MANIPALCIGNA PROHEALTH GROUP INSURANCE POLICY

Policy Contract for Optional Covers
(In conjunction with Policy Terms and Conditions)

D.II Options to Base Covers

This Policy may also provide Options to the Base Covers if these are specified to be applicable in the Policy Schedule and/or the Certificate of Insurance subject to (I) the terms, conditions, exclusions and limitations of the Options set out herein along with Optional Benefits (if any), (II) receipt of premium, statements in the proposal and information disclosed to Us by You or on Your behalf and on behalf of all persons to be insured which is incorporated into the Policy and is the basis of it.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to the Base Cover(Section D of the Policy) shall apply.

The Base Sum Insured referred herein means the Sum Insured for the Base Cover as specified in the Policy Schedule and/or Certificate of Insurance.

D.II.1 Disease Category Sub Limit

We will limit the claim for a distinct Disease Category in a Policy Year up to the amount specified in the Policy Schedule/ Certificate of Insurance per Insured Person in case the Policy provides for cover on an Individual basis and per family if the Policy provides for cover on a Family Floater basis:

i. Any number of claims can be made within any Disease Category up to the limit specified in the Policy Schedule/Certificate of Insurance by any or all Insured Persons.

For the purpose of this Section, "Disease Category" means an Illness/Injury (including its complications) for which a claim has been paid during the Policy Year under the Base Cover.

D.II.2 Maternity Expenses Cover

We will pay the Maternity Expenses for the delivery of a child and/or Maternity Expenses related to a Medically Necessary Treatment and lawful medical termination of pregnancy, during the Policy Year, limited to a maximum of (i) 2 deliveries; or (ii) 2 terminations; or (iii) 1 delivery and 1 termination during the lifetime of an Insured person, subject to the limits and Sub Limits specified in the Policy Schedule/ Certificate of Insurance, provided that:

i. We will pay the Medical Expenses incurred towards Medically Necessary Treatment of the Insured Person, or Surrogate, if opted, in case of normal delivery, routine or elective Caesarean or Complicated Pregnancy.

   For the purpose of this Section, "Complicated Pregnancy" means a medical condition arising during the antenatal stages of pregnancy or a medical condition arising during childbirth that requires a recognised obstetric procedure and post natal check-ups as a result of the complication of pregnancy for a period up to six weeks.

ii. The Insured Person should have been continuously covered under this Policy for the Maternity Waiting Period specified in the Policy Schedule and/or Certificate of Insurance before availing this Benefit.

iii. Payment under this cover will be limited to per event and will be a part of the Base Sum Insured specified in the Policy Schedule and/or Certificate of Insurance. However, any Restored Sum Insured will not be available for payment under this Section.

iv. Any claim under this Benefit shall not impact the Cumulative Bonus, if opted.

We will not be liable to make any payment in respect of the following:

i. Medical Expenses incurred in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future Illnesses.

ii. Medical Expenses for ectopic pregnancy, which will be covered under Section D.I.1 of the Base Cover Terms and Conditions.

iii. Complications arising as a result of infertility Treatment (assisted conception).

Optional limit for Pre-Natal and Post- Natal Medical Expenses

We will pay the Medical Expenses incurred during the Policy Year, in respect of pre-natal check-ups since confirmation of pregnancy, post-natal check-ups for a period up to six weeks from delivery, prescribed pre- natal medicines and diagnostic tests up to the limit specified in the Policy Schedule/ Certificate of Insurance provided that this Benefit is opted under this option.

We will not be liable to make any payment in respect of any Pre Hospitalization Medical Expenses or Post - Hospitalization Medical Expenses paid under the Base Cover.

All claims under this Benefit can be made as per

the process defined under Section G.I. of the Base Cover Terms and Conditions.

D.II.2.a New Born Medical Expenses Cover

We will pay the Medical Expenses incurred during the Policy Year, towards the Treatment of the New Born Baby up to the Sub Limit, inclusive or over and above the Maternity Expenses Cover limit, as specified in the Policy Schedule/ Certificate of Insurance, provided that:

i. The mother is covered as an Insured Person under the Policy.

ii. The Maternity Expenses Cover has been opted under the Policy.

iii. A New Born Baby older than 90 days can be covered under the Policy as an Insured Person only by way of an endorsement or at the next Renewal, whichever is earlier, on payment of the requisite premium.

All claims under this Benefit can be made as per the process defined under Section G.I. of the Base Cover Terms and Conditions.

D.II.3 Out- Patient Treatment Cover

We will pay the Reasonable and Customary Charges incurred in respect of medical Treatment availed during the Policy Year, in a Hospital by an Insured Person as an Out-Patient up to the limit specified in the Policy Schedule/ Certificate of Insurance, provided that:

i. Any one or combination of the following can be opted under the Benefit:
   - i) Consultation
   - ii) Diagnostics
   - iii) Pharmacy
   - iv) Medical aids
   - v) AYUSH
   - vi) Dental
   - vii) Vision
   - viii) Physiotherapy
   - ix) Over the Counter (OTC) Medicine

The Benefit payable will be over and above the Base Sum Insured subject to any applicable Co-Payment as specified in the Policy Schedule/ Certificate of Insurance.

For the purpose of this Section, “AYUSH” means medical Treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems as an Out-Patient. Permanent Exclusion in Section E.II.9.i under the Policy is not applicable in respect of coverage under this Benefit if AYUSH is opted under this Benefit.

The following exclusions will be applicable in addition to the exclusions under the Base Cover Terms and Conditions:

- Facilities and services availed for pleasure or rejuvenation or as a preventive aid, like beauty treatments, Panchakarma, purification, detoxification and rejuvenation.
- Cost of spectacles, Medical Aids.

All claims under this Benefit can be made as per the process defined under Section G.I. of the Base Cover Terms and Conditions and Section G.I of the Optional Cover Terms and Conditions, as applicable.

D.II.4 Accumulate Cover

We will pay the Reasonable and Customary Charges up to the limits specified in the Policy Schedule/ Certificate of Insurance that are incurred during the Policy Year by the Insured Person, provided that the expense is towards:

Any one or combination of the following can be opted under the Benefit:

i. Payment of the Deductible/ Co-Payment/ Non-payable component of an In-patient Hospitalization Expenses claim wherever opted including any Cashless facility in case of an In-patient Hospitalization Expenses claim or Day Care Treatment claim

ii. Consultation

iii. Diagnostics

iv. Pharmacy

v. Medical aids

vi. AYUSH

The following exclusions will be applicable in addition to the exclusions under the Base Cover Terms and Conditions:

- Facilities and services availed for pleasure or rejuvenation or as a preventive aid, like beauty treatments, Panchakarma, purification, detoxification and rejuvenation.

For the purpose of this Section, “AYUSH” means medical Treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems as an Out-Patient.

Any unutilised limit will be carried forward each Policy Year as long as the Policy is Renewed with Us in accordance with the Renewal terms and conditions under the Policy. Where the Policy is not Renewed before the end of the Grace Period and the cover is terminated for the Insured Person, any unutilised limit in respect of the Accumulate Cover shall be available for a claim up to a period

of 12 months from the date of expiry of the Policy or expiry of the coverage for the Insured member, if earlier. All such claims will be in respect of the Insured Persons under the expiring Policy only.

i. All Waiting Periods and Permanent Exclusions including Co-Payment (if any) shall not be applicable.

ii. Any claim under this Benefit shall not impact the Cumulative Bonus, if opted.

All claims under this Benefit can be made as per the process defined under Section G.I. of the Base Cover Terms and Conditions and Section G.I of the Optional Cover Terms and Conditions, as applicable.

Cumulative Bonus under Accumulate Cover:

We will provide a percentage of Cumulative Bonus, if opted and specified in Policy Schedule/ Certificate of Insurance on the unutilised limit available at the end of the Policy Year irrespective of whether a claim is made on the expiring Policy. This unutilised limit plus the earned Cumulative Bonus will be carried forward to the next Policy Year, provided that:

i. The available limit in the current Policy will be the total of the unutilised limit plus earned Cumulative Bonus and the limit of the current Policy Year.

ii. Cumulative Bonus will be calculated for each Policy Year on the balance value of the limit at the end of the year, irrespective of any change in the Sum Insured or limit opted under the Policy.

iii. If the Insured Persons in the expiring Policy are covered on an Individual basis and there is an accumulated limit plus Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater basis then the limit plus Cumulative Bonus that will be carried forward for credit in such Renewed Policy shall be the total of all the Insured Persons moving out.

iv. If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater/Individual policies then the unutilised limit plus Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.

v. Cumulative Bonus on the limit shall not accrue if the Policy is not Renewed with Us within the Grace Period.

D.II.5 In-patient Hospitalization - Limit on Room Rent/Type (Category)

We will, limit Room Rent up to the selected amount/ percentage of Sum Insured or room category, as specified in the Policy Schedule/ Certificate of Insurance, provided that the limit will be applicable for accommodation in a Hospital subject to a claim being admissible under the Base Cover and the Medical Expenses incurred are related to the same Illness/Injury.

If the Insured Person is admitted in a room where the room category or the Room Rent incurred is higher than that which is specified in the Policy Schedule/ Certificate of Insurance, then the Policyholder/ Insured Person shall bear a rateable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category/eligible Room Rent to the Room Rent actually incurred.All other clauses, terms and conditions, Waiting Periods and exclusions applicable to the Base Cover (Section D.I) shall apply and Section G.I of the Optional Cover Terms and Conditions, as applicable.

D.II.6 Sub Limit on Treatment/ Illness Surgery/ Medical Condition

We will pay the Medical Expenses incurred towards claim for a specified Treatment of an Illness / procedure upto the amount of Sub Limit applicable per claim during the Policy Year as specified in the Policy Schedule/ Certificate of Insurance, provided that:

i. For the balance amount, if any, subject to the applicability of Sub Limits on Medical Expenses incurred on specified Treatment of an Illness/ procedure, our liability to make any payment shall be limited to such extent as applicable.

ii. For the amount of Sub Limit, refer table below:

Sub Limit (Amount in ₹)				
S. No.	**Illnesses/ Surgeries / Medical Procedures**	**Option 1**	**Option 2**	**Option 3**
1	Cataract (Per eye)	₹20,000	₹25,000	₹30,000
2	Surgeries for non-malignant Tumors/ Cysts/Nodule/ Polyp/ Abscess	₹15,000	₹30,000	₹45,000
3	Stone in Urinary(Kidney) / Biliary System	₹20,000	₹40,000	₹60,000

4	Hernia (unilateral/ Bilateral) Excluding cost of mess.	₹20,000	₹30,000	₹40,000
5	Appendicitis	₹20,000	₹30,000	₹40,000
6	Hysterectomy/ Benign Prostate Hypertrophy/Fibroid Uterus	₹15,000	₹30,000	₹45,000
7	Any Joint Replace-ment	₹80,000	₹90,000	₹1,00,000
8	Piles/Fissures/ Fistula	₹20,000	₹30,000	₹40,000
9	Ligament Tear	₹40,000	₹50,000	₹60,000

All claims under this Benefit can be made as per the process defined under Section G.I. of the Base Cover Terms and Conditions and Section G.I of the Optional Cover Terms and Conditions, as applicable.

