization or Day Care Treatment.

e. Sum Insured for the Policy Year in which In-patient Care/ Day Care Treatment/ Alternative Treatments/ Technological Advancements & Treatments claim has been incurred shall be reduced.

3.3 Post-hospitalization Medical Expenses

We will indemnify the Insured Person's Post-hospitalization Medical Expenses incurred following an Illness or Injury at Network Providers as listed out in Annexure 2 and updated on our website from time to time, that occurs during the Policy Period as advised by the treating Medical Practitioner provided that:

a. We have accepted a claim under Section 3.1 (In-Patient Care) or Section 3.4 (Day Care Treatment) or Section 3.5 (Living Organ Donor Transplant) or Section 3.7 (Alternative Treatments) or Section 3.8 (Technological Advancements and Treatments) and Post-hospitalization Medical Expenses are incurred for the same condition for which We have accepted the In-Patient Care or Day Care Treatment or Alternative Treatments or Technological Advancements & Treatments claim or Living Organ Donor Transplant.

b. We will not be liable to pay Post-hospitalization Medical Expenses beyond the period specified in the Certificate of Insurance / Policy Schedule) immediately preceding the Insured Person's admission for In-Patient Care / Day Care Treatment / Alternative Treatments / Technological Advancements & Treatments or such expenses incurred prior to inception of the First Policy with Us.

c. Post-hospitalization Medical Expenses can be claimed under the Policy on a Reimbursement basis only.

d. Post-hospitalization Medical Expenses incurred on Physiotherapy will also be payable provided that such Physiotherapy is Medically Necessary and advised by the Medical Practitioner and such Physiotherapy is directly related to current event that led to Hospitalization or Day Care Treatment.

e. Sum Insured for the Policy Year in which In-patient Care/ Day Care Treatment / Alternative Treatments / Technological Advancements & Treatments / Living Organ Donor Transplant claim has been incurred shall be reduced.

3.4 Day Care Treatment

We will indemnify the Medical Expenses upto the amount specified in the Certificate of Insurance / Policy Schedule incurred on the Insured Person's Day Care Treatment at Network Providers during the Policy Period following an Illness or Injury provided that:

a. The Day Care Treatment is Medically Necessary and follows the written advice of a Medical Practitioner.

b. The Medical Expenses incurred are Reasonable and Customary Charges for any procedure where such procedure is undertaken by an Insured Person as Day Care Treatment.

c. We will not cover any OPD Treatment and Diagnostic Services under this Benefit.

d. All Day Care Treatment, as listed out in Annexure 3, are covered under this benefit.

e. Ancillary day care charges.

3.5 Living Organ Donor Transplant

We will indemnify the Medical Expenses upto the amount specified in the Certificate of Insurance / Policy Schedule at Network Provider incurred for a living organ donor's In-Patient treatment for the harvesting of the organ donated provided that:

a. The donation conforms to The Transplantation of Human Organs Act 1994 and amendments thereafter from time to time, and the organ is for the use of the Insured Person.

b. The recipient Insured Person has been Medically Advised to undergo an organ transplant.

c. We have accepted the recipient Insured Person's claim under Section 3.1 (In-Patient Care).

d. Medical Expenses incurred are Reasonable and Customary Charges.

e. We shall not be liable to make any payment in respect of:
   i. Stem cell donation whether or not Medically Necessary except for Bone Marrow Transplant.
   ii. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
   iii. Screening or any other Medical Expenses related to the organ donor which are not incurred during the duration of Insured Person's hospitalization for organ transplant.
   iv. Transplant of any organ/tissue where the transplant is experimental or investigational.
   v. Expenses related to organ transportation or preservation.
   vi. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

3.6 Domestic Road Ambulance Charges

We will indemnify the Reasonable and Customary Charges for ambulance expenses incurred to transfer the Insured Person by surface transport provided that:

a. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is injured or suffers Illness to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Hospitalization.

b. This benefit is available for one transfer per Hospitalization.

c. The ambulance service is offered by a healthcare or ambulance Service Provider during case of emergency admission or in case treatment is not available at the listed healthcare provider.

d. For all planned admissions that require the need for ambulance to commute from the insured's location to the listed healthcare provider, the ambulance services of the listed healthcare provider must be opted.

e. We have accepted a claim under Section 3.1 (In-Patient Care) above.

f. We will cover expenses up to the amount specified in the Certificate of Insurance / Policy Schedule.

g. We will not make any payment under this Benefit if the Insured Person is transferred to any Hospital or diagnostic centre for evaluation purposes only.

3.7 Alternative Treatments

We will indemnify the Medical Expenses upto the amount specified in the Certificate of Insurance / Policy Schedule incurred on the Insured Person's Hospitalization for In-Patient Care during the Policy Period on treatment taken under Ayurveda, Unani, Sidha and Homeopathy. Conditions:

a. The treatment should be taken in a recognized AYUSH Hospital.

b. Exclusions as per Section 8.2.15 (other than for Yoga) shall not apply to the extent this benefit is applicable.

3.8 Technological Advancements and Treatments

a. The following procedures / treatments will be covered either as In-Patient Care or as part of Day Care Treatment upto the amount specified in the Certificate of Insurance / Policy Schedule as per Section 3.1 or Section 3.4 respectively:
   i. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
   ii. Balloon Sinuplasty
   iii. Deep Brain stimulation
   iv. Oral chemotherapy
   v. Immunotherapy- Monoclonal Antibody to be given as injection
   vi. Intra vitreal injections
   vii. Robotic surgeries
   viii. Stereotactic radio surgeries
   ix. Bronchial Thermoplasty

x. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
xi. IONM - (Intra Operative Neuro Monitoring)
xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

b. If We have accepted a claim under this benefit, We will also indemnify the Insured Person's Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses in accordance with Sections 3.2 and Section 3.3 till the overall Sum Insured.

3.9 List of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-I, List-II, List-III and List-IV of Annexure 4.

4. Optional Coverage (Hospitalization)

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that We will pay/restrict the Medical Expenses incurred during the Policy Year under the below listed Covers subject to waiting periods and limits as specified in the Schedule of Benefits on the Policy Schedule / Certificate of Insurance. Subject to otherwise all other terms, conditions, exclusions and waiting periods applicable to the Policy. All coverages under Section 4. 'Optional Coverage (Hospitalization)' are optional in nature. These coverages specifically pertain only to Section 3 'Base coverage (Hospitalization) and can be opted only if the Base Coverage is opted.

4.1 30-Day Waiting Period Modification Option

On availing this option, 30-Day Waiting Period listed under Section 8.1.3. shall stand modified to the period as mentioned in Schedule of Benefits on the Policy Schedule/Certificate of Insurance. All other terms and Conditions of the Policy shall remain unaltered.

4.2 Specific Diseases / Procedures Waiting Period Modification Option

On availing this option, Specific Disease / Procedure Waiting Period listed under Section 8.1.2 shall stand modified from 2 years to the period as mentioned in Schedule of Benefits on the Policy Schedule/Certificate of Insurance. All other terms and Conditions of the Policy shall remain unaltered.

4.3 Pre-Existing Waiting Period Modification Option

On availing this option, Waiting Period listed under Section 8.1.1 shall stand modified from 3 years to the period as mentioned in Schedule of Benefits on the Policy Schedule/Certificate of Insurance. All other terms and Conditions of the Policy shall remain unaltered.

4.4 Initial Health Check-up / Examination for Medical Underwriting

Should we consider that an Initial Health Checkup or Examination is deemed necessary prior to granting coverage to any member of the Group, the cost of such examination shall be borne by us. Coverage for the proposed member shall commence only upon our determination of their insurability. Furthermore, the applicable Waiting Periods, including the 30-Day Waiting Period, Specific Disease/Procedure Waiting Period, and Pre-existing Disease Waiting Period, shall be enforced in accordance with our Underwriting Policy.

4.5 Revive

On availing this option, in the event of complete or partial utilization of the Base Sum Insured due to any claim admitted during the Policy Year irrespective of the utilization of the AccumulatePlus, the Company shall restore the Sum Insured up to the Base Sum Insured for number of times as specified in the Certificate of Insurance / Policy Schedule (as applicable under the current Policy Year) for any subsequent claims, admissible under Section 3 (Base Benefits), subject to the following conditions:

a. The Revive can be triggered upto a number of times as specified in the Certificate of Insurance / Policy Schedule during each

Policy Year and any unutilized amount, in whole or in part, will not be carried forward to the subsequent Policy Year.

b. The Base Sum Insured restoration under the Revive benefit would be triggered only upon complete or partial utilization of the Base Sum Insured by way of first claim admitted under the Policy and be available for subsequent claims thereafter in the Policy Year, for all Insured Persons.
c. In case of a family floater coverage, the Revive will be available on floater basis for all Insured Persons covered under the Certificate of Insurance and will operate in accordance with the above conditions.

4.6 AccumulatePlus

On availing this option, on Renewal of this Policy with the Company without a break, a sum equal to and upto specified amount, as mentioned in the Certificate of Insurance / Policy Schedule, of the Base Sum Insured of the expiring Policy shall be provided as AccumulatePlus irrespective of any claims and shall be available under the Renewed Policy:

This benefit is subject to the following conditions:

a. In case where the Policy coverage is on individual basis as specified in the Certificate of Insurance / Policy Schedule, the AccumulatePlus shall be added and available individually to the Insured Person.
b. In case where the Policy coverage is on floater basis as specified in the Certificate of Insurance / Policy Schedule, the AccumulatePlus shall be added and available to the family on floater basis.
c. AccumulatePlus shall be available only if the Certificate of Insurance / Policy is renewed/ premium paid within the Grace Period, wherever applicable.
d. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Certificate of Insurance / Policy Schedule and there is an accumulated AccumulatePlus for such Insured Persons under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the AccumulatePlus to be carried forward for credit in such Renewed Policy shall be the lowest one that is applicable among all the Insured Persons.
e. In case of floater policies where the Insured Persons Renew their expiring policy by splitting the Sum Insured into two or more floater policies/individual policies or in cases where the Policy is split due to the child attaining the Age of 25 years, the AccumulatePlus of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
f. If the Sum Insured has been reduced at the time of Renewal, the applicable AccumulatePlus shall be reduced in the same proportion to the Sum Insured in current Policy.
g. If the Sum Insured under the Policy has been increased at the time of Renewal, the AccumulatePlus shall be calculated on the Sum Insured of the last completed Policy Year.
h. If the Policy Period is of two/three years, any AccumulatePlus that has accrued for the first/second Policy Year shall be credited post completion of each Policy Year.
i. New Insured Person added to the Policy during subsequent Renewals will be eligible for AccumulatePlus as per their Renewal terms.
j. AccumulatePlus shall be available only if the Cover is specified to be applicable in the Schedule of Benefits on the Certificate of Insurance / Policy Schedule.

4.7 Annual Health Check-up

On availing this option, the Insured Person is eligible for an annual health check-up – defined package as detailed in Annexure 5, and is subject to change from time to time and to be updated on our website, at any of our Network Hospitals and Network Clinics as listed out in Annexure 6 at no additional cost provided that:

a. The Insured Person is above 18 years of age on the commencement of that Policy Year.
b. Any unutilized Annual Health Check-up cannot be carried forward to the next Policy Year.
c. Insured Person is only eligible for one Annual Health Check-up – “Base Package” - within that Policy Year.

