Zuno Health Insurance

Policy wording

Zuno Health Insurance

Health product

a. Policy schedule

b. Preamble

This is a contract of insurance between the Company and the Policyholder which is subject to the realization of the full premium in advance and the terms, conditions and exclusions to this Policy. This Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided by Policyholder in respect of the Insured Persons in the Proposal and the Policy Schedule.
Please inform the Company immediately of any change in the address, or any other changes affecting You or any Insured Person.

c. Definitions

For the purpose of interpretation and understanding of this Policy, the Company has defined below some of the important words used in this Policy. Words not defined below are to be construed in the usual English language meaning as contained in Standard English language dictionaries. The words and expressions defined in the Insurance Act 1938, IRDAI Act 1999, regulations notified by the Insurance Regulatory and Development Authority of India ("Authority") and circulars and guidelines issued by the Authority shall carry the meanings described therein.

The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate:

i. Standard definitions

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

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

3. Ayush hospital

An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH medical practitioner(s) comprising of any of the following

a. Central or State Government AYUSH Hospital; or

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

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

i. Having at least 5 in-patient beds;

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

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

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

4. AYUSH day care centre:

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

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

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

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

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

7. Congenital anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
i. Internal congenital anomaly - Congenital anomaly which is not in the visible and accessible parts of the body.
ii. External congenital anomaly - Congenital anomaly which is in the visible and accessible parts of the body.
8. Co-payment means a cost sharing requirement under a health insurance policy that provides that the Policyholder/Insured will bear a specified percentage of the admissible claims amount. A Co-payment does not reduce the Sum Insured.
9. Cumulative bonus (no claim bonus) means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium
10. Day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under –
i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner/s in charge;
iii. has fully equipped operation theatre of its own where surgical procedures are carried out;
iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
11. Day care treatment means medical treatment, and/or surgical procedure which is:
i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
ii. which would have otherwise required hospitalization of more than 24 hours
Treatment normally taken on an out-patient basis is not included in the scope of this definition
12. Domiciliary hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
ii. the patient takes treatment at home on account of non-availability of room in a hospital
13. Emergency care (emergency) means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.
14. Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received
15. Hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:
i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in- patient beds in all other places;
iii. has qualified medical practitioner(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;
16. Hospitalization means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.
17. Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
i. Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
ii. Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
b. it needs ongoing or long-term control or relief of symptoms
c. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
d. it continues indefinitely
e. it recurs or is likely to recur
18. Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner

19. Inpatient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event

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

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

22. Maternity expenses means:

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

ii. Expenses towards lawful medical termination of pregnancy during the policy period.

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

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

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

26. Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

i. is required for the medical management of the illness or injury suffered by the insured;

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

iii. must have been prescribed by a medical practitioner;

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

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

28. Newborn baby means baby born during the Policy Period and is aged up to 90 days.

29. Non- network provider means any hospital, day care centre or other provider that is not part of the network

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

31. OPD treatment means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

32. Pre-existing disease means any condition, ailment or injury or disease

a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement

b) For which medical advice or treatment was recommended by, or received from, a Physician within 48 months Prior to the effective date of the policy issued by the insurer or its reinstatement

33. Pre-hospitalization medical expenses means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:

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

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

34. Post-hospitalization medical expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and

ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

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

36. Reasonable and customary charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

37. Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

38. Room rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses

39. Surgery or surgical procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

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

41. Critical illnesses:

i. Cancer of specified severity:

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

The following are excluded:

a. 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.

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

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

d. All 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

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

f. Chronic lymphocytic leukemia less than RAI stage 3

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

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

i. All tumors in the presence of HIV infection.

ii. Myocardial infarction (first heart attack of specific severity):

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:

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

b. New characteristic electrocardiogram changes

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

The following are excluded:

a. Other acute Coronary Syndromes

b. Any type of angina pectoris

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

iii. Coronary artery bypass graft (open chest CABG):

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

The following are excluded: Angioplasty and/or any other intra-arterial procedures.

iv. Stroke resulting inpermanent symptoms:

a. 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.

b. 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.

v. Permanent paralysis of limbs:

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

ii. Specific definitions

1. Age means age of the Insured person on last birthday as on date of commencement of the Policy.
2. Ambulance means a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
3. Appendix means a document attached and marked as Appendix to this Policy.
4. Associate medical expenses:
Associate medical expenses: means proportionate deductions of the medical expenses when a higher room category is chosen than the category that is eligible as per terms and conditions of the policy. Proportionate deduction are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

Associate Medical expenses applicable to below categories/ Expenses incurred during Hospitalization-
1. Room Rent
2. Nursing charges for Hospitalization as an Inpatient excluding private nursing charges;
3. Medical practitioners' fees,
4. Physiotherapy
5. Operation theatre charges;

This shall not apply to the below categories:
a. Cost of pharmacy and consumables, b. Cost of implants and medical devices, c) Cost of diagnostics, d) ICU Charges