D.II.7 Voluntary Co-Payment for In- patient Hospitalization

The Insured Person will pay the percentage specified in the Policy Schedule/ Certificate of Insurance as Voluntary Co-Payment and We will pay the remaining part of the amount that We assess as payable amount in respect of any claim under the Policy made by an Insured Person:

The Voluntary Co-Payment percentage will be applicable on all claims under the Base Cover and on all In-patient Hospitalization claims under indemnity based Options on the admissible claim amount.

D.II.8 Annual Aggregate Deductible

The Deductible amount specified in the Policy Schedule/ Certificate of Insurance shall be applicable on the aggregate of all claims made by an Insured Person if covered under the Policy on an Individual basis or by the family if covered under the Policy on a Family Floater basis during the Policy Year, provided that:

i. The Annual Aggregate Deductible will be applied on all claims under the Base Cover and all In-patient Hospitalization claims under indemnity based Options on the admissible claim amount.

ii. For the purpose of calculating the Annual Aggregate Deductible and assessment of admissibility, all claims must be submitted in accordance with Sections G.I.6.and G.I.7 of the claims process under Base Cover and Section G.I of the Optional Cover Terms and Conditions, as applicable.

iii. The consumption of the Deductible amount will be on the basis of the admissible claim amount after applying the Sub Limits of the Policy.

D.II.9 Per Claim Deductible

The Deductible amount specified in the Policy Schedule/ Certificate of Insurance as the Per Claim Deductible shall be applicable on each and every claim made by an Insured Person during the Policy Year, provided that:

i. The Per Claim Deductible will be applied on all claims under the Base Cover and all In-patient Hospitalization claims under indemnity based Options on the admissible claim amount.

ii. For the purpose of calculating the Deductible and assessment of admissibility, all claims must be submitted in accordance with Sections G.I.6 and G.I.7. of the claims process under the Base Cover and Section G.I of the Optional Cover Terms and Conditions, as applicable.

iii. The consumption of the Deductible amount will be on the basis of the admissible claim amount after applying the Sub Limits of the Policy.

D.II.10 Corporate Deductible at a Group Level

The Corporate Deductible amount, as specified in the Policy Schedule, shall be applicable in each Policy Year on the aggregate of all admissible claims for the group during the Policy Year, provided that:

i. Any claim above the Corporate Deductible limit will be payable once the Corporate Deductible is exhausted through one or all the claims made during the Policy Year.

ii. Corporate Deductible will be applied on all claims under the Base Cover and all In-patient Hospitalization claims under indemnity based Options on the admissible claim amount.

iii. For the purpose of calculating the Deductible and assessment of admissibility, all claims must be submitted in accordance with Sections G.I.6 and G.I.7 of the claims process under the Basie Cover and Section G.I of the Optional Cover Terms and Conditions, as applicable.

iv. The consumption of the Deductible amount will be on the basis of the admissible claim amount after applying the Sub Limits of the Policy.

D.II.11 Maximum Limit on Out of Pocket Expenses

We will provide for a maximum limit on out of pocket expenses provided that:

i. The maximum limit on out of pocket expenses shall be the maximum amount that the Insured

Person will bear out of his pocket during the Policy Year against admissible claims.

ii. The amount borne by the Insured Person under the Co-Payment option will be deducted from the out of pocket expenses limit specified in the Policy Schedule/ Certificate of Insurance.

iii. Once this limit is exhausted, all further admitted claims for the same Policy Year will be paid without applying Co-Payment.

iv. The maximum limit on out of pocket expenses will be applied on all claims under the Base Cover and all In-patient Hospitalization claims under indemnity based options on the admissible claim amount in accordance with Sections G.I.6 and G.I.7 of the claims process under the Base Cover and Section G.I of the Optional Cover Terms and Conditions, as applicable.

v.This Benefit can only be opted if an Insured Person has opted for Voluntary Co-Payment for In-patient Hospitalization.

D.II.12 Directed Plan

The Insured Person will pay the percentage specified in the Policy Schedule/ Certificate of Insurance as Co-Payment and We will pay the remaining part of the amount that We assess as payable amount in respect of any claim under the Policy made by an Insured Person, provided that:

i. The Co-Payment percentage will be applicable on all claims under the Base Cover and on all In-patient Hospitalization claims under indemnity based options on the admissible claim amount.

ii. The Co-Payment amount will depend on the Insured Person undertaking the treatment with the Network Provider (as specified in Annexure for Directed Network) or the Non-Network Provider and the type of claim as specified in the Policy Schedule/ Certificate of Insurance.

When this Option is opted for, the Co-Pay mentioned herein will override the Voluntary Co-Payment.

For the list of Specified Healthcare Providers refer Annexure to the Policy Schedule/ Certificate of Insurance.

All claims under this Benefit can be made as per the process defined under Section G.I. under the Base Cover Terms and Conditions and Section III of the Optional Cover Terms and Conditions, as applicable.

D.II.13 Reimbursement Only Cover

All the admissible claims under the Policy will be payable on a reimbursement basis only. Any claim for Cashless facility will not be available under the Policy.

All claims under this Benefit can be made as per the process defined under Section G.I.5. under the Base Cover Terms and Conditions and Section G.I of the Optional Cover Terms and Conditions, as applicable.

D.II.14.a Hospital Daily Cash Benefit (HDCB) Cover

We will pay the Hospital Daily Cash Benefit specified in the Policy Schedule/ Certificate of Insurance for each continuous and completed 24 Hours of Hospitalization during the Policy Year which is more than the number of hours as specified in the Policy Schedule/ Certificate of Insurance, provided that:

i. The Hospitalization claim is admissible under the Base cover.

ii. Any claim shall be payable under this Benefit after applying the opted number of days of Deductible specified in the Policy Schedule/ Certificate of Insurance.

iii. All Benefits will be available up to the maximum number of coverage days selected per Policy Year.

iv. The Benefit under this cover will be over and above the Base Sum Insured. A claim will be payable under any one of the Hospital Daily Cash Benefit or Accidental Hospital Daily Cash Benefit or Worldwide Cash Benefit. In case of Hospitalization in ICU, the Daily Cash Benefit will be twice the Hospital Daily Cash Benefit amount specified in the Policy Schedule/ Certificate of Insurance under cover for which the claim qualifies.

All claims under this Benefit can be made as per the process defined under Section G.I.5. under the Base Cover Terms and Conditions and Sections G.I under Optional Cover Terms and Conditions, as applicable.

D.II.14.b Accidental Hospital Daily Cash Benefit Cover

`If this Benefit is opted under the Policy, We will pay the Accidental Hospital Daily Cash Benefit specified in the Policy Schedule/ Certificate of Insurance for each continuous and completed 24 Hours of Hospitalization during the Policy Year which is more than the number of hours as specified in the Policy Schedule/ Certificate of Insurance and the Hospitalization is due to an injury.

D.II.14.c Worldwide Hospital Daily Cash Benefit Cover

If this Benefit is opted under the Policy, We will pay the Worldwide Hospital Daily Cash Benefit specified in the Policy Schedule/ Certificate of Insurance for each continuous and completed 24 Hours of Hospitalization during the Policy Year which is more than the number of hours as specified in the Policy Schedule/ Certificate of Insurance and the Hospitalization is in a Hospital outside India.

D.II.14.d Convalescence Benefit Cover

We will pay a lump sum amount specified in the Policy Schedule/ Certificate of Insurance over and above the applicable Daily Cash Benefit claim if a Hospitalization claim is admissible under the Base cover and the continuation of such Hospitalization is medically necessary for at least 10 consecutive days, provided that:

This Benefit is payable only once in a Policy Year in respect of an Insured Person.

D.II.14.e Companion Benefit Cover

We will pay an amount for each continuous and completed 24 hours of Hospitalization after application of deductible as specified in the Policy Schedule/ Certificate of Insurance in respect of a person accompanying an Insured Person to take care of the Insured Person.

D.II.14.f ICU Daily Cash Benefit

If this Benefit is opted under the Policy, We will pay the ICU Daily Cash Benefit specified in the Policy Schedule/ Certificate of Insurance for each continuous and completed 24 Hours of Hospitalization in an Intensive Care Unit (ICU) during the Policy Year which is more than the number of hours as specified in the Policy Schedule/ Certificate of Insurance.

D.II.14.g Chemotherapy and Radiotherapy Benefit

If the Insured Person undergoes Medically Necessary Chemotherapy or Radiotherapy as a Day Care Treatment without 24 hours of Hospitalization, We will pay a cash benefit of as specified in the Policy Schedule/Certificate of Insurance for each sitting of Chemotherapy/Radiotherapy for maximum up to the number of sittings opted by the Policyholder in a Policy Year.

D.II.15 Critical Illness Cover

For the purpose of this Section, “Critical Illness” means any Illness, medical event or Surgical Procedure as specifically defined whose signs or symptoms first commence after the period specified under the Critical Illness Waiting Period section in the Policy Schedule/ Certificate of Insurance since the commencement of the Policy Year. The Benefits under this cover (as set out below) will be over and above the Base Sum Insured.

The cover is applicable provided that:

The Critical Illness, which the Insured Person is suffering from, occurs or first manifests itself during the Policy Year as a first incidence.

List of Critical Illnesses cover under this Benefit:

1. CANCER OF SPECIFIED SEVERITY

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

II. The following are excluded –

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

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

2. MYOCARDIAL INFARCTION

(First Heart Attack of specific severity)

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

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

ii. New characteristic electrocardiogram changes

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

II. The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

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

3. OPEN CHEST CABG

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

II. The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

4 OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

5. COMA OF SPECIFIED SEVERITY

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

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

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

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

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

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

7. STROKE RESULTING IN PERMANENT SYMPTOMS

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

II. The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

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

8. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

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

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

II. The following are excluded:

i. Other stem-cell transplants
ii. Where only islets of langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

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

10. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

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

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

12. PRIMARY PULMONARY HYPERTENSION

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.
II. The NYHA Classification of Cardiac Impairment are as follows:
i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.
III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

Coverage under this Critical Illness shall not pay for any form of secondary causes of hypertension.

13. AORTA GRAFT SURGERY

The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen.

For the purpose of this Benefit, Aorta means the thoracic and abdominal aorta but not its branches.

You understand and agree that We will not cover:

a. Surgery performed using only minimally invasive or intraarterial techniques.
b. Angioplasty and all other intraarterial, catheter based techniques, “keyhole” or laser procedures.
c. Congenital narrowing of the aorta and traumatic injury of the aorta are specifically excluded.