4.8 Emergency Air Ambulance Charges

On availing this option, the Company shall indemnify expenses incurred by the Insured Person during the Policy Year towards Ambulance transportation in an airplane or helicopter for Emergency Care which requires immediate and rapid Ambulance transportation that ground transportation cannot provide from the site of first occurrence of the Illness or Accident to any of the Network Provider. The claim is subject to a maximum of Sum Insured as specified in the Schedule of Benefits on the Certificate of Insurance / Policy Schedule against this Cover, and subject to the following conditions:

a. The Air Ambulance transportation is advised in writing by a Medical Practitioner and verified by RMP at Network Provider.

b. Medically Necessary Treatment is not available within 100 kms of the location where the Insured Person is situated at the time of

emergency.

c. The Insured Person is in India and the treatment is taken in India at Network Provider only.

d. No return transportation to the Insured Person's Home or elsewhere by the Air Ambulance will be covered under this Cover.

e. A claim for the same Hospitalization is admissible under Section 3.1 (In-patient Care) or Section 3.8 (Technological Advancements and Treatments).

f. The amount specified in the Schedule of Benefits on the Certificate of Insurance / Policy Schedule against this benefit denotes the Company's maximum liability in respect to the benefit and shall reduce the Sum Insured of the policy.

g. The claims under this benefit shall be payable on a reimbursement basis only.

4.9 Maternity Benefit

On availing this option, we will indemnify Maternity Expenses incurred by the Insured Person under Inpatient Care Section 3.1, incurred during the Policy Year. Specific Conditions applicable to Maternity Benefit:

a. On opting this cover, exclusion pertaining to Maternity Benefit (Code-Excl18) shall be superseded to the extent of coverage provided under this benefit.

b. Under Maternity Benefit, we shall only cover the medical expenses as detailed under Section 3.1, upto the limit as specified in Certificate of Insurance / Policy Schedule against this benefit.

c. Indemnification for expenses concerning Maternity Benefit under this benefit shall be covered only upto the limit specified against this cover in the Schedule of Benefits on the Certificate of Insurance / Policy Schedule.

d. An additional waiting period as specified in the Certificate of Insurance / Policy Schedule against this cover) starting from the date of commencement of this Cover under this Policy shall apply for all Claims under Maternity Cover.

e. Sub-limit for Normal Delivery and Caesarean Section for Non-Network Provider shall be as applicable as specified in the Certificate of Insurance / Policy Schedule.

4.10 Pre and Post Natal Expenses

On availing this option, we will indemnify Medical Expenses incurred during the Policy Year for Pre and Post Natal expenses upto the amount as specified in the Certificate of Insurance / Policy Schedule.

This benefit can only be opted if Maternity Benefit is opted.

4.11 Baby Cover from Day 1

On availing this option, we will indemnify Medical Expenses incurred on Hospitalization during the Policy Year towards Medically Necessary Treatment of the Insured Person's New Born Baby, as advised by the treating Medical Practitioner, up to the amount as specified in the Certificate of Insurance / Policy Schedule. Specific Conditions applicable to Baby Cover from Day 1.

i. Baby Cover from Day 1 does not have an independent Sum Insured, hence any claim admissible under this cover shall reduce the Base Sum Insured.

ii. We will indemnify medical expenses under this cover only for the 1st 90 days from the birth of the new born.

iii. For continued coverage post 90 days under the Policy, the Policyholder must
i. Inform us in writing that he wishes to add the new born as an Insured Person (dependent child) under this Policy and
ii. Pay the requisite premium within the 1st 90 days from the birth of the new born.
iii. Continued coverage shall be offered subject to our underwriting policy.

This benefit can only be opted in combination with Maternity Benefit.

4.12 Daily Deductible

On availing this option, Daily Deductible per day of hospitalization of the amount as specified in the Certificate of Insurance / Policy Schedule shall be applicable on all claims or Non-Surgery or Non-Surgical Procedures basis the option selected and shall be as specified in the Schedule of Benefits on the Certificate of Insurance / Policy Schedule. Daily Deductible shall be applicable for treatment as required in In-patient Care (Section 3.1), Alternative Treatment (Section 3.7), Living Organ Donor Transplant (Section 3.5), Technological Advancements & Treatments (Section 3.8), which must require hospitalization or a Day Care Treatment (Section 3.4) that are Surgery or Surgical Procedures. The following conditions are applicable:

a. No Daily Deductible shall be applicable on both the plans for Day Care Treatment that are Non-Surgery or Non-Surgical Procedure.

b. It is agreed that Our liability to make payment under the Policy in respect of any claim made in that Policy Year will only commence once the total deductible basis the number of hospitalization days has been exhausted.

c. Deductible will not apply to any claim under Domestic Road Ambulance Charges (Section 3.6), Emergency Air Ambulance Charges (Section 4.8), if opted and Annual Health checkup (Section 4.7), if opted.

4.13 Aggregate Deductible

On availing this option, the Insured Person shall bear an amount equal to the Aggregate Deductible as specified in the Schedule of Benefits on the Certificate of Insurance / Policy Schedule for admissible claims made under coverages mentioned in a Policy Year. Specific Conditions applicable to Aggregate Deductible.

a. The liability of the Company to pay the admissible Claims in a given Policy Year will commence only once Aggregate Deductible has been exhausted.

b. This cover shall apply on an annual aggregate basis and not on per claim basis.

c. In case of an Individual Policy, the entire amount of Aggregate Deductible must first be exhausted on per Insured Person basis, once in a Policy Year, before the Company pays for claims of that Insured Person in that Policy Year.

d. In case of a family floater Policy, the entire amount of Aggregate Deductible must first be exhausted by any one or more of the Insured Persons once in a Policy Year before the Company pays for claims of any Family Member covered under the Policy in that Policy Year.

e. Aggregate Deductible shall apply only to covers as mentioned below:
   - In-Patient Care
   - Pre-hospitalization Medical Expenses
   - Post-hospitalization Medical Expenses
   - Day Care Treatment
   - Living Organ Donor Transplant
   - Alternative Treatments
   - Technological Advancements and Treatments
   - Domestic Road Ambulance Charges
   - Emergency Air Ambulance Charges (if opted)
   - Maternity Benefit (if opted)
   - Pre and Post Natal Expenses (if opted)
   - Baby Cover from Day 1 (if opted)
   - Domiciliary Hospitalization (if opted)

4.14 Co-payment

On availing this option, Co-payment as mentioned in the Certificate of Insurance / Policy Schedule will be applied on admissible claim only on the coverages mentioned below for the applicable type of lives as opted and specified in the Policy Scheule / Certificate of Insurance:

- In-Patient Care
- Pre-hospitalization Medical Expenses

- Post-hospitalization Medical Expenses
- Day Care Treatment
- Living Organ Donor Transplant
- Alternative Treatments
- Technological Advancements and Treatments
- Domestic Road Ambulance Charges
- Emergency Air Ambulance Charges (if opted)
- Maternity Benefit (if opted)
- Pre and Post Natal Expenses (if opted)
- Baby Cover from Day 1 (if opted)
- Domiciliary Hospitalization (if opted)

4.15 Corporate Buffer

On availing this option, we will provide for a Corporate Buffer during the Policy Year up to the limits and terms as specified in the Certificate of Insurance / Policy Schedule.

In the event of Insured Person/s covered under this Policy, exhausting their Sum Insured during the policy period on account of payment of admissible claims, then the Sum insured for such Insured Person shall be increased to the extent of amount of claim that exceeds the Sum Insured in respect of the Insured Person from the Corporate Buffer. Upon payment of such additional amounts the Corporate Buffer shall be reduced to the extent of such claim amounts admitted and paid by Us over and above the Insured Person's Sum Insured.

Specific Conditions applicable to Corporate Buffer:

a. All other terms and conditions of the Policy shall remain unaltered.

b. The coverage under this benefit will be only applicable for Insured Persons who have exhausted their Sum Insured limits and under no other circumstances.

c. To be abundantly clear, Corporate Buffer is not intended to pay for any deductions from claim, any adjustments to claims on account of applicable terms and conditions, or due to denial of coverage by Us as per terms and conditions of this Policy

The Corporate Cover may be restricted to below Critical Illnesses as per the selection made by the Proposer.

Sno.	Name of Critical Illness
1	Kidney failure requiring regular dialysis
2	Stroke resulting in permanent symptoms
3	Open chest CABG
4	Cancer of specified severity
5	Encephalitis (Viral)
6	Brain Surgery
7	Total Replacement of Joints
8	Cirrhosis of Liver
9	Injury leading to brain surgery
10	Third Degree Burns

4.16 Domiciliary Hospitalization

On availing this option, the company shall indemnify the Medical Expenses incurred during the Policy Year on Domiciliary Hospitalization of the Insured Person prescribed in writing by treating Medical Practitioner at Preferred Network Provider, provided that:

a. the condition of the Insured Person is such that he/she could not be removed/admitted to a Hospital. or,

b. the Medically Necessary Treatment is taken at Home on account of non-availability of room in a Hospital.

Illnesses / Conditions as listed below shall be excluded under this benefit:

a. Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
b. Arthritis, gout and rheumatism;
c. Ailments of spine/disc;
d. Chronic nephritis and nephritic syndrome;
e. Any liver disease;
f. Peptic ulcer;
g. Diarrhoea and all type of dysenteries, including gastroenteritis;
h. Diabetes mellitus and insipidus;
i. Epilepsy;
j. Hypertension;
k. Pyrexia of any origin.

5. Optional Base Covers

5.1 Personal Accident Cover:
(applicable only for adults greater than 18 years of age at the time of Policy issuance).

5.1.1 Accidental Death

On availing this option, we will pay in lumpsum the amount as specified in the Certificate of Insurance / Policy Schedule against this benefit, if Insured Person sustains Injury during the Policy Period, which shall within twelve months of its occurrence be the sole and direct cause of Death of Insured Person. The payment of claims under this benefit shall not reduce the Base Sum Insured for Base Covers (Hospitalization)

a. Disappearance

We will pay in lumpsum the Base Sum Insured in the event if Insured Person's body cannot be located within 365 Days;

i. after the forced landing, stranding, sinking or wrecking of a conveyance in which Insured Person was known to be a passenger during Policy Period or;
ii. after and as a result of any Catastrophic Event during Policy Period

it shall be deemed, subject to all other terms and provisions of the Policy, that Insured Person shall have suffered Death due to Accident under the Coverage.

If at any time, after the payment of the Accidental death benefit, it is discovered that the Insured Person is still alive, claims settled shall be reimbursed in full to the Company.

Specific condition applicable to Accidental Death:
The Coverage under this Section terminates on admissibility of Liability.

5.1.2 Permanent Disablement

If Insured Person sustains Injury during the Policy Year, which shall within twelve (12) months of its occurrence be the sole and direct cause of Permanent Disablement (PD), We will pay in lumpsum, in accordance to the chosen Benefit Tables (A, B, C and D) below upto maximum of amount as specified in Policy Schedule as stipulated against Permanent Disablement in the Policy Schedule/Certificate of Insurance provided such disablement is certified by the Medical Practitioner. The Sum Insured for this benefit shall be equal to the Base Sum Insured.