5. AYUSH treatment refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems
6. Break in policy occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.
7. Claim means a demand made in accordance with the terms and conditions of the Policy for payment of the specified Benefits in respect of the Insured Person.
8. Claimant means a person who possesses a relevant and valid Insurance Policy which is issued by the Company and is eligible to file a Claim in the event of a covered loss.
9. Company (also referred as We/Us/EGIC) means Zuno General Insurance Company Limited.
10. Diagnostic tests means investigations, such as X-Ray or blood tests, etc to determine the cause of symptoms and/or medical conditions.
11. Diagnosis means pathological conclusion drawn by a registered medical practitioner, supported by acceptable Clinical, radiological, histological, histopathological and laboratory evidence wherever applicable.
12. Edelweiss group means any company or organization which is directly or indirectly a holding of Edelweiss Group.
13. Family floater policy means a Policy described as such in the Policy Schedule where the family members (two or more) named in the Policy Schedule are insured under this Policy. Only the following family members can be covered under a Family Floater Policy:
i. Insured Person; and/or
ii. Insured Person's legally married spouse (for as long as they continue to be married); and/or
iii. Insured Person's children who are less than 26 years of Age on the commencement of the Policy Period (maximum 3 children can be covered).
14. Hazardous or adventurous sports: adventure sports) consist of activities having a high level of danger. These activities normally consist of speed, height, elevated levels of physical exertion, combined with highly specialized gear or spectacular stunts.
Racing on wheels, horseback, base jumping, biathlon, big game hunting, black water rafting, bmx stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, cave tubing, climbing/ trekking , cycle racing, cyclo cross, drag

racing, endurance testing, hang gliding, harness racing, hell skiing, high diving , hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, luging, manual labour, marathon running, martial arts, micro - lighting, modern pentathlon, motor cycle racing, motor rallying, mountaineering/ rock climbing, parachuting, paragliding/ parapenting, piloting aircraft, polo, powerlifting, power boat racing, quad biking, river boarding, river boardings, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting, wrestling and activities of similar nature, mountaineering, winter sports, Skydiving, Scuba Diving, bungee jumping, skiing, ice hockey, ballooning, hand gliding, diving or under-water activity river rafting, canoeing involving rapid waters, polo, yachting or boating outside coastal waters

15. Indemnity/indemnify means compensating the Policy Holder/Insured Person up to the extent of expenses incurred, on occurrence of an event which results in a financial loss and is covered as the subject matter of the insurance cover.

16. Individual policy means a Policy described as such in the Policy Schedule where the individual named in the Policy Schedule is insured under this Policy.

17. Insured person (also referred as Insured) means person named as insured in the Policy Schedule.

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

19. Material facts for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk

20. Policy means these Policy terms and conditions and Appendices thereto, the Proposal Form, Policy Schedule and Optional Cover (if applicable) which form part of the Policy and shall be read together.

21. Policyholder (also referred as You) means the person named in the Policy Schedule as the Policyholder.

22. Policy period means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date as specified in the Policy Schedule.

23. Policy period start date means the date on which the Policy commences, as specified in the Policy Schedule.

24. Policy period end date means the date on which the Policy expires, as specified in the Policy Schedule.

25. Policy schedule means the certificate attached to and forming part of this Policy.

26. Policy year means a period of 12 consecutive months commencing from the Policy Period Start Date or any anniversary thereof.

27. Portability means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

28. Reimbursement means settlement of claims paid directly by the Company directly to the Policyholder/Insured Person

29. Standard single private Room means an air conditioned room in a Hospital where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a Single room in that Hospital.

30. Sum insured means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum , total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

31. Third party administrator or TPA means any person who is licensed under the IRDAI (Third Party Administrators-Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an Insurance Company, for the purposes of providing health services.

32. Total sum insured is the sum total of sum insured and the sum insured accrued under optional cover chosen by the policyholder. It represents the company's maximum, total and cumulative liability for in respect of the insured person for any and all claims incurred during the policy year. If the policy period is more than 12 months, then it is clarified that the sum insured shall be applied separately for each policy year in the policy period.

d. Benefits

General Conditions applicable to all Benefits and Optional Covers:

1. The policy covers reasonable and customary charges incurred towards medical treatment taken by the insured person during the policy period for an illness, injury or conditions described in the sections below, if it is contracted or sustained by an insured person during the policy period.

i. On floater basis, the maximum, total and cumulative liability of the company in respect of all insured person for any and all claims arising/incurred under the policy during the policy year shall not exceed the total sum insured for that policy. However, the benefits under benefit 11, benefit 12 and benefit 13 are over and above the total sum insured.

2. Compulsory co-payment of 20% shall be applicable to each and every claim made, for each insured person aged above 60 years.

3. Option of mid-term inclusion of a person in the policy will be only upon marriage or childbirth (inclusion of child only after completed 90 days); additional differential premium will be calculated on a pro rata basis.

4. Eligible to be covered under the policy, the insured should have completed the age of 90 days for all the plan variants (silver, gold and platinum) and maximum age of entry in the policy will be 65 years for silver and gold variants as on the date of commencement of the policy period as applicable to such insured unless it is renewal of policy, for platinum variant there will be no maximum entry age limit.

d.1 Benefit 1: Hospitalization expenses

1. If an Insured Person is diagnosed with an Illness or suffers an Injury contracted during the Policy Period which requires hospitalization in a hospital in India, on the advice of a medical practitioner then We will pay You, Reasonable and Customary Medical Expenses incurred as below

i. Room rent;
ii. Nursing charges for hospitalization as an inpatient excluding private nursing charges;
iii. Medical practitioners' fees, excluding any charges or fees for standby services;
iv. Physiotherapy, investigation and diagnostics procedures directly related to the current admission;
v. Medicines, drugs as prescribed by the treating Medical Practitioner;
vi. Intravenous fluids, blood transfusion, injection administration charges and /or consumables;
vii. Operation theatre charges;
viii. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
ix. Intensive Care Unit charges.