14. DEAFNESS (LOSS OF HEARING)

Total and irreversible Loss of hearing in both ears as a result of Illness or Injury.

This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means “the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing” in both ears.

15. BLINDNESS (LOSS OF SIGHT)

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.
II. The Blindness is evidenced by:
i. corrected visual acuity being 3/60 or less in both eyes or ;
ii. the field of vision being less than 10 degrees in both eyes.
III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

16. APLASTIC ANAEMIA

Chronic persistent bone marrow failure which results

in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

a. Blood product transfusion;
b. Marrow stimulating agents;
c. Immunosuppressive agents; or
d. Bone marrow transplantation.

The diagnosis must be confirmed by a haematologist Medical Practitioner using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following:

a. Absolute neutrophil count of less than 500/mm³ or less;
b. Platelets count less than 20,000/mm³ or less;
c. Reticulocyte count of less than 20,000/mm³ or less.

We will not cover temporary or reversible Aplastic Anaemia under this Section.

17. CORONARY ARTERY DISEASE

The first evidence of narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, regardless of whether or not any form of coronary artery Surgery has been performed. Coronary arteries herein refer to left main stem, left anterior descending circumflex and right coronary artery and not its branches which is evidenced by the following:

a. evidence of ischemia on Stress ECG (NYHA Class III symptoms)
b. coronary arteriography (Hearth Cath)

18. END STAGE LUNG DISEASE

End Stage Lung Disease, causing chronic respiratory failure. This diagnosis must be supported by evidence of all of the following:

a. FEVI (Forced Expiratory Volume) test results which are consistently less than 1 litre as measured on 3 occasions, 3 months apart;
b. Requiring continuous and permanent supplementary oxygen therapy for hypoxemia;
c. Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less (PaO2 <- 55 mm Hg);and
d. Dyspnoea at rest.

The diagnosis must be confirmed by a respiratory physician Medical Practitioner.

19. END STAGE LIVER FAILURE

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

a. Permanent jaundice;
b. Uncontrollable Ascites; and
c. Hepatic Encephalopathy.
d. Oesophageal or Gastric Varices and portal hypertension.

We will not cover liver disease secondary to alcohol or drug abuse.

20. THIRD DEGREE BURNS (MAJOR BURNS)

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

We will not cover burns arising due to self-infliction under this Section.

21. FULMINANT HEPATITIS

A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

a. Rapid decreasing of liver size;
b. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
c. Rapid deterioration of liver function tests;
d. Deepening jaundice; and
e. Hepatic encephalopathy.

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

22. ALZHEIMER'S DISEASE

`Alzheimer's disease is a progressive degenerative Illness of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a Neurologist Medical Practitioner and supported by Our appointed Medical Practitioner.

The following conditions are however not covered:

a. non-organic diseases such as neurosis and psychiatric Illnesses;

b. alcohol related brain damage; and

c. any other type of irreversible organic disorder/ dementia.

23. BACTERIAL MENINGITIS

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

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

b. A consultant neurologist Medical Practitioner.We will not cover Bacterial Meningitis in the presence of HIV infection under this Section.

24. BENIGN BRAIN TUMOUR

A benign tumour in the brain where all of the following conditions are met:

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

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

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

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

The following conditions are however not covered by Us:

a. cysts;

b. granulomas;

c. vascular malformations;

d. haematoma;

e. Calcification;

f. Meningiomas;

g. Tumours of the pituitary gland or spinal cord; and

h. tumours of acoustic nerve (acoustic neuroma).

25. APALLIC SYNDROME

Universal necrosis of the brain cortex with the brainstem remaining intact. The diagnosis must be confirmed by a Neurologist Medical Practitioner acceptable to Us and the condition must be documented by such Medical Practitioner for at least one month.

26. PARKINSON'S DISEASE

The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist Medical Practitioner acceptable to Us.

The diagnosis must be supported by all of the following conditions:

a. the disease cannot be controlled with medication;

b. signs of progressive impairment; and

c. inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

Activities of daily living:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;

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

iii. Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;

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

v. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.

vi. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence

We will not cover Parkinson's disease secondary to drug and/or alcohol abuse under this Section.

27. MEDULLARY CYSTIC DISEASE

A progressive hereditary disease of the kidneys characterised by the presence of cysts in the medulla, tubular atrophy and interstitial fibrosis with the clinical manifestations of anaemia, polyuria and renal loss of sodium, progressing to chronic renal failure. The diagnosis must be supported by renal biopsy.

28. MUSCULAR DYSTROPHY

A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist Medical Practitioner acceptable to Us, with confirmation of at least 3 of the following 4 conditions:

a. Family history of muscular dystrophy;
b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
c. Characteristic electromyogram;
d. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

Activities of daily living:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;
iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
v. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available;
vi. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence.

29. LOSS OF SPEECH

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

30. SYSTEMIC LUPUS ERYTHEMATOUS

A multi-system, multifactorial, autoimmunedisorder characterised by the development of auto-antibodies directed against various self-antigens. Only those forms of systemic lupus erythematous which involve the kidneys (Class III to Class V lupus nephritis, established by renal biopsy, and in accordance with the World Health Organization (WHO) classification) will be covered by Us under this Section. The final diagnosis must be confirmed by a registered Medical Practitioner specialising in Rheumatology and Immunology acceptable to Us. Other forms of systemic lupus erythematous, discoid lupus and those forms with only haematological and joint involvement are however not covered:

The WHO lupus classification is as follows:

- Class I: Minimal change – Negative, normal urine.
- Class II: Mesangial – Moderate proteinuria, active sediment.
- Class III: Focal Segmental – Proteinuria, active sediment.
- Class IV: Diffuse – Acute nephritis with active sediment and/or nephritic syndrome.
- Class V: Membranous – Nephrotic Syndrome or severe proteinuria.

31. LOSS OF LIMBS

a. The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

32. MAJOR HEAD TRAUMA

a. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.
b. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled

persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

c. The Activities of Daily Living are:

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

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

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

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

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

vi. Feeding: the ability to feed oneself once food has been prepared and made available.

d. The following are excluded:

a. Spinal cord injury; and

b. Head injury due to any other causes.

33. BRAIN SURGERY

The actual undergoing of surgery to the brain, under general anaesthesia, during which a Craniotomy is performed. Burr hole and brain surgery as a result of an accident is excluded. The procedure must be considered necessary by a qualified specialist and the Benefit shall only be payable once corrective surgery has been carried out.

34. CARDIOMYOPATHY

The unequivocal diagnosis by a consultant Mcardiologist of Cardiomyopathy causing impaired ventricular function suspected by ECG abnormalities and confirmed by cardiac echo of variable etiology and resulting in permanent physical impairments to the degree of at least Class IV of the New York Association (NYHA) Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment (Source: "Current Medical Diagnosis and Treatment - 39th Edition"):

a. Class I: No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnoea, or angina pain.

b. Class II: Slight limitation of physical activity. Ordinary physical activity results in symptoms.

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

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

We will not cover Cardiomyopathy related to alcohol abuse under this Section.

35. CREUTZFELDT-JACOB DISEASE (CJD)

A Diagnosis of Creutzfeldt-Jakob disease must be made by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical loss of the ability in mental and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required.

Social functioning is defined as the ability of the individual to interact in the normal or usual way in society.

Mental functioning would mean functions processes such as perception, introspection, belief, imagination reasoning which we can do with our minds.

36. TERMINAL ILLNESS

An Insured Person shall be regarded as terminally ill only if he/ she is diagnosed as suffering from a condition which, in the opinion of two appropriate independent Medical Practitioners, is highly likely to lead to death within 12 months from the date of the diagnosis and the Insured Person is not receiving any active treatment for the terminal illness, other than that of the pain relief. The terminal illness must be diagnosed and confirmed by Medical Practitioners registered with the Indian Medical Association and approved by Us.

We will not cover terminal illness due to, arising from or attributable to AIDS under this Section.

- **Specific Exclusions under Critical Illness Cover in addition to exclusions under Base Cover:**

We shall not be liable to make any payment under this cover, caused by, based on, arising out of, relating to or howsoever attributable to any of the following:

i. Any Illness other than those specified as Critical Illness under this Policy.

ii. Any claim with respect to any Critical Illness diagnosed or which manifested prior to the Inception Date.

iii. Any Pre-Existing Disease or any complication arising therefrom.

iv. Narcotics used by the Insured Person unless taken as prescribed by a registered Medical Practitioner;

v. Working in underground mines, tunneling or involving electrical installations with high tension supply, or as jockeys or circus personnel.

vi. Any loss resulting from, contributed or aggravated or prolonged by childbirth or from pregnancy.

vii. Death of the Insured Person within the stipulated survival period as specified in the Optional Cover.

viii. Any Treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including Caesarean section), abortion or complications arising therefrom. This exclusion will not apply to ectopic pregnancy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to the Base cover (Section D) shall apply.

All claims under this Benefit can be made as per the process defined under Sections G.I.4. and G.I.5. under the Base Cover Terms and Conditions and Section III under Optional Cover Terms and Conditions, as applicable.

(a) Critical Illness - Benefit Cover

If an Insured Person is diagnosed to be suffering from any of the Critical Illnesses of the nature specified above during the Policy Year, then We will pay the a Critical Illness Sum Insured specified in the Policy Schedule/ Certificate of Insurance provided that:

i. The payment of the Benefit shall be subject to survival of the Insured Person for the period specified as Survival Period For Critical Illness in the Policy Schedule/ Certificate of Insurance from the date of diagnosis of the Critical Illness.

ii. Upon Our admission of the first claim under this Benefit in respect of an Insured Person in any Policy Year, the cover under this Benefit shall automatically terminate in respect of that Insured Person.

iii. Our total and cumulative liability in respect of an Insured Person under this Benefit will be limited to the Critical Illness Sum Insured opted.

iv. This Benefit is paid as a lumpsum amount and is over and above the Base Sum Insured.

(b) Critical Illness - Indemnity Cover

If an Insured Person is diagnosed to be suffering from any of the Critical Illnesses of the nature specified above during the Policy Year, then, We will pay the expenses incurred in relation to In-patient Hospitalization, Pre-Hospitalization Medical Expenses, Post-Hospitalization Medical Expenses, Day Care Treatment, Domiciliary Hospitalization and Donor Expenses upto the Sum Insured specified in the Policy Schedule/ Certificate of Insurance, provided that:

i. Our total and cumulative liability during a Policy Year for an Insured Person under this cover will be limited to the Critical Illness Sum Insured opted over and above the Base Sum Insured and Corporate Buffer (if opted).

ii. The Benefit payable will be on an indemnity basis.

iii. Any Restored Sum Insured will not be available for coverage under this Section.