Benefit Table A

Sno.	The Disablement	% of Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance of Limbs)	100%

4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb (physical severance of Limbs)	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10	Permanent Total Loss of Hearing in both ears	75%
11	Permanent Total Loss of one Limb (physical severance of Limbs)	50%
12	Permanent Total Loss of Sight of one eye	50%

Benefit Table B

Sno.	The Disablement	% of Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance or the total and permanent loss of use of such Limb)	100%
4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb (physical severance or the total and permanent loss of use of such Limb)	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
9	Permanent Total Loss of Mastication	100%
10	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	75%
11	Permanent Total Loss of Hearing in both ears	50%
12	Permanent Total Loss of one Limb (physical severance or the total and permanent loss of use of such Limb)	50%

Benefit Table C

Sno.	The Disablement	% of Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance or the total and permanent loss of use)	100%
4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb (physical severance or the total and permanent loss of use)	100%

6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total Loss of Mastication	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10	Permanent Total Loss of Hearing in both ears	75%
11	Permanent Total Loss of one Limb (physical severance or the total and permanent loss of use)	50%
12	Permanent Total Loss of Sight of one eye	50%
13	Permanent Total Loss of Hearing in one ear	15%
14	Permanent Total Loss of the lens in one eye	25%
15	Permanent Total Loss of use of four fingers and thumb of either hand	40%
16	Permanent Total Loss of use of four fingers of either hand	20%
17	Permanent Total Loss of use of one thumb of either hand :	
a)	Both joints	20%
b)	One joint	10%
18	Permanent Total Loss of one finger of either hand :	
a)	Three joints	5%
b)	Two joints	4%
c)	One joint	2%
19	Permanent Total Loss of use of toes :	
a)	All -one foot	15%
b)	Big -both joints	5%
c)	Big -one joint	2%
d)	Other than Big -each toe	2%
20	Established non -union of fractured leg or kneecap	10%
21	Shortening of leg by at least 5cms	8%
22	Ankylosis of the elbow, hip or knee	20%

Benefit Table D

Sno.	The Disablement	% of Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance or the total and permanent loss of use)	100%
4	Permanent Total Loss of Sight in both eyes	100%

5	Permanent Total Loss of Sight of one eye and one Limb (physical severance or the total and permanent loss of use)	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total Loss of Mastication	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10	Permanent Total Loss of Hearing in both ears	75%
11	Permanent Total Loss of one Limb (physical severance or the total and permanent loss of use)	50%
12	Permanent Total Loss of Sight of one eye	50%
13	Permanent Total Loss of Hearing in one ear	15%
14	Permanent Total Loss of the lens in one eye	25%
15	Permanent Total Loss of use of four fingers and thumb of either hand	40%
16	Permanent Total Loss of use of four fingers of either hand	20%
17	Permanent Total Loss of use of one thumb of either hand :	
a)	Both joints	20%
b)	One joint	10%
18	Permanent Total Loss of one finger of either hand :	
a)	Three joints	5%
b)	Two joints	4%
c)	One joint	2%
19	Permanent Total Loss of use of toes :	
a)	All -one foot	15%
b)	Big -both joints	5%
c)	Big -one joint	2%
d)	Other than Big -each toe	2%
20	Established non -union of fractured leg or kneecap	10%
21	Shortening of leg by at least 5cms	8%
22	Ankylosis of the elbow, hip or knee	20%
23	Permanent disablement not otherwise provided for under Items 2-22 inclusive up to a maximum of	75%

Specific Conditions applicable to Permanent Disablement

a. Ankylosis of the fingers (other than thumb and forefinger) and of the toes (other than the big toe) shall be limited to 50% of the Sum Insured payable for the loss of the said members
b. Benefit under item 23 of Benefit Table D shall be determined by the independent Medical Practitioner who will certify the percentage of Sum Insured payable taking into consideration the nature of the Injury and disability in conjunction with the stated percentages Sum Insured for more specific injuries shown in the Table of Benefits.
c. Any claim amount admissible/paid during a given Policy year will reduce the benefit amount payable for the Cover in

respect of subsequent claims that may arise in the remainder of the Policy Year.

d. The total amount payable in respect of more than one disablement due to the same Injury is arrived at by adding together the various percentages of Sum Insured shown in the Table of Benefits.
e. Only one Table out of Benefit Tables A, B, C, D stipulated above can be opted and the same shall be mentioned in the Policy Schedule.

Specific Conditions applicable to Permanent Disablement

a. This cover is offered only on Individual Sum Insured basis
b. In case Insured person opts for Personal Accident section, he would be eligible for both Accidental Death and Permanent Disablement
c. The Sum Insured stipulated against Personal Accident section in the Policy Schedule is a common Sum Insured for Accidental Death and Permanent Disablement coverages
d. In case we have paid a claim under Accidental Death, then the entire Personal Accident cover shall terminate for that Insured Person
e. In case of Permanent Disablement claims, the Company's maximum liability in a particular Policy Year shall never exceed the Sum Insured stipulated against Personal Accident cover
f. In case a claim is paid during the Policy Year under Permanent Disablement cover the Sum Insured for the same shall be replenished post completion of that Policy Year
g. In case we have paid a claim for a particular Permanent Disablement, we shall not be liable to pay future PD claims pertaining to the exact same claim in the lifetime of the Policy
h. In case we have paid a claim for Permanent Disablement during a Policy Year and the Insured person unfortunately succumbs to an Accidental Death in the same Policy Year, only the remaining portion of the benefit amount (if any) stipulated against Personal Accident cover shall be payable as part of the Accidental Death cover.
i. Geography of Personal Accident cover is worldwide
j. No waiting periods whatsoever shall apply to this cover

The coverage under Personal Accident shall be applicable as specified in the Certificate of Insurance / Policy Schedule and restricted to Rail /Road / Public Transport / Air / None as per the option selected and as specified in the Certificate of Insurance / Policy Schedule.

5.2 Hospital Daily Cash

On availing this option, if Insured Person contracts Illness or sustains Injury during Policy Year, which results in Medically Necessary:

a. Hospitalization OR

b. Domiciliary Hospitalization OR

c. Hospitalization for Alternative Treatments of an Insured Person within India,

We will pay the per day cash benefit as specified in the Schedule of Benefits on the Policy Schedule/Certificate of Insurance subject to maximum number of benefit days for each continuous and completed period of 24 hours of such Hospitalization:

Specific Conditions applicable to Hospital Daily Cash benefit:

a. Claim payout shall be subject to the maximum number of days in a Policy Year as specified in the Schedule of Benefits on the Policy Schedule/Certificate of Insurance.

b. All Waiting Periods as specified in the Policy Schedule/Certificate of Insurance against this cover shall apply. Timeframe for these waiting periods shall be as specified against this cover in the Certificate of Insurance / Policy Schedule. Terms, conditions and clauses for the applicable waiting periods are provided under Section 8.1.1, Section 8.1.2 and Section 8.1.3.

c. The utilization of this benefit does not reduce the Base Sum Insured for hospitalization.

6. Healthcare Provider

All In-patient Care Benefits (Section 3.1) under this policy shall be applicable for coverage only at Network Provider.

The coverage shall be extended to Non-network Provider only in the below mentioned scenarios:

a. All cases of emergency as defined in Section 2.1.14.
b. Treatment not available at Network Provider.
c. Insured Person travelling to a location and incurs a case of emergency where Network Provider is not accessible. In this scenario, Insured Person must submit a proof of travel and reason of travel with evidence which shall be accepted by Us.
d. Insured Person relocating to a location where Network Provider is not accessible.
In this scenario, the Insured Person must submit the Proof of Address of the new relocated address within 2 months of relocation or at time of claim, whichever is earlier.

7. Non-intimation Co-payment for Non-Network Provider Claims

For all types of benefits and its coverage under this policy,

a. A Co-payment of 30% shall be applicable over and above the applicable Co-payment as specified in the Certificate of Insurance/Policy Schedule, if the Insured Person is seeking coverage at Non-Network healthcare provider due to either of Section 6 (b) and 6 (d) as defined in Healthcare Provider (Section 6), and does not intimate Us 48 hours prior to the time of admission.

b. A Co-payment of 15% shall be applicable over and above the applicable Co-payment as specified in the Certificate of Insurance/Policy Schedule, if the Insured Person is seeking coverage at Non-Network healthcare provider due to scenario as defined in Section 6 (a) and Section 6 (c) as defined in Healthcare Provider (Section 6), and does not intimate Us within 24 hours from the time of admission.

8. Exclusions

8.1 Standard Exclusions

8.1.1 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 insurer.

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

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

d. Coverage under the Policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

8.1.2 Specified Disease/Procedure waiting period (Code-Excl02):

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident.

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

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

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

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

f. List of specific diseases/procedures is provided below:

Illnesses

i. Pancreatitis
ii. Diseases of gall bladder including cholecystitis
iii. All forms of Cirrhosis
iv. Cataract and other disorders of lens and Retina
v. Perineal Abscesses
vi. Osteoarthritis and osteoporosis
vii. Fibroids (fibromyoma)
viii. Non infective Arthritis
ix. Calculus diseases of Urogenital system e.g. Kidney stone, Urinary Bladder Stone
x. Ulcer and erosion of stomach and duodenum
xi. Gastro Oesophageal Reflux Disorder (GERD)
xii. Perianal Abscesses
xiii. Fissure/fistula in anus, Haemorrhoids including Gout and rheumatism
xiv. Benign Hyperplasia of Prostate
xv. Pilonidal sinus
xvi. Benign tumours, cysts, nodules, polyps including breast lumps
xvii. Polycystic ovarian diseases
xviii. Sinusitis, Rhinitis
xix. Skin tumours
xx. Tonsillitis

Surgical Procedures

i. Adenoidectomy, tonsillectomy
ii. Tympanoplasty, Mastoidectomy
iii. Hernia
iv. Dilatation and curettage (D&C)
v. Nasal concha resection
vi. Surgery for prolapsed inter vertebral disc
vii. Myomectomy for fibroids
viii. Surgery of Genito urinary system unless necessitated by Malignancy
ix. Surgery for varicose veins and varicose ulcers
x. Surgery on prostate

8.1.3 30-day waiting period (Code-Excl03):

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

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

c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

8.1.4 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.

8.1.5 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:

a. 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.

b. Any services for people who are terminally ill to address physical, social, emotional, and spiritual needs.

8.1.6 Obesity/ Weight Control (Code-Excl06):

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

a. Surgery to be conducted is upon the advice of the Doctor.

b. The surgery/Procedure conducted should be supported by clinical protocols.

c. The member has to be 18 years of age or older and;

d. Body Mass Index (BMI);
   i. greater than or equal to 40 or
   ii. 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:
      - Obesity-related cardiomyopathy
      - Coronary heart disease
      - Severe Sleep Apnoea
      - Uncontrolled Type2 Diabetes

8.1.7 Change-of-Gender treatments (Code-Excl07):

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

8.1.8 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.

8.1.9 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.

8.1.10 Breach of law (Code-Excl10):

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

8.1.11 Excluded Providers (Code-Excl11):

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our 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.

The complete list of excluded providers can be referred to on our website.

8.1.12 Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences there-of (Code-Excl12)

8.1.13 Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code-Excl13)

8.1.14 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)

8.1.15 Refractive Error (Code-Excl15):

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

8.1.16 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.

8.1.17 Sterility and Infertility (Code-Excl17):

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

c. Gestational Surrogacy

d. Reversal of sterilization

8.1.18 Maternity (Code-Excl18):

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

b. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the Policy Period.

8.2 Specific Exclusions

8.2.1 Charges related to treatment arising from or contributed or aggravated or accelerated by any of the following:

a. Suicide or attempted suicide, while sane or insane, or due to use, misuse or abuse of narcotic or intoxicating drugs or alcohol or solvent

b. Intentional self-injury

c. Use or consumption of narcotic or intoxicating drugs or alcohol or solvent, or taking of drugs (except under the direction of a Medical Practitioner)

8.2.2 Charges related to a Hospital stay not expressly mentioned as being covered. This will include Resident Medical Officer (RMO) charges, surcharges and service charges levied by the Hospital.

8.2.3 Circumcision:

Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

8.2.4 Conflict & Disaster:

Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.

8.2.5 External Congenital Anomaly: Screening, counseling or treatment related to external Congenital Anomaly.

8.2.6 Dental/oral treatment:

Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.

8.2.7 Hormone Replacement Therapy:

Treatment for any condition / illness which requires hormone replacement therapy.

8.2.8 Multifocal Lens or any kind of eye wear for vision correction

8.2.9 Prosthetics and other Ambulatory devices such as walkers, crutches, splints, stockings of any kind and also any medical equipment which is subsequently used at home.