2. The maximum room rent limits applicable under different variants of this Policy is mentioned as follows:

i. For Silver:-For Sum Insured up to Rs.200000: 1% of the Sum Insured per day;
ICU Charges - 2% of the Sum Insured per day;
ii. For Silver Sum Insured above Rs.200000 and for Gold & Platinum Plan:- Standard Single Private Room. No capping on ICU accommodation.

3. In case of insured person's admission to a room at rates exceeding the per day limits as mentioned above, then all expenses incurred at the Hospital (including applicable surcharges and taxes thereon) with the exception of cost of medicines and consumables, shall be payable in the same proportion of the difference between the admissible rate per day (eligible room rent per day) and the actual rate per day of room rent charges.

4. The nomenclature of Room Rent categories may vary from one hospital to the other. Hence, the final consideration will be as per the definition of the rooms mentioned in the Policy.

d.2 Benefit 2: Pre- hospitalization medical expenses and post-hospitalization medical expenses

Pre-hospitalization medical expenses:- the relevant pre hospitalization medical expenses incurred for a period of 30 days in (silver plan), 60 days (gold plan), 90 days (platinum plan) immediately before insured person was hospitalized, provided that: such medical expenses were incurred for the same illness/injury for which subsequent hospitalization was required, and company have accepted an inpatient hospitalization claim under inpatient hospitalization treatment / domiciliary hospitalization.

Post-hospitalization medical expenses:- the relevant post hospitalization medical expenses incurred for a period of 60 days in (silver), 90 days in (gold), 180 days in (platinum) variant, immediately after insured person were discharged post hospitalization, provided that such costs are incurred in respect of the same illness/injury for which the earlier hospitalization was required, and company have accepted an inpatient hospitalization claim under inpatient hospitalization/ domiciliary hospitalization

d.3 Benefit 3: Day care treatment

The company will indemnify the policy holder/insured person for medical expenses incurred on day care treatment which involve a surgical procedure, through cashless or reimbursement facility, maximum up to the sum insured, provided that the period of treatment of the insured person in the hospital/day care centre does not exceed 24 hours, which would otherwise require an in-patient admission but not in the outpatient department and such day care treatment was prescribed in written, by a medical practitioner, and the medical expenses incurred are reasonable and customary charges that were medically necessary. Please refer to appendix ii for an indicative list of day care treatments.

d.4 Benefit 4: Ambulance cover

The company will indemnify the policy holder/insured person, through cashless or reimbursement facility, up to the amount specified against this benefit, for the reasonable and customary charges necessarily incurred on availing ambulance services offered by a hospital or by an ambulance service provider for the insured person's necessary transportation, provided that the necessity of such ambulance transportation is certified by the treating medical practitioner, subject to the conditions specified below:

1. Such transportation is from the place of occurrence of medical emergency of the insured person, to the nearest hospital; and/or
2. Such transportation is from one hospital to another hospital for the purpose of providing better medical aid to the Insured Person,

following an Emergency.
3. The company will not make a payment under this benefit if the insured person is transferred to a hospital or diagnostic centre for evaluation purposes only and not for treatment purpose.
4. The company has accepted the recipient insured person's claim under benefit d.1 (hospitalization expenses).
The maximum limits applicable per policy year, under different variants of this policy is mentioned as follows:
Silver – Rs.1500/-, Gold—Rs.3000/-, Platinum –Rs.10000/-

d. 5 Benefit 5: Organ donor cover

The company will indemnify the policy holder/insured person, through cashless or reimbursement facility, up to the amount specified against this benefit, for the medical expenses incurred for an organ donor's in-patient treatment for the harvesting of the organ donated, subject to the conditions specified below:
1. The donation conforms to the transplantation of human organs act 1994 and amendments thereafter and the organ is for the use of the insured person.
2. The recipient insured person has been medically advised to undergo an organ transplant.
3. The company has accepted the recipient insured person's claim under benefit d.1 (hospitalization expenses).
The maximum limits applicable under different variants of this policy is mentioned as follows: not applicable in silver variant, for gold rs.1,00,000, for platinum rs. 2,00,000.
The company shall not be liable to make any payment in respect of below:
1. Pre-hospitalization medical expenses or post-hospitalization medical expenses of the organ donor.
2. Screening or any other medical expenses of the organ donor.
3. Costs directly or indirectly associated with the acquisition of the donor's organ.
4. Transplant of any organ/tissue where the transplant is experimental or investigational.
5. Expenses related to organ transportation or preservation.
6. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

d. 6 Benefit 6: domiciliary hospitalization

The company will indemnify the policy holder/insured person, only through reimbursement facility, up to the sum insured, for the medical expenses incurred towards domiciliary hospitalization, i.E. Coverage extended when medically necessary treatment is taken at home, subject to the conditions specified below:
1. The medical expenses are incurred during the policy year.
2. The medical expenses are reasonable and customary charges which are necessarily incurred.
3. This benefit covers pre and post domiciliary hospitalization medical expenses as specified in clause d.2 benefit 2: pre- hospitalization medical expenses and post-hospitalization medical expenses.
4. The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or the patient takes treatment at home on account of non-availability of room in a hospital.