(c) Expert Opinion On Critical Illness

If an Insured Person is diagnosed with a Critical Illness of the nature specified above during the Policy Year, the Insured Person may at his/her sole discretion choose to avail a second opinion from our panel of Medical Practitioners where the opinion will be sent directly to the Insured Person, provided that:

a. We have received a request from the Insured Person to exercise this option.

b. The expert opinion will be based only on the information and documentation provided by the Insured Person that will be shared with the Medical Practitioner.

c. This Benefit can be availed only once by each Insured Person during the Policy Year for a particular Critical Illness or for multiple Illnesses if the Policy is still in force for that particular Insured Person.

d. This Benefit is only a value added service provided by Us and does not deem to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.

e. The Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.

f. We shall not, in any event be responsible for any actual or alleged errors or representations made by any Medical Practitioner or in any expert opinion or for any consequence of actions taken or not taken in reliance thereon.

g. The expert opinion shall be limited to covered Critical Illnesses as listed under this option and shall not be valid for any medico legal purposes.

h. We do not assume any liability towards any loss

or damage arising out of or in relation to any opinion, Medical Advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

If this option is in force, and Worldwide Expert Opinion is opted, in respect of the Insured Person, then Exclusion E.II.7 will be deemed to be inoperative for the purpose of this option in respect of that Insured Person.

(d)Loss of Pay Cover

If an Insured Person is diagnosed to be suffering from any of the conditions as specified in the Policy Schedule/ Certificate of Insurance under this cover while the Policy is in force then We will pay a fixed benefit amount per week as specified in the Policy Schedule/ Certificate of Insurance for the period, subject to a maximum of 50 weeks per Policy Year, provided that:

i. Any one or combination of the following can be opted under the cover:
   - Critical Illness of the specified nature described above
   - Injury due to an Accident leading to disablement
   - Any Illness where Hospitalization is more than the number of days as specified in the Policy Schedule/Certificate of Insurance

ii. The fixed Benefit payment shall be subject to an initial Waiting Period for Hospitalization or/and Survival Period for Critical Illness as specified in the Policy Schedule/ Certificate of Insurance (if applicable).

iii. The Benefit is payable only for one of the specified Critical Illnesses or disablement or Hospitalization for an Insured Person during a particular week.

iv. This Benefit is paid as a lumpsum amount at the end of every month and is over and above the Base Sum Insured. In case the specified condition continues for a period of more than 30 days then, We will make the payment of the amount at the end of every calendar month until recovery, subject to a maximum of 50 weeks per Policy Year.

For the purpose of this Section, “week” in respect of this Benefit will be calculated from the date of absence of the Employee from work for the covered condition (as applicable). The number of days for payment shall be on the basis of a certificate from the employer confirming the absence of the Insured Person.

v. The Benefit is payable if the Insured Person is absent from his occupation for at least 7 consecutive days (in which case, the Benefit will be payable from day 1), after which if the Insured Person is absent for a part of the week, then only a proportionate part of the weekly Benefit will be payable.

vi. A certificate, issued by below mentioned authority, shall be submitted to confirm the inability from engaging in current employment or occupation or business for remuneration or profit due to the covered condition:

- a civil surgeon or the equivalent appointed by the District, State or Government Board for disablement or the attending Medical Practitioner for other cases.

D.II.16 Personal Accident Benefit Cover

If the Insured Person suffers an Injury during the Policy Year solely and directly due to an Accident that occurs during the Policy Year, then We will pay the Sum Insured specified in the Policy Schedule/ Certificate of Insurance and in accordance with the terms, conditions and exclusions mentioned under this Section.

D.II.16.a Accidental Death Benefit Cover

If the Insured Person suffers an Injury during the Policy Year solely and directly due to an Accident that occurs during the Policy Year and that Injury solely and directly results in the death of the Insured Person within 365 days from the date of the Accident, then We will pay the Sum Insured as specified against this Benefit in the Policy Schedule/ Certificate of Insurance, provided that:

i. Where the death of the Insured Person occurs while the Insured Person is a fare paying passenger on a common carrier, We will pay 200% of the opted Sum Insured as specified in the Policy Schedule/ Certificate of Insurance.

ii. Once a claim has been accepted and paid under this Benefit, then this cover will automatically terminate in respect of that Insured Person.

iii. The Benefit under this cover will be over and above the Base Sum Insured.

iv. Any claim payment made in respect of PTD or PPD as described below will be deducted from the Sum Insured before payment.

D.II.16.b Permanent Total Disablement Benefit (PTD) Cover

If the Insured Person suffers an Injury during the Policy Year solely and directly due to an Accident that occurs during the Policy Year and such Injury

solely and directly results in the Permanent Total Disablement of the Insured Person which is of the nature specified in the table below, within 365 days from the date of the Accident, then We will pay the Sum Insured as specified against this Benefit in the Policy Schedule/ Certificate of Insurance, provided that:

i. Where such Permanent Total Disablement occurs while the Insured Person is a fare paying passenger on a common carrier, We will pay 200% of the opted Sum Insured as specified in the Policy Schedule/ Certificate of Insurance.

Type of Permanent Total Disablement
i) Total and irrecoverable loss of sight of both eyes
ii) Loss by physical separation or total and permanent loss of use of both hands or both feet
iii) Loss by physical separation or total and permanent loss of use of one hand and one foot
iv) Total and irrecoverable loss of sight of one eye and loss of a Limb
v) Total and irrecoverable loss of hearing of both ears and loss of one Limb/loss of sight of one eye
vi) Total and irrecoverable loss of hearing of both ears and loss of speech
vii) Total and irrecoverable loss of speech and loss of one Limb/loss of sight of one eye
viii) Permanent total and absolute disablement (not falling under the above) disabling the Insured Person from egaging in any employment or occupation or business for remuneration or profit, of any description whatsoever

For the purpose of this Benefit:

- **Limb** means a hand at or above the wrist or a foot above the ankle.
- **Physical separation of one hand** or **foot** means separation at or above wrist and/or at or above ankle, respectively.

We will pay the Benefit as specified above provided that:

i. The Permanent Total Disablement is proved to our satisfaction and a disability certificate issued by a civil surgeon or the equivalent appointed by the District, State or Government Board is provided to Us.

ii. The Permanent Total Disablement continues for a period of at least 180 days from the commencement of the Permanent Total Disablement, and We are satisfied at the expiry of the 180 days that there is no reasonable medical hope of improvement and such disability is permanent at the end of this period.

iii. If the Insured Person dies before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit.

iv. Once a claim has been accepted and paid under this Benefit then the Insured Person's insurance cover under this Section (Personal Accident Benefit) will immediately and automaticallyN terminate.

v. The benefit under this cover will be over and above the Base Sum Insured.

vi. Any claim payment made in respect of PPD as described will be deducted from the Sum Insured before payment.

D.II.16.c Permanent Partial Disablement Benefit (PPD) Cover

If the Insured Person suffers an Injury during the Policy Year solely and directly due to an Accident that occurs during the Policy Year and that Injury solely and directly results in the Permanent Partial Disablement of the Insured Person which is of the nature specified in the table below within 365 days from the date of the Accident, We will pay the amount specified in the table below not exceeding the Sum Insured specified in the Policy Schedule/ Certificate of Insurance.

Nature of Permanent Partial Disablement	Percentage of the Sum Insured payable
Total and irrecoverable loss of sight in one eye	50%
Loss of one hand or one foot	50%
Loss of all toes - any one foot	10%
Loss of toe great - any one foot	5%
Loss of toes other than great, if more than one toe lost, each	2%
Total and irrecoverable loss of hearing in both ears	50%
Total and irrecoverable loss of hearing in one ear	15%
Total and irrecoverable loss of speech	50%
Loss of four fingers and thumb of one hand	40%
Loss of four fingers	35%
Loss of thumb - both phalanges	25%
Loss of thumb - one phalanx	10%

Loss of index finger - three phalanges	10%
Loss of index finger - two phalanges	8%
Loss of index finger-one phalanx	4%
Loss of middle/ring/little finger - three phalanges	6%
Loss of middle/ring/little finger - two phalanges	4%
Loss of middle/ring/little finger - one phalanx	2%

We will pay the Benefit as specified above provided that:

i. The Permanent Partial Disablement is proved to our satisfaction and a disability certificate issued by a civil surgeon or the equivalent appointed by the District, State or Government Board is provided to Us.

ii. The Permanent Partial Disablement continues for a period of at least 180 days from the commencement of the Permanent Partial Disablement and We are satisfied at the expiry of the 180 days that there is no reasonable medical hope of improvement and such disability is permanent at the end of this period.

iii. If the Insured Person dies before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit.

iv. If the Insured Person suffers a loss that is not of the nature of Permanent Partial Disablement specified in the table above, then a disability certificate issued by a civil surgeon or the equivalent appointed by the District, State or Government Board will determine the degree of disablement and the amount payable, if any.

v. In case Accidental Death and/or Permanent Total Disablement optional cover have been opted with this cover, We will not make any payment under this Benefit if We have already paid or accepted any claims under Accidental Death Benefit and/or Permanent Total Disablement Benefit in respect of the Insured Person and the total amount paid or payable under the claims is cumulatively greater than or equal to the Sum Insured under Accidental Death Benefit or Permanent Total Disability Benefit for that Insured Person.

vi. Once a claim has been accepted and paid under this Benefit, the Insured Person's insurance cover under this Policy shall continue, subject to availability of the Sum Insured.

vii. The Benefit under this cover will be over and above the Base Sum Insured.

- **Specific Exclusions under Personal Accident Benefit in addition to exclusions under Base Cover:**

We shall not be liable to make any payment for any claim under this Policy in respect of any Insured Person, caused by, based on, arising out of, relating to or howsoever attributable to any of the following unless otherwise stated in the Policy:

1. Any payment in case of more than one claim under the Policy during any one Policy Year by which Our maximum liability in that Policy Year would exceed the Sum Insured in respect of Accidental Death Benefit, Permanent Total Disablement Benefit, and Permanent Partial Disablement Benefit.
2. Certification by a Medical Practitioner who shares the same residence as the Insured Person or who is a member of the Insured Person's family.
3. Death or disablement caused by or associated with any venereal disease, sexually transmitted disease.
4. Benefit under Accidental Death Benefit, Permanent Total Disablement Benefit, Permanent Partial Disablement Benefit arising from any Illness except as necessary solely and directly as a result of an Accident.
5. Any change of profession after Inception Date which results in the enhancement of Our risk under the Policy, if not accepted and endorsed by Us on the Policy Schedule/ Certificate of Insurance.
6. Death or disablement resulting from contributed or aggravated or prolonged by childbirth or from pregnancy or a consequence thereof including ectopic pregnancy unless specifically arising due to an Accident.
7. Death or disablement caused by participation of the Insured Person in any flying activity, except as a bona fide, fare-paying passenger of a recognised airline on regular routes and on a scheduled timetable.
8. Insured Persons whilst engaging in a speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports in so far as they involve the training for or participation in

competitions or professional sports, or involving a naval, military or air force operation and is specifically specified in the Policy Schedule Certificate of Insurance.