8.2.10 Sexually transmitted Infections & diseases (other than HIV / AIDS)
Screening, prevention and treatment for sexually related infection or disease (other than HIV / AIDS).

8.2.11 Sleep disorders:

Treatment for any conditions related to disturbance of normal sleep patterns or behaviours.

8.2.12 Any treatment or medical services received at Non-network Provider except for scenarios as defined in Section 6 (a), 6 (b), 6 (c) and 6 (d)

For treatment or medical services received at Non-network Provider, the clause of excluded provider (section 8.1.11) shall apply.

8.2.13 Unrecognized Physician or Hospital:

For treatment of those covered under the policy that are not available at the listed network healthcare provider and the Insured Person seeks the treatment beyond the listed network healthcare provider, the coverage will be denied if:

a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central council of Homeopathy.

b. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.

c. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India.

8.2.14 Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state as demonstrated by:

a. Deep coma and unresponsiveness to all forms of stimulation; or

b. Absent pupillary light reaction; or

c. Absent oculovestibular and corneal reflexes; or

d. Complete apnoea.

8.2.15 Alternative Treatment:
Any form of Alternative Treatments, except as mentioned under Section 3.7.

8.2.16 Treatment of injury or illness due to participation or involvement in naval, military or air force operation.

8.2.17 Any Legal Liability due to any errors or omission or representation or consequences of any action taken on the part of any Hospital or Medical Practitioner.

9. Moratorium Period

After completion of sixty (60) continuous months under this policy no look back would be applied. This shall be applicable to ported policies as well subject to the condition that the coverage has been continuous. This period of 60 months is called the moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 60 continuous months would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of the Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

10. Claim Procedure

10.1 For treatment at Network Provider:

Cashless admission facility shall be extended to the Insured Person in case of at the listed Network Provider for the coverage as defined under the Benefits in this document.

Procedure for the Cashless Claim at listed Network Provider:

a. While no intimation is required for pre-authorization of cashless admission for the coverage of benefits under In-Patient Care, Day Care Treatment, Alternate Treatment and Technological Advancement and Treatment, Living Organ Donor Transplant, it is recommended that the Insured Person intimates the Customer Support team in case of planned treatment to check the coverage applicability to avoid any confusion. A detailed description of the intimation process is available in the claims manual at the company website www.narayanahealth.insurance.

b. Insured Person must produce the Digital Health Card or the Certificate of Insurance or the Policy Number along with valid government Proof of Identity at the Insurance Desk of the Network Provider to register for cashless processing, on the date of admission and before admission.

We reserve the right to reject the cashless claim for planned admission if the treatment sought is beyond the coverage benefit of the policy.

10.2 For treatment at Non-Network Provider except listed Excluded Providers pertaining to Section 6 (b), 6 (c) & 6 (d):

Cashless admission facility shall be extended to the Insured Person in case of planned admissions in such cases. The procedure for availing the cashless benefit in such cases are as below:

a. Cashless request form available with the healthcare provider shall be completed and sent to Us for authorization.

b. We, upon getting cashless request form and related medical information from the Insured Person/ network provider will issue pre-authorization letter to the hospital after verification.

c. At the time of discharge, the Insured Person has to verify and sign the discharge papers, pay for inadmissible expenses and deductible as per the policy.

d. We reserve the right to deny pre-authorization in case the Insured Person is unable to provide the relevant medical details.

In case of denial of cashless access, the Insured Person may obtain the treatment as per treating doctor's advice and submit the claim documents to Us for reimbursement.

10.3 For Emergency admissions (Section 6(a)) at Non-network Provider, where admission at Network Provider was not reasonably possible

We shall extend the cashless facility in such cases subject to the concerned healthcare provider agreeing to such arrangements.

In case of denial of cashless admission by the concerned Healthcare Provider, the Insured Person may obtain the treatment as per treating doctor's advice and submit the claim documents to Us for reimbursement.

Please note:

- Turnaround time for initial request: Decide on the request for cashless authorization immediately but not more than one hour of receipt of request.
- Turnaround time for final approval: Final authorization within three hours of the receipt of discharge authorization request from the hospital
- Reimbursement option shall be availed for admissible Pre-hospitalization, Post-hospitalization expenses or for any expenses where cashless was not availed at the Healthcare Provider.
- Turnaround time for claim settlement – 15 days from the time the last required document has been received by Us.

10.4 Procedure for reimbursement of claim:

For reimbursement of claims the Insured Person may submit the necessary documents to Us within the prescribed time limit as specified hereunder:

S No	Type of Claim	Prescribed Time limit
1	Reimbursement of In-patient Care, Day Care Treatment, Pre-hospitalization expenses, Alternative Treatment, Technological Advancement and Treatment and Global Health Cover (Emergency Treatment Only) if opted	Within 30 days of date of discharge from hospital
2	Reimbursement of post-hospitalization expenses	Within 15 days from completion of Post-hospitalization treatment

a. Notification of Claim:

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

b. Documents to be submitted:

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly Completed claim form
ii. Photo Identity proof of the patient
iii. Medical practitioner's prescription advising admission
iv. Original bills with itemized break-up
v. Payment receipts
vi. Discharge summary including complete medical history of the patient along with other details.
vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgery/surgical procedure cases)
ix. Sticker/Invoice of the Implants, wherever applicable
x. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, wherever applicable
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
xiii. Legal heir/succession certificate, wherever applicable
xiv. Any other relevant document required by Company/TPA for assessment of the claim

We may specify the documents required in original and waive off any of above required as per their claim procedure

Note:

- We shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
- In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction by Us
- Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

Please note that the Claim forms are available at the website www.narayanahealth.insurance.

11. Claim Settlement (Provision for Penal Interest)

11.1 The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

11.2 In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the concerned beneficiary from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

11.3 However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such an investigation at the earliest in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.

11.4 In case of delay beyond stipulated 45 days the company shall be liable to pay interest to the concerned beneficiary at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

12. Payment of Claim

All claims under the policy shall be payable in Indian currency only.

13. Value Added Services

We may provide discretionary discounts to You on Out-patient expenses such as consultation, medicine, lab tests, diagnostic tests, etc. at our service providers listed on our website - www.narayanahealth.insurance.

14. General Terms and Conditions (applicable only to Non-Employer-Employee group type)

14.1 Disclosure of Information

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

14.2 Condition Precedent to Admission of Liability

The due observance and fulfilment of the terms and conditions of the policy, by the Insured Person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

14.3 Loading of Premium

Based on Our discretion, upon the disclosure of the health status of the persons proposed for insurance and declarations made during the pre-policy medical check-up for underwriting purposes, We may apply a risk loading on the premium payable (excluding statutory levies and taxes) or Special Conditions on the Policy. The maximum risk loading shall be as per our Underwriting Guideline. These loadings will be applied from inception date of the First Policy including subsequent Renewal(s) with Us.

14.4 Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

14.5 Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

14.6 Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal heir/ representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim

14.7 Notice & Communication

a. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.

b. Such communication shall be sent to the address of the Company or through any other electronic modes.

c. The Company shall communicate with the Insured at the address or through any other electronic modes.

14.8 Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

14.9 Multiple Policies

a. In case of multiple policies taken by an Insured Person during a period from the same or one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer if 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.

b. 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(s) shall independently settle the claim subject to the terms and conditions of this policy.

c. 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.

d. Where an Insured Person has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

14.10 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 there-of, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the Policy Schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud", inter alia, means any of the following acts committed by the Insured Person or by his agent, 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

14.11 Cancellation

a. Except in case any claim has been admitted or has been lodged or any benefit has been availed under the Policy, the Insured may cancel this Policy by giving 7 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period.

Note: For Policies where premium is paid by instalment: In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.

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

14.12 Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate:

d. In the case of his/her (Insured Person) demise. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other Insured Persons may also apply to renew the policy. In case the other Insured Person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardians appointed by court. All relevant particulars in respect of such a person (including his/her relationship with the Insured Person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the Insured Person. Pro-rata refund of premium of the deceased Insured Person for the balance period of the policy will be effective.

e. Upon exhaustion of Sum Insured for the policy year.

However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

14.13 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

14.14 Portability

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

a. The waiting periods specified in Pre-existing Diseases Excl01 (Section 8.1.1), Specific Disease Procedure Waiting Period Excl02 (Section 8.1.2) shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

b. Portability benefit will be offered to the extent of sum of previous Sum Insured and accrued bonus (as part of the base Sum Insured), portability benefit shall not apply to any other additional increased Sum Insured.

The extant Guidelines related to portability are as below:

- Portability means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained from one insurer to another insurer.
- By porting, the policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc. from the Existing Insurer to the Acquiring Insurer in the previous policy.
- The Acquiring and the Existing Insurers shall jointly, ensure that the entire underwriting details and claim history of the Policyholders are seamlessly transferred.
- The existing insurer shall provide the information sought by the Acquiring insurer immediately but not more than 72 hours of receipt of request through Insurance Information Bureau of India (IIB) https://iib.gov.in/portal
- The Acquiring insurer shall decide and communicate on the proposal at the earliest possible time but not more than 5 days of receipt of information from Existing insurer.

- A policyholder desirous of porting his/her policy to another insurer shall apply 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 renewal. Insurers are free to consider proposal for portability even if the policyholder has approached within 15 days from the renewal date of the existing policy, but in all such cases acquiring insurer shall ensure that there is no break in policy.
- No charges shall be levied on the policyholder for porting-in or porting-out

For Detailed Guidelines on Portability, please visit the weblink: https://irdai.gov.in/document-detail?documentId=5625747.

14.15 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the Insured Person. The Company is not bound to give notice that it is due for renewal.

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

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

c. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.

d. If not renewed within Grace Period after due renewal date, the Policy shall stand terminated with effect from the due date of renewal.

14.16 Multi-year Premium Payment

The Insured Person may choose to pay Premium for multi years for coverage upto a maximum of 3 Years. The Insured Person is eligible for discount on Premium basis the below slab, provided Insured has paid the premium in advance as a single premium.

No of years of coverage	Applicable Discount on premium (excl. taxes)
1 Year	0%
2 Years	7.5%
3 Years	7.5%

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

The Company may revise or modify the terms of the policy including the premium rates as per applicable IRDAI regulations. The Insured Person shall be notified three months before the changes are affected.

14.18 Free Look Period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

The insured shall be allowed a period of thirty days from the date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.

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

a. A refund of the premium paid; or

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

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

14.19 Endorsements (Changes in Policy)

a. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

b. The Primary Insured may be changed only at the time of renewal. The new Primary Insured must be the legal heir / immediate family members. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The Primary Insured may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

14.20 Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal subject to underwriting by the Company.

14.21 Terms and conditions of the Policy

The terms and conditions contained herein shall be deemed to form part of the Policy and shall be read together as one document.

14.22 Nomination:

The Insured Person is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the Insured Person. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the Insured Person. 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 Insured Person whose discharge shall be treated as full and final discharge of its liability under the Policy. Nomination can be changed any time during the term of the policy.

14.23 Premium Payment in Instalments

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

1 Grace Period as mentioned in the table below would be given to pay the instalment premium due for the Policy

Options	Instalment Premium Option	Grace period applicable
Option 1	Multi-Year / Yearly	30 days
Option 2	Half-yearly	30 days
Option 3	Quarterly	30 days
Option 4	Monthly	15 days

2 If Premium is paid in instalments, then coverage will be available during the grace period also.

14.24 Redressal of Grievance

Step 1:
Call the Customer Support at +91 9821 034071
or email us at support@narayanahealth.insurance

Senior citizens may call at 1800-203-0234 or email us at seniorcitizencare@narayanahealth.insurance for priority assistance.