d. 7 Benefit 7: AYUSH

The Company will Indemnify the Policy Holder/Insured Person, the Reasonable and Customary Charges, up to the amount specified against this Benefit, for Medical Expenses incurred on the Insured Person's Medically Necessary and Medically Advised Inpatient Hospitalization during the Policy Period, on treatment taken under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems in AYUSH Hospitals or AYUSH Day Care Centre

d. 8 Benefit 8: No claims bonus

At the end of each policy year, the company will enhance the sum insured, on a cumulative basis, as a no claims bonus for each completed and continuous policy year, provided that no claim has been lodged or paid by the company in the expiring policy year, subject to the conditions specified below:
1. If you renew your policy with us without any break in the policy period and there has been no claim in the preceding year, then we will increase the limit of indemnity by 10% of sum insured per annum in silver, 50 % in gold and platinum variant, as cumulative bonus. The maximum cumulative increase in the limit of indemnity will be limited to following percentage, in silver 50%, gold 100 % and platinum 100% of sum insured as cumulative bonus.
2. In case no claim is made in a particular policy year, no claims bonus would be credited automatically to the subsequent policy year, even in case of multi-year policies (with policy term of 2 years and 3 years).
3. In case a claim is made during the policy year, the no claims bonus will reduce at the same rate at which it is allotted for every claim-free year, but in no case shall the total sum insured be less than the sum insured.

4. This clause does not alter the Company's right to decline renewal or cancellation of the Policy for reasons as specified in Clause f.5 (Disclosure to Information Norm).

d. 9 Benefit 9: health check-up

The company will cover health check-up expenses, through cashless facility, as specified against this benefit in the benefit schedule, for health check-up of the insured person after every claim-free year for insured persons aged above 18 years of age, subject to the conditions specified below:-

1. The insured person may avail a health check-up under this benefit from hospitals and network providers empanelled by the company or through our empanelled tpa.
2. Any unutilized amount cannot be carried forward to the next policy year.
3. Below tests are applicable for different variants under this policy per year.(for floater policies below package will be allowed to any one insured in the policy.)
4. Below is the indicative list of free health check-up tests, this is subject to change by the company.

Silver	Gold	Platinum
MER, ECG, CBC/ESR, Lipid Profile, HBA1C, Sr. Creatinine, Urine Analysis.	MER, ECG, CBC/ESR, Lipid Profile, HBA1C, Sr. Creatinine, Urine Analysis, Chest X Ray, SGOT, SGPT and GGT.	MER, ECG, CBC/ESR, Lipid profile, HBA1C, Sr. Creatinine, Urine Analysis, Chest X ray, SGPT, USG-Abdomen-Pelvis and TMT.

d. 10 Benefit 10: maternity benefit

The company will cover maternity expenses, through cashless or reimbursement facility, up to the amount specified against this benefit, for the delivery of a child limited to maximum 2 deliveries and / or medically necessary and lawful termination of pregnancy of an insured person during the lifetime of an insured / insured person above 18 years, subject to the conditions specified below:

1. The female insured person in respect of whom a claim for maternity benefit is made must have been covered as an insured person for a period of 48 months of continuous coverage with maternity as a benefit, with the company.
2. On renewal, if an enhanced sum insured is applied, 48 months of continuous coverage would apply afresh to the extent of the increased benefit amount.
3. Maternity expenses incurred in connection with the voluntary medical termination of pregnancy during the first 12 weeks from the date of conception shall not be admissible under this benefit.

For this purpose 'week' shall constitute any consecutive 7 days.

4. Medical expenses for ectopic pregnancy are not covered under this benefit. However, these expenses are covered under benefit d.1 (hospitalization expenses).
5. The company shall be liable to make payment in respect of any hospitalization arising due to involuntary medical termination of pregnancy, as per mtp act, 1971 (amended) and other applicable laws and rules.
6. Medical expenses for new born baby are not covered.
7. The maximum limits applicable for different variants under this policy are as follows:
8. Silver -not applicable, gold rs.50,000/- and platinum rs.2,00,000/-

d. 11 Benefit 11: Hospital cash

The company will pay a fixed amount, as specified against this benefit , up to a maximum 7 days of hospitalization during the policy year for each continuous and completed period of 24 hours of hospitalization of the insured person, subject to the conditions specified below:

1. The hospitalization period exceeds 3 continuous days.
2. The company will be liable to pay from the 4th day till the 10th day for a block of continuous hospitalization arising from any one illness or accident.
3. The company has accepted the insured person's claim under benefit d.1 (hospitalization expenses).
4. The fixed amount limit per day applicable for different variants under this policy are as follows: silver rs.500/-, gold rs.1000/- and platinum rs.1500/-

d. 12 Benefit 12: Recovery benefit

The company will pay a fixed amount, as specified against this benefit, up to a maximum 10 days of hospitalization during the policy year for each continuous and completed period of 24 hours of hospitalization for recovery of the insured person, subject to the conditions specified below:

1. The hospitalization period exceeds 10 continuous days.

2. The company will be liable to pay from the 11th day till the 20th day for a block of continuous hospitalization arising from any one illness or accident.
3. The company has accepted the recipient insured person's claim under benefit d.1 (hospitalization expenses).
4. The fixed amount limit per day applicable for different variants under this policy are as follows: silver - not applicable, gold rs.1000/- and platinum rs.1500/-

D. 13. Benefit 13: shared accommodation benefit

1. The insured person will be eligible to receive a reimbursement on occupying a shared accommodation for each continuous and completed period of 24 hours of stay in such accommodation.
2. Provided the company has accepted the recipient insured person's claim under benefit d.1 (hospitalization expenses).
3. The benefit will not be applicable where the sanction is on package rates.
4. Accommodation for intensive care unit or high dependency units/wards will not be counted for this purpose.
5. The benefit will not be applicable for silver variant with sum insured up to 2 lacs.

The fixed amount applicable for different variants under this policy are as follows:

Variant	Limit per day
Silver	Rs. 800 per day up to a maximum of Rs. 4,000
Gold	Rs. 1,000 per day up to a maximum of Rs. 5,000
Platinum	Rs. 1,200 per day up to a maximum of Rs. 6,000

d.14 Benefit 14: Critical illness coverage

The company will indemnify the policy holder/insured person, through cashless/reimbursement facility, up to the amount specified in this benefit, in addition to the payment under benefit d.1 (hospitalization expenses), subject to the conditions specified below:
1. The insured person is first diagnosed as suffering from a critical illness during the policy period, and
2. For the purpose of this benefit, "critical illness" includes coronary artery bypass graft (open chest cabg), myocardial infarction (first heart attack of specific severity), cancer of specified severity, stroke resulting in permanent symptoms, permanent paralysis of limbs.
3. In case the additional critical illness sum insured is not utilized in a policy year, it shall not be carried forward to subsequent policy year.
4. The policy shall not cover the expenses if:
i. The insured person is first diagnosed as suffering from a critical illness within 90 days of the commencement of the policy period and the insured person has not previously been insured continuously and without interruption under a policy.
Ii. The insured person has already made a claim for the same critical illness.
The maximum limits applicable for different variants under this policy are as follows:
silver -not applicable, gold 50% of sum insured and platinum 100% of the sum insured.

d.15. Benefit 15: Restoration

The company will restore 100% of the sum insured once in a policy year on indemnity basis (in built cover in gold and platinum variant) in case the total sum insured inclusive of earned no claim bonus (if any) is insufficient due to claims paid or accepted as payable during the policy year, subject to the conditions specified below:
1. This restored sum insured can be utilized only for illness / disease unrelated to the illness / diseases for which claim/s was / were made in the particular policy year.
2. The restoration benefit will be triggered by benefit d.1 (hospitalization expenses), benefit d.2 (pre hospitalization medical expenses and post hospitalization medical expenses), benefit d.3 (day care treatment), benefit d.4 (ambulance cover), benefit d.5 (organ donor cover), benefit d.6 (domiciliary hospitalization), benefit d.7 (ayush), benefit 3.10 (maternity benefit)
3. Restoration will not trigger on the first claim.
4. In case the restored sum insured is not utilized in a policy year, it shall not be carried forward to subsequent policy year.
5. Any restored sum insured will not be used to calculate the no claim bonus.
6. No claim bonus shall not be considered while calculating restored sum insured.
7. For individual policies, restored sum insured will be available on individual basis whereas in case of a family floater policy it will be available on floater basis.
8. For any single claim during a policy year, the maximum claim amount payable shall be sum of:

i. The sum insured
Ii. No claim bonus (if earned).
9. During a policy year, the aggregate claim amount payable, subject to admissibility of the claim, shall not exceed the sum of:
i. The sum insured
Ii. No claim bonus (if earned)
iii. Restored sum insured.
10. In case of portability, the credit for continuity in Sum Insured would be available only to the extent of Sum Insured of the expiring policy, including Restoration.

d. 16. Benefit 16: In-built assistance services

The below services will be available when the insured/insured member/s is/are more than 150 kilometres away, within indian territory, from their residential address as his/her last known address to us (as recorded in the policy document) and has not been away from such residence in india for more than 90 days. The services would be provided by us /through our appointed service provider, with prior intimation and acceptance by the company, no claims for reimbursement are accepted:-

d. 16.1 Medical referral

Insured person will have telephone access to operations center staffed twenty-four hours a day, every day of the year, with multilingual personnel for medical referral.

d. 16.2 Emergency medical evacuation

When an adequate medical facility is not available proximate to the insured person, as determined by the we/our service provider's consulting physician and the insured person's attending physician, we/our service provider will arrange transportation under appropriate medical supervision, by an appropriate mode of transport to the nearest medical facility capable of providing the required care within india.

d. 16.3 Medical repatriation

We/our service provider will arrange for transportation under medical supervision to the insured person's residence in india or to a medical or rehabilitation facility near the insured person's residence when we/our service provider's consulting physician and the insured person's attending physician determines that transportation is medically necessary, at such time as the insured person is medically cleared for travel by we/our service provider's consulting physician and the attending physician.