9. Working in underground mines, tunneling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in hazardous activities.
10. Death or disablement arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.
11. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
12. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing microorganisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesised toxins) which are capable of causing any Illness, incapacitating disablement or death.
13. Bacterial infections (except pyogenic infection which occurs through a cut or wound due to Accident).

All other applicable clauses, terms and conditions, Waiting Periods and exclusions applicable to the Base cover (Section D) shall apply.

All claims under this Benefit can be made as per the process defined under Sections G.I. under the Base Cover Terms and Conditions and Section G.I under Optional Cover Terms and Conditions, as applicable.

D.II.17 Dental Expenses Cover

We will pay the Medical Expenses incurred during the Policy Year towards Dental Treatment for each of the opted Benefits set out below up to the Sum Insured specified in the Policy Schedule/ Certificate of Insurance for each of the Benefits, provided that the Benefits payable under this cover will be over and above the Base Sum Insured.

Any one or combination of the following can be opted under this cover:

a) Class 1 (Investigative and Preventative Treatment) We will, on a reimbursement basis, pay the Reasonable and Customary Charges towards fees of a Dentist and associated Medical Expenses for carrying out the following routine procedures in relation to Dental Treatment of an Insured Person:

- Clinical oral examinations
- Palliative Treatment for dental pain
- Minor procedures
- Tooth cleaning
- Normal compound fillings or
- Simple non-surgical extractions

We will not be liable to make any payment in respect of Orthodontic Treatment, restorative Treatment and dental implants.

b) Class 2 (Basic Restorative, Periodontal Treatment)

We will, on a reimbursement basis, pay the Reasonable and Customary Charges towards fees of a Dentist and associated Medical Expenses for carrying out the following specified procedures in relation to Dental Treatment of an Insured Person:

- Amalgam filling
- Composite/Resin filling
- Root canal Treatment
- Osseous Surgery
- Periodontal scaling and root planning
- Adjustments
- Recement bridge
- Routine extractions
- Surgical removal of impacted tooth
- Local or general Anaesthesia including sedation

We will not be liable to make any payment in respect of Orthodontic Treatment, routine Treatment and dental implants.

c) Class 3 (Major Restorative and Orthodontic Treatment)

We will, on a reimbursement basis, pay the Reasonable and Customary Charges towards fees of a Dentist carrying out restorative Dental Treatment and associated Medical Expenses for carrying out the following specified procedures in respect of an Insured Person:

- Removal of impacted or buried teeth
- Removal of roots
- Removal of solid odontomes
- Apicectomy
- New or repair of bridge work

- New or repair of crowns
- Root canal Treatment
- New or repair of upper or lower dentures
- Removal of wisdom teeth

For the purpose of this Section, "Orthodontic Treatment" includes Orthodontic work-up including X-rays, diagnostic casts and Treatment plan and the first month of active Treatment including all active Treatment and retention appliances.

We will not be liable to make any payment in respect of dental implants.

All claims under this Benefit can be made as per the process defined under Section G.I.5. under the Base Cover Terms and Conditions and Section G.I under Optional Cover Terms and Conditions, as applicable.

We will not be liable to make any payment in respect of the following Treatments under this Benefit:

i. Replacing any dental appliance which is lost or stolen.

ii. Replacing a bridge, crown or denture which is or can be made useable according to a standard acceptable to a Dentist of ordinary competence and skill.

iii. Replacing a bridge, crown or denture within five years of original fitting unless:

a. The replacement is needed because of the placement of an original opposing full denture or extraction of natural teeth is needed; or

b. The bridge, crown or denture, while in the mouth, has been damaged beyond repair because of an Injury the Employee/ Member or their Dependant receives while being covered under the Policy.

iv. Porcelain or acrylic veneers on the upper and lower first, second and third molars and premolars.

v. Crowns or pontics on or replacing the upper and lower first, second and third molars unless they are constructed of either porcelain bonded-to metal or metal alone, e.g. gold alloy crown; or a temporary crown or pontic is required as part of routine or Emergency Dental Treatment.

vi. Surgical implants of any type including any attaching prosthetic device.

vii. Procedures and materials which are experimental or which do not meet accepted dental standards.

viii. Instruction for plaque control, oral hygiene and diet.

ix. Procedures, services and supplies which are deemed by Us to be medical procedures, services and supplies including mouthwashes and also including services and supplies provided in a Hospital (except where Dental Treatment is neither wholly nor partly the reason for the stay in Hospital).

x. Bite registration, precision or semi-precision attachments.

xi. Procedures, appliances or restorations (except full dentures) whose main purpose is to:

- Change vertical dimensions; or
- Diagnose or treat conditions or dysfunction of the temporo-mandibular joint; or
- Stabilise periodontally involved teeth; or
- Restore occlusion; or
- Major Treatment on deciduous or baby teeth for Dependent Children;

D.II.18 Vision Expenses Cover

We will, on a reimbursement basis, pay the Reasonable and Customary Charges incurred during the Policy Year, by the Insured Person up to the Sum Insured specified in the Policy Schedule/ Certificate of Insurance and will be over and above the Base Sum Insured in relation to the following:

i. Eye examination by an optometrist or ophthalmologist

ii. Cost of lenses to correct refractory errors

We will not be liable to make any payment in respect of the following:

i. Cost of frames for the prescribed lenses.

ii. Sunglasses, unless medically prescribed by a Medical Practitioner.

iii. Medical or surgical Treatment of the eye.

iv. Lenses which are not medical necessary and are not prescribed by an optometrist or ophthalmologist.

All claims under this Benefit can be made as per the process defined under Section G.I.5. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.19 Refractive Error Correction beyond +/- 5 Expenses Cover

We will pay the Reasonable and Customary Charges incurred during the Policy Year, by the Insured Person for Laser-Assisted In Situ Keratomileusis (LASIK) Surgery, including refractive keratotomy (RK) and photorefractive keratectomy (PRK) or any other advanced Surgical Procedures conducted to

correct the refractive errors beyond +/- 5 to change the refraction of one or both eyes., provided that:

i. If this Option is in force in respect of the Insured Person, then the part of Exclusion E.I.15 will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person up to the Sum Insured specified for this Benefit.

ii. The Benefit will be limited to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance and would be a part of the Sum Insured.

We will not be liable to make any payment in respect of any other non-Surgical Procedures.

All claims under this Benefit can be made as per the process defined under Sections G.I.4. and G.I.5 under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.20 OPD Physiotherapy Charges Cover

We will, on a reimbursement basis, pay the Reasonable and Customary Charges incurred during the Policy Year, by the Insured Person for a prescribed physiotherapy Treatment which is a Medically Necessary Treatment undertaken as an Out-Patient in a Hospital up to the Sum Insured specified in the Policy Schedule/ Certificate of Insurance and would be over and above the Base Sum Insured.

All claims under this Benefit can be made as per the process defined under Section G.I.5. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.21 Routine Immunisations Cover

We will, on a reimbursement basis, pay the Reasonable and Customary Charges incurred during the Policy Year in relation to vaccination expenses as per the WHO recommendations for Routine Immunisation of the New Born Baby till he/ she completes 2 years of Age, provided that:

i. Coverage of the New Born Baby on birth shall be subject to addition of the New Born Baby into the Policy by way of an endorsement or at the next Renewal whichever is earlier on payment of the requisite premium.

ii. The Benefit will be limited to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance and would be a part of the Base Sum Insured.

All claims under this Benefit can be made as per the process defined under Section G.I.5. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.22 Home Nursing Charges Cover

We will, on a reimbursement basis, pay the Reasonable and Customary Charges incurred during the Policy Year towards a Qualified Nurse arranged by the Hospital to visit the Insured Person's home to give expert nursing services limited to the Sub Limit specified in Policy Schedule/ Certificate of Insurance, provided that:

i. The Insured Person must have significant difficulty coping with the required activities of daily living and specialist Medical Practitioner who treated the Insured Person must have recommended these services in writing.

ii. The Benefit becomes payable provided that a claim has been admitted under In-patient Hospitalization Expenses Benefit under the Base Cover and is related to the same condition.

iii. The Benefit will cover visits by a Qualified Nurse for as long as it is required for a Medically Necessary Treatment which would normally have been provided in a Hospital subject to a maximum of 15 days in a Policy Year.

iv. The Benefit under this cover will be a part of the Base Sum Insured.

v. The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons).

vi. This Benefit is not related to any Domiciliary Hospitalization.

vii. If this Option is in force in respect of the Insured Person, then the part of Exclusion E.I.5 pertaining to the Optional Cover will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person up to the limit specified for this Benefit.

For the purpose of this Section, "activities of daily living" means:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene.

ii. Dressing: the ability to put on, take off, secure

and unfasten all garments and, as appropriate, any braces, artificial limbs or other Surgical Appliances.

iii. Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa.

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

v. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.

vi. Mobility: the ability to move indoors from room to room on level surfaces at the normal place of residence.

All claims under this Benefit can be made as per the process defined under Section G.I.5. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to the Base Cover (Section D) shall apply.

D.II.23 Health Check- Up Benefit

i. The Insured Person may avail a comprehensive health check-up with Our Network Provider which may be arranged by Us and conducted by Our Network Providers as per the opted package:

   The eligibility of the Insured Person, frequency of heath check ups and dependency of health check ups on claim status will be as defined in the Policy Schedule/ Certificate of Insurance.

ii. List of tests which can be undertaken under this Benefit are set out in Annexure 3.

All claims under this Benefit can be made as per the process defined under Section G.I. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.24 Compassionate Cover for family member in case of Emergency or Accident

I f an Insured Person is Hospitalised in a Hospital which is situated at a distance of at least 100 kilometres from his actual place of residence and the attending Medical Practitioner recommends personal attendance of an immediate family member, then We will, on a reimbursement basis, pay the amount up to the Sum Insured specified against this Benefit in the Policy Schedule/ Certificate of Insurance , over and above the Base Sum Insured, incurred during the Policy Year in respect of the immediate family member of the Insured Person for transportation by one way airfare (economy class) for air travel in India or one way first class railway ticket in a licensed common carrier to the place of Hospitalization of the Insured Person.

All claims under this Benefit can be made as per the process defined under Section G.I.5. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.25 Air Ambulance Cover

We will, on a reimbursement basis, pay the Reasonable and Customary Charges incurred during the Policy Year towards transportation of the Insured Person to the nearest Hospital by an air ambulance or to move the Insured Person to and from healthcare facilities during an Emergency within India only up to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance, provided that:

i. The Illness/Injury is covered under the base Cover.

ii. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment's vital to monitoring and treating the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECG's, monitoring units, CPR equipment and stretchers.