Step 2:
If the issue is not resolved in Step 1 and the customer wants to make a further suggestion or a complaint, they can email us at grievance@narayanahealth.insurance

Step 3:
If the customer for some reason feels that we have not been able to resolve the issue even in Step 2 and customer wishes to raise a concern, please write to Grievance Redressal Officer at gro@narayanahealth.insurance.

Step 4:
In case a complainant is not satisfied with the resolution from the above escalation authority, they may choose to log in their grievance at **IRDAI Integrated Grievance Management System** - https://igms.irda.gov.in/ or they can approach the Insurance Ombudsman. The detailed addresses of all the Insurance Ombudsman can be found in the link below.

The contact details of the Insurance Ombudsman offices have been provided as Annexure 7.

15. General Terms and Conditions (applicable only to Employer-Employee Group Type)

15.1 Disclosure of Information

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

15.2 Condition Precedent to Admission of Liability

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

15.3 Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

15.4 Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

15.5 Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

15.6 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 all the accrued continuity benefits in waiting periods as per the IRDAI guidelines on migration.

15.7 Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

15.8 Multiple Policies

a. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder 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 if chosen by the policy holder 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.

b. Policyholder 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(s) shall independently settle the claim subject to the terms and conditions of this policy.

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

d. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

15.9 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 there-of, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the Policy Schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud", inter alia, means any of the following acts committed by the Insured Person or by his agent, 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

15.10 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.

15.11 Payment of Premium

The premium payable under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the Company. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorized official of the Company.

15.12 Terms and conditions of the Policy

The terms and conditions contained herein shall be deemed to form part of the Policy and shall be read together as one document.

15.13 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

15.14 Policy Period

The Policy can be issued for minimum tenure of 1 year.

15.15 Renewal and Cancellation

a. This Policy may be renewed by mutual consent and in such event; the renewal premium shall be paid to the Company on or before the date of expiry of the Policy or of the subsequent renewal thereof.

b. Any medical expenses incurred as a result of disease condition/ Accident contracted during the break period will not be admissible under the policy.

c. The Company may cancel this insurance by giving the Insured Person at least 15 days written notice, and if no claim has been made then the Company shall refund a pro-rata premium for the unexpired Policy Period.

d. The Insured Person may cancel this insurance by giving the Company at least 7 days written notice, and if no claim has been made then the Company shall refund a pro-rata premium for the unexpired Policy Period

e. In case the Policy Period exceeds one year, this Policy may be cancelled by the Insured Person at any time by giving at least 7 days written notice to Us and if no claim has been made, We will refund premium on a pro-rata basis.

f. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

g. The Policyholder shall throughout the period of insurance keep and maintain a record containing the names of all the insured persons. The Policyholder shall declare to the company any additions in the number of insured persons as and when arising

during the period of insurance and shall pay the additional premium as agreed

h. It is hereby agreed and understood that, this insurance being a group policy availed by the Insured covering members, the benefit thereof would not be available to members who cease to be part of the group for any reason whatsoever. Such members may obtain further individual insurance directly from the Company and any claims shall be governed by the terms thereof.

i. The premium rates or loadings for the product would not be changed without approval from Authority. However the performance of the product will be reviewed annually and further pricing will be done on experience basis.

15.16 Addition and Deletion of members

We shall include / exclude a group member/Employee of the Policyholder and/or his/her Dependent(s) including as an Insured Person under the Policy in accordance with the following procedure:

a. The new members of the Group Insurance Policy can be added at periodic intervals. However, the insurance coverage for every member of the group insurance policy shall not exceed the maximum policy term.

b. The Company may issue multiple group insurance policies in tranches to the Group Organizer, subject to minimum group size and maximum policy term, for providing insurance coverage to the new members on an ongoing basis.

c. We agree for providing cover for additions from the date of joining of the new employee by charging pro rata premium from the date of joining till the expiry of the policy, subject to maintenance of free and adequate balance under Cash Deposit maintained by the Policyholder with us or the coverage will be effective from the date of payment of premium.

d. We agree to exclude a group member from the cover by adjusting the pro-rated premium from the date of exclusion under Cash deposit maintained by the Policyholder with us and the coverage shall cease to exist from the date of exclusion for such group member.

15.17 Stamp Duty

Stamp duty shall be paid by the Policyholder as per applicable laws.

15.18 Redressal of Grievance

Step 1:
Call the Customer Support at +91 9821 034071
or email us at support@narayanahealth.insurance

Senior citizens may call at 1800-203-0234 or email us at seniorcitizencare@narayanahealth.insurance for priority assistance.

Step 2:
If the issue is not resolved in Step 1 and the customer wants to make a further suggestion or a complaint, they can email us at grievance@narayanahealth.insurance

Step 3:
If the customer for some reason feels that we have not been able to resolve the issue even in Step 2 and customer wishes to raise a concern, please write to Grievance Redressal Officer at gro@narayanahealth.insurance.

Step 4:
In case a complainant is not satisfied with the resolution from the above escalation authority, they may choose to log in their grievance at **IRDAI Integrated Grievance Management System** - https://igms.irda.gov.in/ or they can approach the

Insurance Ombudsman. The detailed addresses of all the Insurance Ombudsman can be found in the link below.

The contact details of the Insurance Ombudsman offices have been provided as Annexure 7.

Customer Information Sheet

Sno	Title	Description	Policy Clause No.
1	Name of Insurance Product / Policy	Narayana Group Health Insurance	NA
2	Policy Number	To be allotted at Policy Issuance	NA
3	Type of Insurance Product / Policy	d. Health Insurance Indemnity e. Personal Accident Benefit (optional) f. Hospital Daily Cash (optional)	NA
4	Sum Insured (Basis) (Along with amount)	Base Sum Insured for Hospitalization Cover: INR 3 Lacs / 5 Lacs / 7.5 Lacs / 10 Lacs / 15 Lacs / 20 Lacs / 25 Lacs / 50 Lacs / 1 Crore Benefit Amount for Personal Accident Cover: as specified in Certificate of Insurance / Policy Schedule	As specified in Certificate of Insurance / Policy Schedule
5	Policy Coverage (What the policy covers?) (Policy Clause Number/s)	Coverage available at NETWORK PROVIDER in India **Base Coverage (Hospitalization):** 14.25 **In-patient Care** (covered upto Base Sum Insured) – Hospitalization beyond continuous 24 hours of admission Room Rent for Room Type – As specified in Certificate of Insurance / Policy Schedule 14.26 **Pre-hospitalization expenses** – covered upto certain no of days (as specified in Certificate of Insurance / Policy Schedule) before the admission date 14.27 **Post-hospitalization expenses -** covered upto certain no of days (as specified in Certificate of Insurance / Policy Schedule) post the discharge date 14.28 **Day Care Treatment –** covered upto the amount as specified in Certificate of Insurance / Policy Schedule 14.29 **Living Organ Donor Transplant -** covered upto the amount as specified in Certificate of Insurance / Policy Schedule 14.30 **Domestic Road Ambulance Charges -** covered upto the amount as specified in Certificate of Insurance / Policy Schedule 14.31 **Alternative Treatment** - covered upto the amount as specified in Certificate of Insurance / Policy Schedule 14.32 **Technological Advancement and Treatment** - covered upto the amount as specified in Certificate of Insurance / Policy Schedule **Optional Coverage (Hospitalization):** *To be in force only if opted and specified in Certificate of Insurance / Policy Schedule*	Section 3, Section 4, and Section 5

		• **Initial Waiting Period Modification Option** • **Specific Disease / Procedure Waiting Period Modification Option** • **Pre-Existing Waiting Period Modification Option** • **Initial Health Check-up / Examination for Medical Underwriting** • **Revive:** Reinstation of Base Sum Insured in the same Policy Year upon complete or partial utilization of Base Sum Insured and upto a certain number of times as specified in Certificate of Insurance / Policy Schedule • **AccumulatePlus:** Additional Sum Insured each Policy Year, limit as specified in Certificate of Insurance / Policy Schedule • **Annual Health Check-up** Defined Health check-up package at empaneled Health Check-up provider for >18 years old • **Emergency Air Ambulance Charges** - at actuals for admission at Network Provider • **Maternity Benefit -** covered upto the specified amount at Network Provider with limits for Normal / Caesarean Delivery at Non-Network Provider as specified in Certificate of Insurance / Policy Schedule • **Pre and Post Natal Expenses** Only applicable if Maternity Benefit has been opted • **Baby Cover from Day 1** Only applicable if Maternity Benefit has been opted • **Daily Deductible –** Specific amount to be paid per day of hospitalization by the Insured • **Aggregate Deductible –** Aggregate amount to be paid by the Insured for any claim before any hospitalization or ambulance can apply • **Co-payment –** Specified Percentage amount that is to be paid by the Insured before any hospitalization or ambulance benefit can apply • **Corporate Buffer** • **Domiciliary Hospitalization** If opted, covered upto Base Sum Insured with below exclusions: i. Asthma, bronchitis, tonsillitis and upper respiratory tract	

		infection including laryngitis and pharyngitis, cough and cold, influenza; ii. Arthritis, gout and rheumatism; iii. Ailments of spine/disc; iv. Chronic nephritis and nephritic syndrome; v. Any liver disease; vi. Peptic ulcer; vii. Diarrhoea and all type of dysenteries, including gastroenteritis; viii. Diabetes mellitus and insipidus; ix. Epilepsy; x. Hypertension; xi. Pyrexia of any origin. **Optional Base Covers** **e. Personal Accident Cover** Accidental Death and / or Permanent Disablement as specified in Certificate of Insurance / Policy Schedule with option to restrict the coverage to Rail /Road / Public Transport / Air / None. **f. Hospital Daily Cash**	
6	Exclusions (What the policy does not cover?)	**Standard Exclusions** d. Pre-existing Disease (Code-Excl01) e. Specific Disease/Procedure waiting period (Code-Excl02) f. 30-Day Waiting Period (Code-Excl03) g. Investigation & Evaluation (Code-Excl04) h. Rest Cure, rehabilitation, and respite care (Code-Excl05) i. Obesity/ Weight Control (Code-Excl06): j. Change-of-Gender treatments (Code-Excl07): k. Cosmetic or Plastic Surgery (Code-Excl08) l. Hazardous or Adventure sports (Code-Excl09) m. Breach of law (Code-Excl10) n. Excluded Providers (Code-Excl11) o. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences there-of (Code-Excl12) p. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code-Excl13) q. 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) r. Refractive Error (Code-Excl15): Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 diopters. s. Unproven Treatments (Code-Excl16): t. Sterility and Infertility (Code-Excl17)	Section 8.1, Section 8.2, and Section 4.16

u. Maternity (Code-Excl18)

Specific Exclusions

v. Any treatment or medical services received outside the listed Network Provider except for scenarios as defined in Section 6 (a), 6 (b), 6 (c) and 6 (d)

w. Charges related to treatment arising from or contributed or aggravated or accelerated by any of the following:
   a. Suicide or attempted suicide, while sane or insane, or due to use, misuse or abuse of narcotic or intoxicating drugs or alcohol or solvent
   b. Intentional self-injury
   c. Use or consumption of narcotic or intoxicating drugs or alcohol or solvent, or taking of drugs (except under the direction of a Medical Practitioner)

x. Charges related to a Hospital stay not expressly mentioned as being covered. This will include Resident Medical Officer (RMO) charges, surcharges and service charges levied by the Hospital.

y. Circumcision

z. Conflict & Disaster

aa. External Congenital Anomaly

bb. Dental/oral treatment, unless due to accident

cc. Hormone Replacement Therapy:

dd. Multifocal Lens or any kind of eye wear for vision correction

ee. Prosthetics and other Ambulatory devices

ff. Sexually transmitted Infections & diseases (other than HIV / AIDS)

gg. Sleep disorders:

hh. Unrecognized Physician or Hospital

ii. Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state

jj. Any form of Alternative Treatments, except as mentioned under Section 3.7

kk. Treatment of injury or illness due to participation or involvement in naval, military or air force operation.

ll. Any Legal Liability due to any errors or omission or representation or consequences of any action taken on the part of any Hospital or Medical Practitioner.