d. 16.4 Medical monitoring

Medical personnel will monitor Insured person's condition and will (i) stay in regular communication with the attending physician and/or hospital and (ii) relay necessary and legally permissible information to family members.

d. 16.5 Compassionate visit

When an insured person will be hospitalized for more than seven (7) consecutive days and is traveling in india without a companion, we/our service provider will arrange for a family member or personal friend to travel to visit the insured person in india by providing an appropriate means of transportation via economy carrier transportation as determined by us/our service provider. The family member or personal friend is responsible to meet all visa and travel document requirements, if applicable.

d. 16.6. Return of mortal remains

In the case of an insured person's death in india, we/our service provider will arrange and pay for the return of mortal remains to an authorized funeral home proximate to the insured person's legal residence in india.

d. 16.7. Second medical opinion

We/our Service provider will arrange for second medical opinions for eligible insured person for such services upon request in the following instances: (i) when a eligible insured person's medical condition is undiagnosed by a treating physician; (ii) when a eligible insured person seeks an additional medical opinion following an original diagnosis; and (iii) when the determination of the most appropriate course of medical treatment is required based on a current diagnosis. The service relates solely to the provision of a medical opinion and does not include personal visits or follow up discussions for the implementation of course of treatment

d.16.8. Exclusions applicable to assistance services:-

We/ service provider will not provide services in the following instances:

· travel undertaken specifically for securing medical treatment

· injuries resulting from participation in acts of war or insurrection commission of an unlawful act(s)

· injuries incurred while participating in criminal activity or as result of the unlawful consumption of drugs.

· attempt at suicide.

· incidents involving the use of drugs unless prescribed by a physician.

· eligible insured person is transferred, or is to be transferred, from one medical facility to another of similar capabilities which provides a similar level of care.

· we/ service provider will not evacuate or repatriate an eligible insured person, if the eligible insured person has:-

(I) no medical authorization; (ii) mild lesions, simple injuries such as sprains, simple fractures, or mild sicknesses which can be treated by local doctors and do not prevent the eligible insured person from continuing the trip and returning home; (iii) if the eligible insured person is pregnant and beyond the end of the 28th week and with respect to the child born from the pregnancy, we/ service provider will not evacuate or repatriate a child born while the eligible insured person was traveling beyond the 28th week; or (iv) a mental or nervous disorder, unless hospitalized.

· we/ service provider will not provide services for trips exceeding 90 days from legal residence.

d.I. Optional benefits

Optional cover 1: critical illness coverage –

Option available only in silver variant, limit is 50% of the sum insured.

For definition and conditions, please refer clause, benefit d.14: critical illness coverage

Optional Cover 2: Restoration

Option available only in silver variant, limit is 100% of the sum insured

For definition and conditions, please refer clause, benefit d.15: restoration.

Optional cover 3: Recharge (option available in gold and platinum variant only)

the company will replenish 100% of the sum insured on indemnity basis once in a policy year in case the total sum insured inclusive of earned no claim bonus (if any) is insufficient due to claims paid or accepted as payable during the policy year, subject to the conditions specified below:

1. The recharge benefit will be triggered by benefit d.1 (hospitalization expenses), benefit d.2 (pre hospitalization medical expenses and post hospitalization medical expenses), benefit d.3 (day care treatment), benefit d.4 (ambulance cover), benefit d.5 (organ donor cover), benefit d.6 (domiciliary hospitalization), benefit d.7 (ayush), benefit d.10 (maternity benefit)
2. Recharge benefit can be utilized even for the same hospitalization or for the treatment of diseases / illness / injury / for which claim was paid / payable under the policy.
3. In case the recharge sum insured is not utilized in a policy year, it shall not be carried forward to subsequent policy year.
4. Any recharge sum insured will not be used to calculate the no claim bonus.
5. No claim bonus shall not be considered while calculating the recharge sum insured.
6. For individual policies, sum insured will be available on individual basis whereas in case of a family floater policy it will be available on floater basis.
7. In case of portability, the credit for continuity in sum insured would be available only to the extent of sum insured of the expiring policy.

Optional cover 4: Voluntary co-payment

1. In lieu of insured person opting a voluntary co-pay cover, the company shall only pay 90% for 10% co-pay option or 80% for 20% co-pay option of the claim amount that is assessed for the payment or reimbursement under the policy balance of 10% or 20% as the case may be will be borne by the insured person.
2. Insured person with age 60 years or less is eligible for this option.
3. This co-pay is applicable for each and every claim made by the insured person except fixed benefit covers and health check-ups.
4. Eligible insured person will get discount on premium on opting this optional cover.

E. Exclusions

I. Standard exclusions

1. Waiting periods

1.1 30-day waiting period -code-excl 03

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

B) this exclusion shall not, however, apply if the insured person has continuous coverage for more than twelve months.

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

1.2. Specified disease/ procedure waiting period- code-excl-02

A) expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of twenty four months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident

B) in case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

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

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

E) if the insured person is continuously covered without any break as defined under the applicable norms on portability stipulated by irdai, then waiting period for the same would be reduced to the extent of prior coverage.