All claims under this Benefit can be made as per the process defined under Section G.I.5. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.26 Emergency Evacuation Cover

In case of an Emergency during the Policy Year. in respect of an Insured Person, if adequate medical facilities are not available locally, We will, on a reimbursement basis, pay the amount up to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance for this Benefit towards the arrangement of an Emergency evacuation of the Insured Person to the nearest facility capable of providing adequate care, provided that:

i. The medical evacuations must be determined by Our medical team to be medically necessary to prevent the immediate and significant effects of Illness/Injury which if left untreated could result in a significant deterioration of health and

it has been determined that the Treatment is not available locally.

ii. The Emergency medical evacuation is pre-authorised by the Our medical team. If it is not possible for pre-authorisation to be sought before the evacuation takes place, authorisation must be sought as soon as possible thereafter. We will only authorise medical evacuations after the evacuation has occurred where it was not reasonably possible for authorisation to be sought before the evacuation took place.

iii. In making Our determinations, We will consider the nature of the Emergency, the Insured Person's medical condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions and distance to be covered.

iv. The Insured Person's medical condition must require the accompaniment of a qualified Medical Practitioner during the entire course of the evacuation to be considered an Emergency and requiring Emergency evacuation.

v. Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or Ambulance depending upon the medical needs and available transportation specific to each case.This Benefit is available in India only.

vi. Our medical assistance service may arrange for the transport of the Insured Person to the nearest Hospital offering the Medically Necessary Treatment under proper medical supervision.

All claims under this Benefit can be made as per the process defined under Sections G.I.4. and G.I.5. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.27 Medical Equipment Cover

We will, on a reimbursement basis, pay the Reasonable and Customary Charges up to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance for prescription medical equipment that are medically necessary and which are otherwise classified as non-payable items under the Base Cover, provided that:

i. The Benefit covers Medical Expenses incurred on hearing aids, instrument used in the Treatment of Sleep Apnea Syndrome, Oxygen Concentrator for Bronchial Asthmatic condition, infusion pump or any other external devices, Prostheses, corrective devices and Medical Appliances, which are not required intra-operatively.

ii. The Benefit payable will be a part of the Base Sum Insured and becomes payable only if we have admitted an In-patient Hospitalization Expenses claim during the Policy Year.

iii. If this Option is in force in respect of the Insured Person, then the part of Exclusion E.II.3 and E.II.5 pertaining to the Optional cover will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person.

All claims under this Benefit can be made as per the process defined under Section G.I.5. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.28 Bariatric Surgery Cover

We will pay the Medical Expenses up to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance incurred towards Hospitalization during the Policy Year, in case the Insured Person is undergoing Bariatric Surgical Procedure subject to such Surgery being a Medical Necessary Treatment as certified by an authorised Medical Practitioner, provided that:

i. The Benefit payable will be a part of the Base Sum Insured.

ii. The requirement to undergo the Bariatric Surgical Procedure should be found appropriate by one qualified surgeon and the Insured Person shall obtain prior approval for Cashless facility from Us.

iii. To make a claim, the Insured Person should satisfy the following criteria as devised by NIH (National Institute of Health):

  a. The BMI should be greater than 40 or greater than 35 with co-morbidities (like Diabetes, High Blood Pressure); and

  b. Is unable to lose weight through traditional methods like diet and exercise.

iv. If this Option is in force in respect of the Insured Person, then the part of Exclusion E.I.8. pertaining to the Optional cover will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person.

All claims under this Benefit can be made as per the process defined under Sections G.I. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.29 Adventure Sports Cover

We will pay the Reasonable and Customary Charges incurred during the Policy Year, up to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance and which would be a part of the Base Sum Insured, incurred in relation to an Injury sustained while the Insured Person is engaged in an adventure sport carried out in accordance with the guidelines, codes of good practice and recommendations for safe practices as laid down by a governing body or authority, provided that:

i. The following exclusions listed under Section E.I.8 will stand deleted for this Option:

- Boxing, base jumping, canoeing (above grade 5), cliff diving, endurance races, flying (except passengers in licensed passenger-carrying aircraft), gorge swinging, hunting, ice caving, ice hockey, martial arts (competitions), mountaineering/free climbing (expeditions, or without use of ropes or guides), parachuting/ skydiving (extended free fall or acrobatics), power boating, private flying, rafting (above grade 5), scuba diving (in excess of 30 metres), sky surfing, trekking/walking (over 6,000 metres), wreck diving, wrestling, zorbing; or
- any professional or semi-professional sporting activity; or
- any kind of racing except racing on foot; or
- any kind of manual work.

All claims under this Benefit can be made as per the process defined under Sections G.I. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.30 Birth Control Procedure Cover

We will pay the Reasonable and Customary Charges for the Medical Expenses incurred during the Policy Year, of an Insured Person up to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance and which would be a part of the Base Sum Insured, provided that:

i. The Medical Expenses are incurred towards implanted/ injected contraceptives post appropriate counselling, surgical therapies which are medically necessary including but not limited to Tubal Ligation, Vasectomies including any associated Medical Expenses.

All claims under this Benefit can be made as per the process defined under Sections G.I. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.31 Infertility Treatment Cover

We will pay the Medical Expenses incurred during the Policy Year, for diagnostic infertility services to determine the cause of infertility, Treatment and procedures, provided that:

i. Our maximum liability for each Policy Year is subject to the limits specified in the Policy Schedule/ Certificate of Insurance for Treatment of infertility as In-patient Hospitalization, Day Care Treatment or OPD treatment once a Policy year.

ii. The Benefit payable will be a part of the Base Sum Insured or Maternity Expenses Cover limit, as specified in the Policy Schedule/Certificate of Insurance.

iii. We will be liable to pay for the Medical Expenses incurred in relation to the following:

   a. Fertility hormones

   b. Artificial insemination

   c. Surgery

   d. Assisted reproductive technology (ART)

iv. The Benefit under this cover will have a maximum limit for procedures and OPD treatment as specified in the Policy Schedule/ Certificate of Insurance.

v. If this Option is in force in respect of the Insured Person, then the part of Exclusion E.I.17 pertaining to the Optional cover will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person.

   We will not be liable to make any payment in respect of the following:

   i. Infertility services beyond 8 weeks of pregnancy;

   ii. Infertility services for persons who have undergone voluntary sterilisation procedures; and

   iii. Infertility services for women with natural menopause at the age 40 years and older.

All claims under this Benefit can be made as per the process defined under Sections G.I. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.32 In-patient Hospitalization Cover for AYUSH Treatment

We will pay the Medical Expenses incurred during the Policy Year, up to the limits specified in the Policy Schedule/ Certificate of Insurance of an Insured Person in case of Medically Necessary Treatment taken during In-patient Hospitalization for AYUSH

Treatment for an Illness or Injury that occurs during the Policy Year, provided that:

a. The Insured Person has undergone AYUSH Treatment in a government Hospital or in any institute recognised by government and/or accredited by Quality Council of India/ National Accreditation Board on Health.

b. The amount payable under this Benefit will be a part of the Base Sum Insured.

c. If this Option is in force in respect of the Insured Person, then Exclusion E.II.9 will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person.

d. The following exclusions will be applicable in addition to the exclusions under Section E of the Base Cover:

- Facilities and services availed for pleasure or rejuvenation or as a preventive aid, like beauty treatments, Panchakarma, purification, detoxification and rejuvenation.

All claims under this Benefit can be made as per the process defined under Sections G.I. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.33 Enhanced Hospitalization Cover

We will pay the Sum Insured specified in the Policy Schedule/ Certificate of Insurance for Hospitalization of the Insured Person during the Policy Year due to an Accident or a Critical Illness, as opted, in the Policy Year, provided that:

i. The Sum Insured will be over and above the Base Sum Insured.

ii. The Sum Insured cannot be utilised for any Hospitalization other than Hospitalization of the Insured Person due to an Accident or Critical Illness, as opted.

iii. The Base Sum Insured will also be payable in case of Hospitalization of the Insured Person due to an Accident or Critical Illness, as opted, along with the Sum Insured as specified in thisBenefit.

All claims under this Benefit can be made as per the process defined under Section G.I. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.34 Worldwide Emergency Cover

We will pay the Medical Expenses incurred during the Policy Year, for Emergency Treatments of the Insured Person for an Illness or Injury sustained or contracted outside of India which cannot be postponed until the Insured Person has returned to India up to the Sub Limit specified in the Policy Schedule/ Certificate of Insurance and admissible under In-patient Hospitalization Expenses Cover as per the Base Cover, provided that:

i. Such Treatment received outside India is a Medically Necessary Treatment and has been certified as an Emergency by a Medical Practitioner and the intimation of such Hospitalization has been made to Us within 48 hours of such admission.

ii. The Medical Expenses will be paid in India and in Indian Rupees on reimbursement basis. In case where Cumulative Bonus accumulated is used for payment of claim under this Benefit, the maximum liability under a single Policy Year shall not exceed the opted Sum Insured including Cumulative Bonus (if opted and accrued).

If this Option is in force in respect of the Insured Person, then Exclusion E.II.7 will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person.

All claims under this Benefit can be made as per the process defined under Section G.I.5. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.35 Restoration of Sum Insured

We will provide for a 100% restoration of the Base Sum Insured once or as per the number of times in a Policy Year as specified in the Policy Schedule/ Certificate of Insurance, provided that:

i. The Sum Insured inclusive of earned Cumulative Bonus (if any) is insufficient as a result of previous claims in that Policy Year.

ii. If when restoration for unrelated illness is applicable, the Restored Sum Insured shall not be available for claims towards an Illness / Injury (including its complications) for which a claim has been paid in the current Policy Year for the same Insured Person under the Base Cover.

iii. The Restored Sum Insured will not be considered while calculating the Cumulative Bonus (if opted).

iv. If the Policy is issued on an Individual basis, the Restored Sum Insured will be available to each Insured Person.

v. If the Policy is issued on a Family Floater basis, the Restored Sum Insured will be available on a Family Floater basis and can be utilised by the Insured Persons who are covered under the Policy before the Sum Insured was exhausted.

All claims under this Benefit can be made as per the process defined under Section G.I. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable..