Exclusions for Domiciliary Hospitalization

mm. Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;

nn. Arthritis, gout and rheumatism;

oo. Ailments of spine/disc;

pp. Chronic nephritis and nephritic syndrome;

qq. Any liver disease;

rr. Peptic ulcer;

ss. Diarrhea and all types of dysenteries, including gastroenteritis;

		tt. Diabetes mellitus and insipidus; uu. Epilepsy; vv. Hypertension; ww. Pyrexia of any origin.	
7	Waiting Period e. Time period during which specified diseases/treatments are not covered f. It is counted from the beginning of the policy coverage.	Determined by our Underwriting Policy: i. Pre-existing disease waiting period – as specified in the Certificate of Insurance / Policy Schedule, maximum of 3 years ii. Specific Disease / Procedure waiting period - as specified in the Certificate of Insurance / Policy Schedule, maximum of 2 years iii. 30-Day Waiting Period – as specified in the Certificate of Insurance / Policy Schedule, maximum of 30 days	Section 8.1.1, Section 8.1.2, Section 8.1.3, Section 4.1, Section 4.2. Section 4.3 and Section 4.4
8	Financial Limits of Coverage i. Sub-limit (It is a pre-defined limit and the insurance company will not pay any amount in excess of this limit) ii. Co-payment (It is a specified amount/percentage of the admissible claim amount to be paid by policyholder/insured). iii. Deductible (It is a specified amount: - up to which an insurance company will not pay any claim, and - which will be deducted from total claim amount (if claim amount is more than the specified amount) iv. Any other limit (as applicable)	Co-payment – as specified in the Certificate of Insurance / Policy Schedule Aggregate Deductible – as specified in the Certificate of Insurance / Policy Schedule Daily Deductible – as specified in the Certificate of Insurance / Policy Schedule Non-Intimation Co-payment: e. 30% copay, if the Insured Person is seeking coverage at Non-Network healthcare provider due to either of Section 6 (b) and 6 (d) as defined in Healthcare Provider (Section 6), and does not intimate Us 48 hours prior to the time of admission. f. 15% copay, if the Insured Person is seeking coverage at Non-Network healthcare provider due to scenario as defined in Section 6 (a) and Section 6 (c) as defined in Healthcare Provider (Section 6), and does not intimate Us within 24 hours from the time of admission.	Section 4.12, Section 4.13, Section 4.14, Section 7
9	Claims / Claims Procedure	For coverage within the Network Provider: **Cashless:** c. No intimation is required for pre-authorization for availing cashless hospitalization for planned / emergency admissions d. Hassle-free claim settlement process post discharge e. TAT for claim settlement– 1 hour post discharge of the Insured Person by the healthcare provider **Reimbursement:** f. For expenses pertaining to Pre-hospitalization, post-hospitalization which are covered by the policy or for expenses that have not been claimed for cashless settlement, reimbursement can be availed g. TAT for claim settlement – 30 days after the last required document has been received by Us	Section 10

		For admission at Non-Network provider: You are requested to intimate the Claims team within 24 hours after hospitalization for Emergency (Section 6 (a)) and 48 hours before hospitalization for scenarios mentioned in Section 6 (b), 6 (c) and 6 (d). Turn Around Time (TAT) for claims settlement at Non-Network provider: For Cashless Process: h. TAT for pre-authorization of cashless facility: 1 hour from the time the last necessary document is received. i. TAT for cashless final bill authorization: 3 hours from the time the last necessary document is received. (Note: In case of internal verification, the final stand will be confirmed within 24 hours from the time the last necessary document is received by us) For Reimbursement Process: TAT for Claim settlement: 15 days from the time the last necessary document is received. (Note: In case of internal verification, the final stand will be confirmed within 45 days from the time the last necessary document is received by us)	
10	Policy Servicing	Contact the customer support at +91 98210 34071 or support@narayanahealth.insurance for end-to-end policy servicing. Senior citizens may call at 1800 203 0234. For more details, visit us at: www.narayanahealth.insurance.	NA
11	Grievance / Complaints	**Step 1:** Call the Customer Support at +919821034071 or email us at **support@narayanahealth.insurance** Senior citizens may call at 1800 203 0234 or email us at **seniorcitizencare@narayanahealth.insurance** for priority assistance. **Step 2:** If the issue is not resolved in Step 1 and the customer wants to make a further suggestion or a complaint, they can email us at **grievance@narayanahealth.insurance** **Step 3:** If the customer for some reason feels that we have not been able to resolve the issue even in Step 2 and customer wishes to raise a concern, please write to Grievance Redressal Officer at **gro@narayanahealth.insurance** **Step 4:** In case a complainant is not satisfied with the resolution from the above escalation authority, they may choose to log in their grievance at BIMA BHAROSA GRIEVANCE REDRESSAL PORTAL - bimabharosa.irdai.gov.in or they can approach the Insurance Ombudsman. The detailed addresses of all the Insurance Ombudsman can be found in the link below. The contact details of the Insurance Ombudsman offices have been provided as Annexure-7	Section 14.24 and Section 15.18

12	Things to Remember	**Free Look Cancellation:** You may cancel the insurance policy if you do not want it, within 30 days from the beginning of the policy. Please contact the customer support at +91 98210 34071 or email us at support@narayanahealth.insurance for requesting Free Look Cancellation. **Policy Renewal:** Except on grounds of fraud, moral hazard or mis representation or non-co-operation, renewal of your policy shall not be denied, provided the policy is not withdrawn **Migration and Portability:** When your policy is due for renewal, you may migrate to another policy with us or port your policy to another insurer. Please contact the customer support at +91 98210 34071 or email us at support@narayanahealth.insurance for requesting Migration and Portability. For detailed guidelines on Portability, kindly refer the link https://irdai.gov.in/document-detail?documentId=5625747 **Moratorium period:** After completion of 60 continuous months under the policy no look back to be applied. This period of 60 months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. **Change in Sum Insured:** Sum insured can be changed (increased/ decreased) only at the time of renewal subject to underwriting by the Company. **Value-added Services:** We may provide discretionary discounts to You on Out-patient expenses such as consultation, medicine, lab tests, diagnostic tests, etc. at our service providers listed on our website - www.narayanahealth.insurance.	Section 14.18, Section 14.15, Section 14.14, Section 9, Section 14.20, Section 13
13	Your Obligations	Please disclose all pre-existing disease/s or condition/s or any other material information, as may be required, and fill in the complete details in the proposal form before buying a policy. Non-disclosure may affect the claim settlement.	NA

Annexure 1 – Schedule of Benefits

Base Coverage (Hospitalization)

Base Sum Insured: <as specified in the Certificate of Insurance / Policy Schedule at the time of issuance

SN	Base Coverage (Hospitalization)	Coverage Criteria
1	In-patient Care	Covered up to Sum Insured, as specified in the Certificate of Insurance / Policy Schedule at the time of issuance Room Rent for Room Type: as specified in the Certificate of Insurance / Policy Schedule at the time of issuance
2	Pre-hospitalization Medical Expenses	Coverage amount and number of days before admission, as specified in the Certificate of Insurance / Policy Schedule at the time of issuance
3	Post-hospitalization Medical Expenses	Coverage amount and number of days post discharge, as specified in the Certificate of Insurance / Policy Schedule at the time of issuance
4	Day Care Treatment	Coverage amount as specified in the Certificate of Insurance / Policy Schedule at the time of issuance for listed Day Care Treatment as in Annexure 3
5	Living Organ Donor Transplant	Coverage amount as specified in the Certificate of Insurance / Policy Schedule at the time of issuance
6	Domestic Road Ambulance Charges	Coverage amount as specified in the Certificate of Insurance / Policy Schedule at the time of issuance
7	Alternative Treatments	Coverage amount as specified in the Certificate of Insurance / Policy Schedule at the time of issuance
8	Technological Advancements and Treatment	Coverage amount as specified in the Certificate of Insurance / Policy Schedule at the time of issuance

Optional Coverage (Hospitalization)

SN	Optional Coverage (Hospitalization)	Coverage Criteria
1	Initial Waiting Period Modification Option	Yes / No, Waiting Period to be specified in the Certificate of Insurance / Policy Schedule
2	Specific Disease / Procedure Waiting Period Modification Option	Yes / No, Waiting Period to be specified in the Certificate of Insurance / Policy Schedule
3	Pre-Existing Waiting Period Modification Option	Yes / No, Waiting Period to be specified in the Certificate of Insurance / Policy Schedule
4	Initial Health Check-up / Examination for Medical Underwriting	NA
5	Revive	Yes / No, number of times to be specified in the Certificate of Insurance / Policy Schedule
6	AccumulatePlus	Yes / No, amount and maximum limit to be specified in the Certificate of Insurance / Policy Schedule
7	Annual Health Check-up	Yes / No, 1 health check up per adult > 18 years of age
8	Emergency Air Ambulance Charges	Yes / No, Coverage amount as specified in the Certificate of Insurance / Policy Schedule at the time of issuance

9	Maternity Benefit	Yes / No, Coverage amount for Preferred Network Provider and limit of coverage for Normal / Caesarean delivery as specified in the Certificate of Insurance / Policy Schedule at the time of issuance
10	Pre and Post Natal Expenses	Yes / No, Coverage amount as specified in the Certificate of Insurance / Policy Schedule at the time of issuance
11	Baby Cover from Day 1	Yes / No, Coverage amount as specified in the Certificate of Insurance / Policy Schedule at the time of issuance
12	Daily Deductible	Yes / No, Daily Deductible amount and its applicability basis type of claim as specified in the Certificate of Insurance / Policy Schedule at the time of issuance
13	Aggregate Deductible	Yes / No, amount as specified in the Certificate of Insurance / Policy Schedule at the time of issuance
14	Co-payment	Yes / No, % amount and its applicability on type of lives and Healthcare Provider as specified in the Certificate of Insurance / Policy Schedule at the time of issuance
15	Corporate Buffer	Yes / No, Limit and Sum Insured restricted to family / individual and whether Restricted to listed Critical Illness - as specified in the Certificate of Insurance / Policy Schedule at the time of issuance
16	Domiciliary Hospitalization	Yes / No, Coverage amount as specified in the Certificate of Insurance / Policy Schedule at the time of issuance

Waiting Periods for Hospitalization Cover

SN	Type of Waiting Period	Duration
1	30 Day Waiting Period	To be specified in the Certificate of Insurance / Policy Schedule, basis Underwriting Policy
2	Specific Disease / Procedure Waiting Period	To be specified in the Certificate of Insurance / Policy Schedule, basis Underwriting Policy
3	Pre-Existing Waiting Period	To be specified in the Certificate of Insurance / Policy Schedule, basis Underwriting Policy

Optional Base Covers

SN	Optional Coverage (Hospitalization)	Coverage Criteria
1	Personal Accident Cover	Yes / No, Accidental Death and/or Permanent Disablement (Table A/B/C/D) Restricted to Rail / Road / All public transport / Flight / None as specified in the Certificate of Insurance / Policy Schedule
2	Hospital Daily Cash	Yes / No, Per day amount, maximum no of days and Waiting Period, as specified in the Certificate of Insurance / Policy Schedule