F) list of specific diseases/procedures

I. Any treatment related to arthritis (if non-infective), osteoarthritis and osteoporosis, gout, rheumatism, spinal disorders(unless caused by accident), joint replacement surgery (unless caused by accident), arthroscopic knee surgeries/acl reconstruction/meniscal and ligament repair

Ii. Surgical treatments for benign ear, nose and throat (ent) disorders and surgeries (including but not limited to adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty), nasal septum deviation, sinusitis and related disorders

Iii. Benign prostatic hypertrophy

Iv. Cataract

V. Dilatation and curettage

Vi. Fissure / fistula in anus, hemorrhoids / piles, pilonidal sinus, gastric and duodenal ulcers

Vii. Surgery of genito-urinary system unless necessitated by malignancy

Viii. All types of hernia & hydrocele

Ix. Hysterectomy, unless necessitated by malignancy

X. Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant

Xi. Kidney stone / ureteric stone / lithotripsy / gall bladder stone

Xii. Myomectomy for fibroids

Xiii. Varicose veins and varicose ulcers

Xiv. If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing then exclusion 3 mentioned below will be applicable.

1.2-a. 90 days waiting period

I. Diabetes & related complications include: diabetic retinopathy, diabetic nephropathy, diabetic foot / wound, diabetic angiopathy, diabetic neuropathy, hyper /hypoglycaemic shocks.

Ii. Hypertension & related complications include: coronary artery disease, cerebrovascular accident, hypertensive nephropathy, internal bleed / haemorrhages.

Iii. Cardiac conditions

Iv. If these diseases are pre-existing and disclosed at the time of underwriting, then exclusion e.I.1 mentioned below will be applicable.

The following list of permanent exclusions is applicable to all the benefits and optional covers.

Any claim in respect of any insured person for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the policy terms and conditions.

2. Pre-existing disease code -excl 01
A) expenses related to the treatment of a pre-existing disease (ped) and its direct complications shall be excluded until the expiry of 48 months (silver), 36 months (gold) and 24 months (platinum) of continuous coverage after the date of inception of the first policy with insurer.
B) in case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
C) if the insured person is continuously covered without any break as defined under the portability norms of the extant irdai (health insurance) regulations, then waiting period for the same would be reduced to the extent of prior coverage.
D) coverage under the policy after the expiry of 48 months (silver), 36 months (gold) and 24 months (platinum) months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer.
E) if the sum insured is reduced on any renewal of this policy, the credit for waiting periods as defined above in clauses e.I.1.1.1, e.I.1.1.2 & 1.2-a) and e.I.1.1.3 shall be restricted to the lowest sum insured under the previous policy.
F) the waiting periods as defined in clauses e.I.1.1.1, e.I.1.1.2 & 1.2-a) and e.I.1.1.3 shall be applicable individually for each insured person and claims shall be assessed accordingly.
G) if coverage for benefits or optional covers or members are added afresh at the time of renewal of this policy, the waiting periods as defined above in clauses e.I.1.1.1, e.I.1.1.2 & 1.2-a) and e.I.1.1.3 shall be applicable afresh to the newly added members or benefits or optional covers, from the time of such renewal/ addition.
H) first diagnosis as suffering from a critical illness within 90 days of first commencement of the policy period

3. Sterility and infertility: **code- excl-17**
Expenses related to sterility and infertility. This includes:
(i) any type of contraception, sterilization
(Ii) assisted reproduction services including artificial insemination and advanced reproductive technologies such as ivf, zift, gift, icsi
(Iii) gestational surrogacy
(Iv) reversal of sterilization

4. Investigation & evaluation- **code- excl-04**
A) expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
B) any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

5. Rest cure, rehabilitation and respite care- c**ode- excl05**
A) expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
Ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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

7. Cosmetic or plastic surgery -**code-excl-08**
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an accident, burn(s) or cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending medical practitioner

8. Refractive error: **code- excl-15**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

9. Change of gender treatment **code -excl-07**
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

10. Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **code- excl-14**

11. Unproven treatments: **code- excl-16**
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness

12. Breach of law- **code- excl-l0**
Expenses for treatment directly arising from or consequent upon any insured person committing or attempting to commit a breach of law with criminal intent.

13. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- excl-12**

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

15. Obesity/ weight control: **code- excl06**
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
1) surgery to be conducted is upon the advice of the doctor
2) the surgery/procedure conducted should be supported by clinical protocols
3) the member has to be 18 years of age or older and
4) body mass index (bmi);
A) greater than or equal to 40 or
B) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
i. Obesity-related cardiomyopathy
Ii. Coronary heart disease
Iii. Severe sleep apnea
Iv. Uncontrolled type2 diabetes

16. Excluded providers: **code-excl-11**
Expenses incurred towards treatment in any hospital or by any medical practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

17. Maternity expenses : **code – excl-18**
I. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
Applicable for silver plan.

18. Other permanent exclusions
Irrespective of waiting period or portability, below mentioned disease are permanently excluded under this policy in case where such disease are pre-existing or disclose by the customer in the proposal form at the time of first proposal of this product with us. These pre-existing illnesses will not be covered even if the optional cover pre-existing waiting period waiver/reduction has been opted. We will permanently exclude these conditions with due consent of proposer or persons to be insured.