D.II.36 Cumulative Bonus

We will add a Cumulative Bonus as a percentage (specified in the Policy Schedule/ Certificate of Insurance) of the Base Sum Insured at the end of the Policy Year if the Policy is Renewed with Us, provided that:

a. No Cumulative Bonus will be added if the Policy is not renewed with Us by the end of the Grace Period.

b. The Cumulative Bonus will not be accumulated in excess of 100% of the Base Sum Insured under the current Policy with Us under any circumstances.

c. Any Cumulative Bonus that has accrued for a Policy Year will be credited at the end of that Policy Year if the policy is renewed with us within grace period and will be available for any claims made in the subsequent Policy Year.

d. Merging of policies: If the Insured Persons in the expiring Policy are covered under multiple policies and such expiring Policy has been Renewed with Us on a Family Floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest percentage of Cumulative Bonus applicable on the lowest Sum Insured of the last policy year amongst all the expiring polices being merged.

e. Splitting of policies: If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater/ Individual policies then the Cumulative Bonus shall be continued with the base Policy and no Cumulative Bonus will be carried forward to the split policies.

f. Reduction in Sum Insured: If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be calculated on the revised Sum Insured on pro-rata basis.

g. Increase in Sum Insured: If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

All claims under this Benefit can be made as per the process defined under Section G.I under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.37 Corporate Buffer

We will provide a Corporate Buffer of the amount or percentage of the Base Sum Insured as specified in the Policy Schedule during the Policy Year, provided that:

i. All other terms, exclusions and conditions contained in the Policy or endorsed thereon remain unchanged.

ii. This Benefit will be available for those Insured Persons who have already exhausted their Sum Insured limit subject to per Insured Person/ family limit as mentioned in the Policy Schedule.

iii. This Benefit will be restricted to Individual/ family/ Illness/ amount specified in the Policy Schedule in respect of each and every Insured Person/ family, as opted.

iv. If the Policy is issued on a Family Floater basis, the enhanced Sum Insured on account of the Corporate Buffer applicable will also be available on a Family Floater basis.

v. Any Benefit accrued under this cover cannot be carried forward to the subsequent Policy Year.

vi. The Benefit payable will be over and above the Base Sum Insured.

All claims under this Benefit can be made as per the process defined under Sections G.I. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable..

D.II.38 Corporate Buffer for Critical Illness only

We will provide a Corporate Buffer of the amount or percentage of the Base Sum Insured as specified in the Policy Schedule during the Policy Year for Critical Illnesses listed under the Section on ”Critical Illness”, provided that:

i. All other terms, exclusions and conditions contained in the Policy or endorsed thereon remain unchanged.

ii. This Benefit will be available for those Insured Persons who have already exhausted their Sum Insured limit subject to per Insured Person/ family limit as mentioned in the Policy Schedule.

iii. This Benefit will be restricted to Individual/ family/ Illness/ amount specified in the Policy Schedule in respect of each and every Insured Person/ family, as opted.

iv. If the Policy is issued on a Family Floater basis, the enhanced Sum Insured on account of the Corporate Buffer applicable will also be available

on a Family Floater basis.

v. Any Benefit accrued under this cover cannot be carried forward to the subsequent Policy Year.

vi. The Benefit payable will be over and above the Base Sum Insured.

All claims under this Benefit can be made as per the process defined under Sections G.I. under the Base Cover Terms and Conditions and Section G.I under the Optional Cover Terms and Conditions, as applicable.

D.II.39 Healthy Living Reward Program

Our Healthy Living Reward Program encourages the Insured Persons to regularly assess their health status and engage in activities which aid in improving their overall well-being. Any one or a combination of the following activities specified in the Policy Schedule/ Certificate of Insurance will be offered under this program:

- Enrollment into a Wellness Program
- Health Risk Assessment (HRA)
- Targeted Risk Assessment (TRA)
- Online Lifestyle Management Program (LMP)
- Chronic Condition Management Programs
- Participating in Programs sponsored by Us and worksite or online/offline health initiatives
- Health Check Up

We will inform You/Insured Person regarding the programs proposed to be provided as specified in the Policy Schedule/ Certificate of Insurance at the time of Policy issuance or any other notification/ communication required to be sent hereunder on Your/Insured Person's registered email ID or address specified in the Policy Schedule/ Certificate of Insurance.

<u>Earning of Healthy Rewards Points under this Benefit</u>

Healthy Living Reward Points may be awarded on enrollment in the Policy or upon completing various activities listed in the Policy Schedule/ Certificate of Insurance. Healthy Reward points will be rewarded as specified in the Policy Schedule and shall not be linked to any dynamic factor

<u>Utilisation of Healthy Reward Points</u>

Each earned reward point will be valued at 1 Rupee. Accumulated reward points can be redeemed in the following ways –

- A discount in premium from 1st Renewal of the Policy.
- Equivalent value of OPD, if opted for, anytime during the policy.
- Equivalent value of Accumulate Limit, if opted for, anytime during the policy.

The Insured Person can approach Us for redemption of earned Healthy Reward Points as per modes defined in the Policy Schedule/ Certificate of Insurance. Any unutilized Healthy Reward Points at the end of a Policy Year will be carried forward to the next Policy Year at renewal and will lapse at the end of the Grace Period if the coverage is not Renewed with Us.

If the Insured Person wishes to know the present amount of the Healthy Reward Points earned hereunder, then he/she may contact Us at Our toll free number. In any event, We will send the Insured Person an updated statement of the Healthy Reward Points as a part of the Policy Schedule/ Certificate of Insurance at the time of Renewal on his/her registered email ID or residential address.

Details of the Program will be updated on Our Website

D.II.40 Condition Management Reward Program

We will offer Reward Points under this Benefit based on certain health parameters or activities related to an Illness. The Reward Points may be awarded on adherence to health check up schedule , maintenance of health i.e. if test results are within the limits specified by Us, and upon competition of health activities defined under the program, provided that:

i. The Insured Person can redeem the Reward Points as per the modes defined in the Policy Schedule/ Certificate of Insurance.

ii. For the list of tests, Reward Points against the values for tests conducted, and conversion to discount in premium, please refer Annexure to the Policy Schedule/ Certificate of Insurance.

iii. We will inform You/Insured Person regarding the programs/services proposed to be provided as specified in the Policy Schedule/ Certificate of Insurance at the time of Policy issuance or any other notification/communication required to be sent hereunder on Your/Insured Person's registered email ID or address specified in the Policy Schedule/ Certificate of Insurance.

iv. If the Insured Person wishes to know the present amount of the Reward Points earned hereunder, then he/she may contact Us at Our toll free number or through Our website. In any event, We will send the Insured Person an updated statement of the Reward Points as a part of the Policy Schedule/ Certificate of Insurance at the time of Renewal on his/her registered email ID or residential address.

v. Reward Points earned in a Policy Year will not be carried forward to the next Policy Year and will lapse if not utilized at renewal.

vi. This Optional cover will be offered for policy coverage on Individual basis only.

vii. Reward points will be rewarded as specified in the Policy Schedule and shall not be linked to any dynamic facto Details of the Program will be updated on Our Website

D.II.41 Wellness Services Program

We will provide the various wellness benefits/ services under this Benefit. Any one or a combination of the following programs specified in the Policy Schedule/ Certificate of Insurance can be offered under this program:

Wellness Management Services:

1) Track your Health
2) Medical Concierge services
3) Health check up
4) Medical Practitioner's consultations
5) Health tips or newsletters
6) Well-Baby Care
7 Well-Mother Care

We will inform you/Insured Person regarding the wellness services proposed to be provided as specified in the Policy Schedule/ Certificate of Insurance at the time of Policy issuance or any other notification/communication required to be sent hereunder on Your/Insured Person's registered email ID or address specified in the Policy Schedule/ Certificate of Insurance.

D.II.42 Sub-Limits Cover

If the Benefit is in force, Our liability under the Base and/ or Optional Covers/ Benefits for the Insured Person, as opted, shall be sub-limited basis one or more combination of the following parameter/s as specified under the Policy Schedule/ Certificate of Insurance:

1. Sum Insured
2. Age of the Insured Member
3. Illness/ Injury or both
4. With/ Without medical reports
5. Disease Category like Viral infection, vector-borne etc, Specific Diseases like Dengue, Malaria, Covid-19 etc
6. Per Claim/ Per Insured/ Per Policy/ Selective Hospital
7. Pre-existing/ Chronic/ Congenital/Specific Disease/Side effect of medicine.
8. Frequency of availability of cover (in Policy Year/ specified months duration between Claims).
9. Irrespective of claim/In case of no claim/ in case of claim
10. Limit for specified period from date of pregnancy/ date of delivery/ date of start of first cover/ date of member joining
11. Limit on a part/particular section of scope of cover
12. Limit the scope of cover to a section/ part of the cover.
13. Limit per event/aggregate of a claim/ per claim/ per visit/ per Insured for Lifetime under one or multiple benefits/ covers.
14. Co-payment, Deductible on per event/ per claim/ Aggregate of claim/ per visit/ Member level/ PPN/ Selective Hospitals (Deductible can also be opted in duration from 1 hour to 365 days)
15. Limit on Claim payout basis: Reimbursement, Cashless, Pre-authorised, Network, Non-Network
16. Limit basis date of date of pregnancy/ date of delivery/ date of start of first cover/ date of member joining
17. Limit basis Gazette rate or Government sponsored medicare rate or lower/ higher of both.
18. Limit waiting period/ Sum Insured on the basis of date of joining/ date of travel/ for Specific Disease/ Area of cover/ Network/ Non-Network/ PPN
19. Limit on category of treatment - Preventive, Primary, Emergency, Medically necessary
20. Limit/ relaxation on room category, room rent
21. Limit pre-existing disease Waiting period/ Specified disease/procedure waiting period/ 30-day waiting period/ any group specific waiting period
22. Duration of Hospitalization
23. Convert lumpsum payment into Staggered payout within Regulatory guidelines
24. Limited to post Hospitalization / Linked to Hospitalization / Without Hospitalization
25. Line of treatment - Diagnosis, Consultation, Pharmacy, AYUSH etc.
26. Limit on Normal course of recovery without Hospitalization
27. Per event/claim/policy/person/ Hospitalization limit
28. Limit maximum number of events in a policy year

and apply per event limit for multiple events

29. Limit scope of cover to one or more trigger events
30. Condition for cover eligibility after continuous Hospitalization of 1 hr - 30 days.
31. Limited to Treatment/ Program/ Membership fees
32. Limit on specific treatment/s (eg Robotic Surgery, Stem cell treatment etc.) or diseases
33. Limit on Non - medical/ non-payables, items, aids
34. Maximum limit on out of pocket expenses against Co-pay/ deductible/ limits etc.
35. Limit on claim payout/ total liability, maximum up to outstanding loan amount or Sum Insured, whichever is lower
36. Increasing/Decreasing Sum Insured
37. Limit the cover for Day Care, Domiciliary and Donor Expenses to 0 - 99% of Sum Insured

E EXCLUSIONS AND WAITING PERIODS SPECIFIC TO OPTIONAL COVERS

E.1 Maternity Waiting Period

Any Treatment arising from or traceable to pregnancy, childbirth including caesarean section will not be covered until continuous coverage of the period specified in the Policy Schedule/ Certificate of Insurance has elapsed for the particular Insured Person since the inception of the first Policy or coverage for the Insured Person. However, this exclusion / Waiting Period will not apply to Ectopic pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.