Annexure 2 – List of Network Providers

PREFERRED NETWORK PROVIDERS

SN	Hospital Name	Hospital Address	Rohini ID	Location (City)
1	Narayana Multispeciality Hospital-Mysore	CAH/1, 3rd Phase, Devanur, 2nd Stage, R.S.Naidu Nagar, Mysuru, Karnataka 570019	8900080192119	MYSORE
2	Narayana Institute of Cardiac Sciences, Bangalore	#258/A, Narayana Hrudayalaya Health City, Bommasandra Industrial Area, Anekal Taluk	8900080190269	BANGALORE
3	Mazumdar Shaw Medical Centre, Bangalore	#258/A, Narayana Hrudayalaya Health City, Bommasandra Industrial Area, Anekal Taluk	8900080539952	BANGALORE
4	RL Jalappa Narayana Heart Centre, Kolar	SDUMC Campus, TAMAKA, KOLAR, KARNATAKA, INDIA - PIN - 563101	8900080191082	KOLAR
5	SDM Narayana Heart Centre, Dharwad	Sdm College of Medical Science & Hospital Manjushree Nagar, Sattur	8900080196834	DHARWAD
6	Sahyadri Narayana Multispeciality Hospital, Shimoga	Sahyadri Narayana Multispecialty Hospital, New Thirthahalli Road, Harakere, Shimoga - 577202	8900080344280	SHIMOGA
7	SS Narayana Heart Centre, Davangere	SS NARAYANA HEART CENTRE JNANASHANKAR, NH-4 BYPASS ROAD,DAVANGERE - 577055	8900080333604	DAVANGERE
8	Narayana Multispeciality Hospital, HSR Bangalore	Basanth Health Centre, No 1, 18th Main, Opposite HSR Club, Sector 3, HSR Layout, Bangalore	8900080327757	BANGALORE
9	Narayana Multispeciality Hospital, Ahmedabad	Opposite Rakhiyal Police Station, Rakhiyal Cross Road, Ahmedabad, Gujarat - 380023	8900080080003	AHMEDABAD
10	NH-Mumbai SRCC	SRCC CHILDREN'S HOSPITAL (Managed by Narayana Health.),1-A HAJI ALI PARK, K KHADYE MARG, MAHALAXMI, MUMBAI - 400034	8900080368392	MUMBAI
11	NH-Jaipur Health City, Jaipur	Narayana Multispeciality Hospital, Sector - 28, Rana Sanga Marg, Kumbha Marg, Pratap Nagar, Sanganer, Jaipur, Rajasthan 302033	8900080062566	JAIPUR
12	NH-Narayana Superspeciality Hospital, Gurugram	Plot 3201, Block -V, DLF phase -3 , Sector 24	8900080388185	GURGAON
13	Rabindranath Tagore International Institute of Cardiac Sciences, Kolkata	Premises No: 1489, Mukundapur Main Road, 124, Eastern Metropolitan Bypass, Mukundapur, Kolkata, West Bengal 700099	8900080236394	KOLKATA
14	Brahmananda Narayana Multispeciality Hospital, Jamshedpur	Near Pardih Chowk,Tamolia, NH33, Jamshedpur 831012	8900080253421	JAMSHEDPUR
15	MMI Narayana Multispeciality Hospital, Raipur	Dhamtari Road, Lalpur, Raipur , PIN Code-492001	8900080188495	RAIPUR
16	Narayana Superspeciality Hospital, Guwahati	Tularam Bafna Civil Hospital Complex, Amingaon, Guwahati, Kamrpu, Assam - 781031	8900080246737	GUWAHATI
17	Narayana Multispeciality Hospital, Barasat	78, Jessore Road (South), Barasat, 24 Pgs (N) - 700127	8900080236905	KOLKATA
18	Shri Mata Vaishno Devi Narayana Superspeciality Hospital, Jammu and Kashmir	Kakryal (Village & Post) Katra Tehsil Reasi District, Katra, Jammu and Kashmir 182320	8900080335080	JAMMU
19	Dharamshila Narayana Superspeciality Hospital, Delhi	Metro Station, Dharamshila marg, Vasundhara Enclave Near Ashok Nagar, Dallupura, New Delhi, Delhi 110096	8900080004702	DELHI
20	Narayana Superspeciality Hospital, Howrah	120, 1, Andul Rd, near Nabanna, Shibpur, Howrah, West Bengal 711103	8900080327269	HOWRAH

21	Narayana Multispeciality Hospital, Howrah	Andul Rd, near Chunabati, Podara, Mourigram, Howrah, West Bengal 711109	8900080335332	HOWRAH

Annexure 3 – List of Day Care Treatments

SNO.	LIST OF DAY-CARE TREATMENTS
	ENT
1	STAPEDOTOMY
2	MYRINGOPLASTY (TYPE I TYMPANOPLASTY)
3	REVISION STAPEDECTOMY
4	LABYRINTHECTOMY FOR SEVERE VERTIGO
5	STAPEDECTOMY UNDER GA
6	OSSICULOPLASTY
7	MYRINGOTOMY WITH GROMMET INSERTION
8	TYMPANOPLASTY (TYPE III)
9	STAPEDECTOMY UNDER LA
10	REVISION OF THE FENESTRATION OF THE INNER EAR.
11	TYMPANOPLASTY (TYPE IV)
12	ENDOLYMPHATIC SAC SURGERY FOR MENIERE'S DISEASE
13	TURBINECTOMY
14	REMOVAL OF TYMPANIC DRAIN UNDER LA
15	ENDOSCOPIC STAPEDECTOMY
16	FENESTRATION OF THE INNER EAR
17	INCISION AND DRAINAGE OF PERICHONDRITIS
18	SEPTOPLASTY
19	VESTIBULAR NERVE SECTION
20	THYROPLASTY TYPE I
21	TYMPANOPLASTY (TYPE II)
22	REDUCTION OF FRACTURE OF NASAL BONE
23	EXCISION AND DESTRUCTION OF LINGUAL TONSILS
24	CONCHOPLASTY
25	THYROPLASTY TYPE II
26	TRACHEOSTOMY
27	EXCISION OF ANGIOMA SEPTUM
28	TURBINOPLASTY
29	INCISION & DRAINAGE OF RETRO PHARYNGEAL ABSCESS
30	UVULO PALATO PHARYNGO PLASTY
31	PALATOPLASTY
32	TONSILLECTOMY WITHOUT ADENOIDECTOMY
33	ADENOIDECTOMY WITH GROMMET INSERTION
34	ADENOIDECTOMY WITHOUT GROMMET INSERTION
35	VOCAL CORD LATERALISATION PROCEDURE
36	INCISION & DRAINAGE OF PARA PHARYNGEAL ABSCESS
37	TRANSORAL INCISION AND DRAINAGE OF A PHARYNGEAL ABSCESS
38	TONSILLECTOMY WITH ADENOIDECTOMY

39	TRACHEOPLASTY
40	RECONSTRUCTION OF THE MIDDLE EAR
41	MASTOIDECTOMY
42	EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE NOSE
43	INCISION (OPENING) AND DESTRUCTION (ELIMINATION) OF THE INNER EAR
44	INCISION OF THE MASTOID PROCESS AND MIDDLE EAR
45	NASAL SINUS ASPIRATION
46	OTHER MICROSURGICAL OPERATIONS ON THE MIDDLE EAR
47	OTHER OPERATIONS ON THE AUDITORY OSSICLES
48	PLASTIC SURGERY TO THE FLOOR OF THE MOUTH
49	INCISION OF THE HARD AND SOFT PALATE
50	EXTERNAL INCISION AND DRAINAGE IN THE REGION OF THE MOUTH, JAW AND FACE
51	OTHER OPERATIONS ON THE SALIVARY GLANDS AND SALIVARY DUCTS
	OPHTHALMOLOGY
52	INCISION OF TEAR GLANDS
53	OTHER OPERATION ON THE TEAR DUCTS
54	INCISION OF DISEASED EYELIDS
55	EXCISION AND DESTRUCTION OF THE DISEASED TISSUE OF THE EYELID
56	REMOVAL OF FOREIGN BODY FROM THE LENS OF THE EYE.
57	CORRECTIVE SURGERY OF THE ENTROPION AND ECTROPION
58	OPERATIONS FOR PTERYGIUM
59	CORRECTIVE SURGERY OF BLEPHAROPTOSIS
60	REMOVAL OF FOREIGN BODY FROM CONJUNCTIVA
61	REMOVAL OF FOREIGN BODY FROM CORNEA
62	INCISION OF THE CORNEA
63	OTHER OPERATIONS ON THE CORNEA
64	OPERATION ON THE CANTHUS AND EPICANTHUS
65	REMOVAL OF FOREIGN BODY FROM THE ORBIT AND THE EYEBALL.
66	SURGERY FOR CATARACT
67	TREATMENT OF RETINAL LESION
68	REMOVAL OF FOREIGN BODY FROM THE POSTERIOR CHAMBER OF THE EYE
	ONCOLOGY
69	IV PUSH CHEMOTHERAPY
70	CONTINUOUS INFUSIONAL CHEMOTHERAPY
71	INFUSIONAL CHEMOTHERAPY
72	CCRT-CONCURRENT CHEMO + RT
73	SRS- STEREOTACTIC RADIOSURGERY
74	TBI- TOTAL BODY RADIOTHERAPY
75	ADJUVANT RADIOTHERAPY
76	RADICAL CHEMOTHERAPY
77	NEOADJUVANT RADIOTHERAPY

78	PALLIATIVE RADIOTHERAPY
79	RADICAL RADIOTHERAPY
80	PALLIATIVE CHEMOTHERAPY
81	NEOADJUVANT CHEMOTHERAPY
82	ADJUVANT CHEMOTHERAPY
83	INDUCTION CHEMOTHERAPY
84	CONSOLIDATION CHEMOTHERAPY
85	MAINTENANCE CHEMOTHERAPY
	UROLOGY
86	AV FISTULA
87	URSL WITH STENTING
88	URSL WITH LITHOTRIPSY
89	ESWL
90	HAEMODIALYSIS
91	CYSTOSCOPY AND REMOVAL OF POLYP
92	EXCISION OF URETHRAL DIVERTICULUM
93	REMOVAL OF URETHRAL STONE
94	URETER ENDOSCOPY AND TREATMENT
95	SURGERY FOR PELVI-URETERIC JUNCTION OBSTRUCTION
96	INJURY PREPUCE- CIRCUMCISION
97	FRENULAR TEAR REPAIR
98	MEATOTOMY FOR MEATAL STENOSIS
99	SURGERY FOR FOURNIER'S GANGRENE SCROTUM
100	SURGERY FILARIAL SCROTUM
101	SURGERY FOR WATERING CAN PERINEUM
102	REPAIR OF PENILE TORSION
103	DRAINAGE OF PROSTATE ABSCESS
104	CYSTOSCOPY AND REMOVAL OF FB
105	TRANSURETHRAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
106	TRANSURETHRAL AND PERCUTANEOUS DESTRUCTION OF PROSTATE TISSUE
107	OPEN SURGICAL EXCISION AND DESTRUCTION OF PROSTATE TISSUE
108	RADICAL PROSTATOVESICULECTOMY
109	OTHER EXCISION AND DESTRUCTION OF PROSTATE TISSUE
110	INCISION OF THE PROSTATE
111	INCISION AND EXCISION OF PERIPROSTATIC TISSUE
112	OTHER OPERATIONS ON THE PROSTATE
	GYNAECOLOGY
113	HYSTEROSCOPIC REMOVAL OF MYOMA
114	D&C
115	HYSTEROSCOPIC RESECTION OF SEPTUM
116	HYSTEROSCOPIC ADHESIOLYSIS

117	POLYPECTOMY ENDOMETRIUM
118	HYSTEROSCOPIC RESECTION OF FIBROID
119	LLETZ
120	CONIZATION
121	POLYPECTOMY CERVIX
122	HYSTEROSCOPIC RESECTION OF ENDOMETRIAL POLYP
123	VULVAL WART EXCISION
124	LAPAROSCOPIC PARAOVARIAN CYST EXCISION
125	UTERINE ARTERY EMBOLIZATION
126	BARTHOLIN CYST EXCISION
127	LAPAROSCOPIC CYSTECTOMY
128	ENDOMETRIAL ABLATION
129	VAGINAL WALL CYST EXCISION
130	VULVAL CYST EXCISION
131	LAPAROSCOPIC PARATUBAL CYST EXCISION
132	HYSTEROSCOPY, REMOVAL OF MYOMA
133	TURBT
134	LAPAROSCOPIC MYOMECTOMY
135	SURGERY FOR SUI
136	PELVIC FLOOR REPAIR (EXCLUDING FISTULA REPAIR)
137	LAPAROSCOPIC OOPHORECTOMY
138	INCISION OF THE OVARY
139	INSUFFLATION OF THE FALLOPIAN TUBES
140	DILATATION OF THE CERVICAL CANAL
141	CONISATION OF THE UTERINE CERVIX
142	HYSTEROTOMY
143	THERAPEUTIC CURETTAGE
144	CULDOTOMY
145	INCISION OF THE VAGINA
146	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE VAGINA AND THE POUCH OF DOUGLAS
147	INCISION OF THE VULVA
	GENERAL SURGERY
148	INFECTED KELOID EXCISION
149	INCISION OF A PILONIDAL SINUS / ABSCESS
150	INFECTED SEBACEOUS CYST
151	INFECTED LIPOMA EXCISION
152	MAXIMAL ANAL DILATATION
153	SURGICAL TREATMENT OF HAEMORRHOIDS
154	LIVER ABSCESS- CATHETER DRAINAGE
155	FISSURE IN ANO- FISSURECTOMY
156	FIBROADENOMA BREAST EXCISION

157	OESOPHAGEAL VARICES SCLEROTHERAPY
158	ERCP – PANCREATIC DUCT STONE REMOVAL
159	PERIANAL ABSCESS I&D
160	PERIANAL HEMATOMA EVACUATION
161	FISSURE IN ANO SPHINCTEROTOMY
162	UGI SCOPY AND POLYPECTOMY OESOPHAGUS
163	BREAST ABSCESS I& D
164	FEEDING GASTROSTOMY
165	ESOPHAGOSCOPY AND BIOPSY OF GROWTH OESOPHAGUS
166	ERCP – BILE DUCT STONE REMOVAL
167	ILEOSTOMY CLOSURE
168	POLYPECTOMY COLON
169	SPLENIC ABSCESSES LAPAROSCOPIC DRAINAGE
170	UGI SCOPY AND POLYPECTOMY STOMACH
171	RIGID ESOPHAGOSCOPY FOR FB REMOVAL
172	FEEDING JEJUNOSTOMY
173	COLOSTOMY
174	ILEOSTOMY
175	COLOSTOMY CLOSURE
176	SUBMANDIBULAR SALIVARY DUCT STONE REMOVAL
177	PANCREATIC PSEUDOCYSTS ENDOSCOPIC DRAINAGE
178	SUBCUTANEOUS MASTECTOMY
179	EXCISION OF RANULA UNDER GA
180	RIGID ESOPHAGOSCOPY FOR DILATION OF BENIGN STRICTURES
181	EVERSION OF SAC
182	1. A) UNILATERAL
183	B) BILATERAL
184	LORD'S PLICATION
185	JABOULAY'S PROCEDURE
186	SCROTOPLASTY
187	SURGICAL TREATMENT OF VARICOCELE
188	EPIDIDYMECTOMY
189	CIRCUMCISION FOR TRAUMA
190	MEATOPLASTY
191	INTERSPHINCTERIC ABSCESS INCISION AND DRAINAGE
192	PSOAS ABSCESS INCISION AND DRAINAGE
193	THYROID ABSCESS INCISION AND DRAINAGE
194	TIPS PROCEDURE FOR PORTAL HYPERTENSION
195	PAIR PROCEDURE OF HYDATID CYST LIVER
196	EXCISION OF CERVICAL RIB
197	SURGERY FOR FRACTURE PENIS

198	PARASTOMAL HERNIA
199	REVISION COLOSTOMY
200	PROLAPSED COLOSTOMY- CORRECTION
201	LAPAROSCOPIC CARDIOMYOTOMY (HELLERS)
202	LAPAROSCOPIC PYLOROMYOTOMY (RAMSTEDT)
203	ORCHIECTOMY
204	INCISION OF THE BREAST
205	OPERATIONS ON THE NIPPLE
206	INCISION AND EXCISION OF TISSUE IN THE PERIANAL REGION
207	SURGICAL TREATMENT OF ANAL FISTULAS
208	DIVISION OF THE ANAL SPHINCTER (SPHINCTEROTOMY)
209	GLOSSECTOMY
210	RECONSTRUCTION OF THE TONGUE
211	INCISION, EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE TONGUE
212	OPERATIONS ON THE SEMINAL VESICLES
213	OTHER OPERATIONS ON THE SPERMATIC CORD, EPIDIDYMIS AND DUCTUS DEFERENS
214	LOCAL EXCISION AND DESTRUCTION OF DISEASED TISSUE OF THE PENIS
215	OTHER OPERATIONS ON THE PENIS
216	OTHER EXCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
217	OTHER INCISIONS OF THE SKIN AND SUBCUTANEOUS TISSUES
218	SIMPLE RESTORATION OF SURFACE CONTINUITY OF THE SKIN AND SUBCUTANEOUS TISSUES
219	FREE SKIN TRANSPLANTATION, DONOR SITE
220	FREE SKIN TRANSPLANTATION, RECIPIENT SITE
221	RECONSTRUCTION OF THE TESTIS
222	INCISION OF THE SCROTUM AND TUNICA VAGINALIS TESTIS
223	EXCISION IN THE AREA OF THE EPIDIDYMIS
224	REVISION OF SKIN PLASTY
225	OTHER RESTORATION AND RECONSTRUCTION OF THE SKIN AND SUBCUTANEOUS TISSUES
226	DESTRUCTION OF DISEASED TISSUE IN THE SKIN AND SUBCUTANEOUS TISSUES
	ORTHOPAEDICS
227	ARTHROSCOPIC REPAIR OF ACL TEAR KNEE
228	ARTHROSCOPIC REPAIR OF PCL TEAR KNEE
229	TENDON SHORTENING
230	ARTHROSCOPIC MENISCECTOMY – KNEE
231	TREATMENT OF CLAVICLE DISLOCATION
232	ARTHROSCOPIC MENISCUS REPAIR
233	HEMARTHROSIS KNEE- LAVAGE
234	ABSCESS KNEE JOINT DRAINAGE
235	REPAIR OF KNEE CAP TENDON
236	ORIF WITH K WIRE FIXATION- SMALL BONES
237	ORIF WITH PLATING- SMALL LONG BONES

238	ARTHROTOMY HIP JOINT
239	SYME'S AMPUTATION
240	ARTHROPLASTY
241	PARTIAL REMOVAL OF RIB
242	TREATMENT OF SESAMOID BONE FRACTURE
243	AMPUTATION OF METACARPAL BONE
244	REPAIR / GRAFT OF FOOT TENDON
245	REVISION/REMOVAL OF KNEE CAP
246	REMOVE/GRAFT LEG BONE LESION
247	REPAIR/GRAFT ACHILLES TENDON
248	BIOPSY ELBOW JOINT LINING
249	BIOPSY FINGER JOINT LINING
250	TENDON LENGTHENING
251	SURGERY OF BUNION
252	TENDON TRANSFER PROCEDURE
253	REMOVAL OF KNEE CAP BURSA
254	TREATMENT OF FRACTURE OF ULNA
255	TREATMENT OF SCAPULA FRACTURE
256	REMOVAL OF TUMOR OF ARM/ ELBOW UNDER RA/GA
257	REPAIR OF RUPTURED TENDON
258	REVISION OF NECK MUSCLE (TORTICOLLIS RELEASE)
259	TREATMENT FRACTURE OF RADIUS & ULNA
260	INCISION ON BONE, SEPTIC AND ASEPTIC
261	CLOSED REDUCTION ON FRACTURE, LUXATION OR EPIPHYSEOLYSIS WITH OSTEOSYNTHESIS
262	REDUCTION OF DISLOCATION UNDER GA
	PAEDIATRIC SURGERY
263	VAGINOPLASTY
264	DILATATION OF ACCIDENTAL CAUSTIC STRICTURE OESOPHAGEAL
265	PRESACRAL TERATOMAS EXCISION
266	REMOVAL OF VESICAL STONE
267	EXCISION SIGMOID POLYP
268	STERNOMASTOID TENOTOMY
269	HIGH ORCHIDECTOMY FOR TESTIS TUMORS
270	EXCISION OF CERVICAL TERATOMA
271	RECTAL-MYOMECTOMY
272	RECTAL PROLAPSE (DELORME'S PROCEDURE)
273	ORCHIDOPEXY FOR UNDESCENDED TESTIS
274	DETORSION OF TORSION TESTIS
275	LAP. ABDOMINAL EXPLORATION IN CRYPTORCHIDISM
276	EUA + BIOPSY MULTIPLE FISTULA IN ANO
277	EXCISION OF FISTULA-IN-ANO

	OTHERS
278	CORONARY ANGIOGRAPHY
279	ULTRASOUND GUIDED ASPIRATIONS
280	CHEMOSURGERY TO THE SKIN

Annexure 4

LIST I – Consumables or Non-Medical expenses that are covered by the Policy

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

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

S No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

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

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

S 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

Annexure 5 – Health check-up defined package

S No.	Test name
1	VITALS, BMI
2	CBC
3	ESR
4	RENAL PACKAGE
5	THYROID PROFILE (TSH, T4)
6	HBA1C
7	RANDOM BLOOD SUGAR
8	LIPID PROFILE INCLUDING SERUM APOLIPOPROTEIN A & B
9	ROUTINE URINE ANALYSIS
10	URINE MICRO ALBUMIN LEVELS
11	LIVER FUNCTION TESTS
12	ECG
13	ECHO
14	USG ABDOMEN PELVIS
15	CHEST X-RAY
16	PSA TEST (MALES > 45 YEARS)
17	ORAL CAVITY CHECK-UP (FOR PRE-CANCEROUS LESIONS)
18	EYE CHECK-UP (LENS)
19	PHYSICIAN CONSULTATION

Annexure 6 – Health check-up provider

Sno	Clinic / Hospital Name	City
1	Narayana Clinic, Chandapura	Bengaluru
2	Narayana Clinic, Electronic City	Bengaluru
3	Narayana Clinic, Harlur Road	Bengaluru
4	Narayana Clinic, HSR Layout	Bengaluru
5	Narayana Clinic, Jayanagar	Bengaluru
6	Narayana Clinic, Manipal County	Bengaluru
7	Narayana Clinic, Sarjapur	Bengaluru
8	Narayana Wellness Hub, Prestige Tech Park	Bengaluru
9	Narayana Institute of Cardiac Sciences, Bangalore	Bengaluru
10	Mazumdar Shaw Medical Centre, Bangalore	Bengaluru
11	Narayana Multispeciality Hospital, HSR Bangalore	Bengaluru

Annexure 7 – List of Insurance Ombudsman

AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in JURISDICTION: Gujarat, Dadra & Nagar Haveli, Daman and Diu.	BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in JURISDICTION: Karnataka.
BHOPAL Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in JURISDICTION: Madhya Pradesh, Chattisgarh.	BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in JURISDICTION: Odisha.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in JURISDICTION: Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.	CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in JURISDICTION: Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in JURISDICTION: Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.	ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in JURISDICTION: Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in JURISDICTION: Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in JURISDICTION: Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in JURISDICTION: Rajasthan.	KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in JURISDICTION: West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in JURISDICTION: 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, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in JURISDICTION: Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).