E.2 Critical Illness Waiting Period

We shall not be liable to make any payment in respect of any Critical Illness of the nature specified above whose signs or symptoms first occur within the period specified in the Policy Schedule/ Certificate of Insurance from the Inception Date.

This exclusion does not apply to an Insured Person having a health insurance policy in India at least for a period specified in the Policy Schedule/ Certificate of Insurance under this Section, where such policy is obtained prior to taking this Policy and is accepted by Us under Migration as well as for subsequent Renewals with Us without a break.

Calculation of Days of Waiting Period

Days of Waiting Period are calculated from the date of inception of the policy to the actual final diagnosis which confirms the Critical Illness or date on which the Surgical Procedure is done, whichever is earlier.

In case an Insured Person is diagnosed with a Critical Illness during the Waiting Period, he/she will not get paid if it is a Critical Illness as set out in the Policy as the diagnosis of the Critical Illness is within the opted number of days.

However if a person is diagnosed with heart blockage during the Waiting Period but undergoes Coronary Artery Bypass Graft after the completion of the Waiting Period, the claim for Critical Illness will be paid for Coronary Artery Bypass Graft as the Surgical Procedure was carried out after the completion of the Waiting Period.

E.3 Survival Period For Critical Illness

The Benefit payment shall be subject to survival of the Insured Person for the period specified in the Policy Schedule/ Certificate of Insurance, following the first diagnosis of the Critical Illness or undergoing the Surgical Procedure for the first time, whichever is earlier, unless it has been specially waived on payment of additional premium.

G Other terms and conditions

G.I Claim Process

G.I.1 Claim Intimation

In addition to the claim intimation process set out in the Base Cover, the following conditions apply in relation to the respective Options.

Upon the discovery or occurrence of an Accident/ Critical Illness or any other contingency that may give rise to a claim under this Policy, then as a Condition Precedent to Our liability under the Policy, the Insured Person or the Nominee, as the case may be, must notify Us/ Our TPA either at the call centre or in writing and shall undertake the following:

- In the case of Accidental Death Benefit/ PTD/ PPD/ Critical Illness (if applicable) -The Insured Person or the Nominee, as the case may be, shall notify Us either at the call centre or in writing, within 10 days from the date of occurrence of such Accident/diagnosis of a Critical Illness.

G.I.2 Reimbursement Process

In addition to the documents mentioned in the Base Cover claim reimbursement process, the following additional documents will be required for reimbursement claim for the respective Options.

Optional Cover	Additional documents required.
Critical Illness - Indemnity Cover	• Medical certificate confirming the diagnosis of Critical Illness • Discharge certificate/ card from the Hospital, if any. • Investigation test reports confirming the diagnosis. • First consultation letter and subsequent prescriptions. • Indoor case papers, if applicable. • Specific documents listed under the respective Critical Illness. • Any other documents as may be required by Us. • In those cases where Critical Illness arises due to an Accident, a copy of the FIR or medico legal certificate will be required, wherever conducted.
Critical Illness - Benefit Cover	The Insured Person may submit the following documents for reimbursement of the claim to Our branch or head office at his/her own expense ninety (90) days from the date of first diagnosis of the Illness/ date of Surgical Procedure or date of occurrence of the medical event, as the case may be • Medical certificate confirming the diagnosis of Critical Illness. • Discharge certificate/ card from the Hospital, if any. • Investigation test reports confirming the diagnosis. • First consultation letter and subsequent prescriptions. • Indoor case papers, if applicable. • Specific documents listed under the respective Critical Illness. • Any other documents as may be required by Us. • In those cases where Critical Illness arises due to an Accident, a copy of the FIR or medico legal certificate will be required, wherever conducted.

Accidental Death Benefit Cover	• Copy of FIR/ Panchnama /police inquest report (if conducted) duly attested by the concerned police station. • Copy of medico legal certificate (if conducted) duly attested by the concerned Hospital. • Original death certificate issued by the office of Registrar of Birth & Deaths. • Copy of post mortem report, if conducted. • Copy of chemical analysis / forensic report, if applicable. • Death summary, if death in Hospital. • Copies of medical records, investigation reports, if admitted to Hospital. • Identity proof of Nominee or original succession certificate/original legal heir certificate or any other proof to Our satisfaction for the purpose of a valid discharge in case nomination is not filed by deceased Insured Person. • Any other document as may be deemed necessary by Us to evaluate the claim.
PTD/PPD Cover	• Copy of FIR/ Panchnama /police inquest report (if conducted) duly attested by the concerned police station. • Copy of medico legal certificate(if conducted) duly attested by the concerned Hospital. • Disability certificate issued by a civil surgeon or the equivalent appointed by the District, State or Government Board (or) certificate from the treating Medical Practitioner certifying the extent of disability. • Original treating Medical Practitioner's certificate describing the disablement. • Original discharge summary from the Hospital. • Photograph of the Insured Person reflecting the disablement;. • Copies of medical records, investigation reports, if admitted to Hospital. • Any other document as may be deemed necessary by Us to evaluate the claim.

Accumulate Cover	(a) Submission of claim The Insured Person can send the • Claim form along with the invoices, • treating Medical Practitioner's prescription, reports, duly signed by the Insured Person to Our branch office or head office at the Insured Person's expense. The benefit under all plans can be claimed only once during the Policy Year up to the extent of limit under this Benefit or a maximum amount specified in the Policy Schedule/ Certificate ofInsurance. In respect of Benefit under the Accumulate Cover which is utilised for payment of opted Deductible or Co-Payment the same can be settled along with the claim under the respective sections wherever applicable. (b) Assessment of claim documents We shall assess the claim documents and assess the admissibility of the claim subject to terms and conditions of the Policy. (c) Settlement & Repudiation of a claim We shall settle claims, including its rejection, within 5 (five) working days of the receipt of the last 'necessary' document but not later than 30 days.
Out- Patient Cover	The Insured Person shall avail these benefits as defined in Policy T&C if opted for. a) Submission of claim Invoices, treating Medical Practitioner's prescription, reports, duly signed by Insured Person as the case may be, to the TPA Head Office b) Assessment of claim documents We shall assess the claim documents and ascertain the admissibility of claim. c) Settlement & Repudiation of a claim We shall settle claims, including its rejection, within 30 days of the receipt of the last 'necessary' document.
Dental Expenses Cover & Vision Expenses Cover	The Insured Person shall avail these Benefits as defined below, if opted for. a) Submission of claim Insured Person can send the claim form provided along with the invoices, treating Medical Practitioner's prescription, reports, duly signed by the Insured Person as the case may be, to Our branch office or head office. b) Assessment of claim documents We shall assess the claim documents and ascertain the admissibility of claim. c) Settlement & Repudiation of a claim We shall settle claims, including its rejection, within 30 days of the receipt of the last 'necessary' document. d) In respect of Orthodontic Treatment claims for Dependent Children below 18 years, pre-authorisation is a must. For claims in respect of Orthodontic Treatment towards Dependent Children below 18 years, the Employee/ Member or Dependant must send the following information prepared by the Dentist who is to carry out the proposed Treatment to Us before Treatment starts, so that We can confirm the Benefit that will be payable: • a full description of the proposed Treatment; • X-rays and study models; • an estimate of the cost of the Treatment. Any Benefit will be payable only if We have authorised the cover before Treatment starts.
Refractive Error Correction Beyond +/- 5 Expenses Cover	Prescription from Specialist Medical Practitioner specifying the refractive error and medical necessity of the Treatment.
OPD Physiotherapy Charges Cover	Bills supported by prescription from registered Medical Practitioner specifying the physiotherapy Treatment taken as an Out-Patient in the Hospital.
Worldwide Emergency Cover	a) In an unlikely event of the Insured Person requiring Emergency medical Treatment outside India, the Insured Person must notify Us either at Our call centre or in writing within 48 hours of such admission. b) The Insured Person shall file a claim for reimbursement in accordance with Section V.5 of the Policy.
Routine Immunisations Cover	Immunisation or vaccination chart, Medical Practitioner's prescription and supporting pharmacy bills.
Home Nursing Charges Cover	Bills from registered nursing service provider.

Health Check Up Benefit	(a) The Insured Person shall seek an appointment by calling Our call centre. (b) We will facilitate the Insured Person's appointment and will guide him/her to the nearest Network Provider for conducting the medical examination. Reports of the medical tests can be collected directly from the centre. A copy of the medical reports will be retained by the medical centre which will be forwarded to Us along with the invoice for reimbursement.
Expert Opinion On Critical Illness Cover	(a) Receive request for Expert Opinion on Critical Illness The Insured Person can submit a request for an expert opinion by calling Our call centre or register his/her request through email. (b) Facilitating the process We will schedule an appointment or facilitate delivery of medical records of the Insured Person to a Medical Practitioner. The expert opinion is available only in the event of the Insured Person being diagnosed with a covered Critical Illness.
Compassionate Cover for family member in case of Emergency or Accident	Certificate of Medical Practitioner recommending personal attendance of an immediate family member. Railway travel ticket/ Air flight boarding pass
Air Ambulance Cover	Air ambulance ticket for registered service provider.
Emergency Evacuation Cover	a) In the event of an Insured Person requiring Emergency evacuation and repatriation, the Insured Person must notify Us immediately either at Our call centre or in writing. b) Emergency medical evacuations shall be pre-authorised by Us. c) Our team of Specialists in association with the Emergency assistance service provider shall determine the medical necessity of such Emergency evacuation or repatriation post which the same will be approved.
Medical Equipment Cover	Prescriptions of treating Specialist for support items and original invoice of actual Medical Expenses incurred.
Bariatric Surgery Cover.	Certificate by qualified medical surgeons indicating the medical necessity of the procedure
Birth Control Procedure Cover	All medical records and treating Medical Practitioner's certificate on the indication.
Infertility Treatment Cover	Certificate from Specialist Medical Practitioner detailing the cause of infertility, Treatment, procedure.
Deductible (Corporate/ Aggregate/ Per Claim)	a) Any claim towards Hospitalization during the Policy Year must be submitted to Us for assessment in accordance with the claim process laid down under Section V. of the Policy towards Cashless facility or reimbursement respectively in order to assess and determine the applicability of the Deductible on such claim. Once the claim has been assessed, if any amount becomes payable after applying the Deductible, We will assess and pay such claim in accordance with Section V6. and 7 of the Policy. b) Wherever such Hospitalization claims as stated under Section V above is being covered under another policy held by the Insured Person, We will assess the claim on available photocopies duly attested by the Insured Person's insurer / TPA as the case may be.

We may call for any additional document information as requiredbased on the circumstances of the claim wherever the claim is under further investigation or available documents do not provide clarity.