Sr. no.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, · C15-C26 Malignant neoplasms of digestive organs, · C30-C39 Malignant neoplasms of respiratory and intrathoracic organs· C40-C41 Malignant neoplasms of bone and articular cartilage· C43-C44 Melanoma and other malignant neoplasms of skin · C45-C49 Malignant neoplasms of mesothelial and soft tissue · C50-C50 Malignant neoplasms of breast · C51-C58 Malignant neoplasms of female genital organs · C60-C63 Malignant neoplasms of male genital organs · C64-C68 Malignant neoplasms of urinary tract · C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system · C73-C75 Malignant neoplasms of thyroid and other endocrine glands · C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites · C7A-C7A Malignant neuroendocrine tumours · C7B-C7B Secondary neuroendocrine tumours · C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue· D00-D09 In situ neoplasms · D10-D36 Benign neoplasms, except benign neuroendocrine tumours · D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes · D3A-D3A Benign neuroendocrine tumours · D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy
4	Heart ailment congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25) Ischemic heart diseases, I50 Heart failure, I42 Cardiomyopathy; I05-I09 - Chronic rheumatic heart diseases. · Q20 Congenital malformations of cardiac chambers and connections · Q21 Congenital malformations of cardiac septa · Q22 Congenital malformations of pulmonary and tricuspid valves · Q23 Congenital malformations of aortic and mitral valves · Q24 Other congenital malformations of heart · Q25 Congenital malformations of great arteries · Q26 Congenital malformations of great veins · Q27 Other congenital malformations of peripheral vascular system· Q28 Other congenital malformations of circulatory system · I00-I02 Acute rheumatic fever · I05-I09 · Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): · disease (I05.9) · failure (I05.8) · stenosis (I05.0). When of unspecified cause but with mention of: · diseases of aortic valve (I08.0), · mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency · Mitral (valve): incompetence / regurgitation - · NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease. I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
5	Cerebrovascular disease (stroke)	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 -
6	Inflammatory bowel diseases	Other Crohn's disease; K50.9 - Crohn'sdisease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.

7	Chronic liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classifiedelsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta-(super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's disease, Parkinson's disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	Loss of hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
14.	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
15.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

Ii. Specific exclusions

1. Any item specified in list i (items for which coverage is not available in the policy)
2. Any condition directly caused by or associated with any sexually transmitted disease, including genital warts, syphilis, gonorrhoea, genital herpes, chlamydia, pubic lice and trichomoniasis, human t-cell lymphotropic virus type iii (htlv–iii or iitlb-iii) or lymphadenopathy associated virus (lav) or the mutants derivative or variations deficiency syndrome or any syndrome or condition of a similar kind.
3. Any medical expenses incurred on new-born /children below age of 91 days will not be covered under the policy.
4. Treatment taken from anyone who is not a medical practitioner or from a medical practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.
5. Charges incurred in connection with routine ear examinations, dentures, artificial teeth and all external appliances and / or devices whether for diagnosis or treatment.
6. Any expenses incurred on purchase of external prosthesis, corrective devices, external durable medical equipment, wheelchairs,

walkers, , crutches. Ambulatory devices, and oxygen concentrator for asthmatic condition
7. Any treatment related to acupressure, acupuncture, magnetic therapy.
8. Treatment of any external congenital anomaly, or illness or defects or anomalies or treatment relating to external birth defects.
9. Charges incurred in connection with cost of spectacles and contact lenses, hearing aids, routine eye and ear examinations,
10. Circumcision unless necessary for treatment of an illness or as may be necessitated due to an accident.
11. Vaccination including inoculation and immunizations (except in case of post-bite treatment),.
12. All expenses related to donor treatment including surgery to remove organs from the donor, in case of transplant surgery.
13. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
14. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
i. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.
Ii. 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.
Iii. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.
15. Alopecia wigs and/or toupee and all hair or hair fall treatment and products.
16. Stem cell storage except for allogeneic bone marrow transplantation
17. Taking part or is supposed to participate in a naval, military, air force operation or aviation in a professional or semi-professional nature.
18. Any other exclusion as specified in the policy schedule.

F. General terms and conditions

I. Standard general terms and conditions

1) premium payment in instalments

The policy will be issued for a period of 1 year, 2 year or 3 years. The sum insured and benefit will be applicable on policy year basis.
The insured person can choose to pay premium for this policy on any one of the following basis:
i. Single premium
Ii. Instalment premium
Lf the insured person has opted for payment of premium on an instalment basis i.E. Half yearly, quarterly or monthly, as mentioned in the policy schedule/certificate of insurance, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)
i. Grace period of 15 days would be given to pay the instalment premium due for the policy.
Ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by company.
Iii. The insured person will get the accrued continuity benefit in respect of the "waiting periods", "specific waiting periods" in the event of payment of premium within the stipulated grace period.
Iv. No interest will be charged lf the instalment premium is not paid on due date
V. Ln case of instalment premium due not received within the grace period, the policy will get cancelled.
Vi. Ln the event of a claim, all subsequent premium instalments shall immediately become due and payable.
Vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

2. Claim settlement (provision for penal Interest)

i) the company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
Ii) In the case of delay in the payment of a claim, the company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2 % above the bank rate.
Iii) however, where the circumstances of a claim warrant an investigation in the opinion of the company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
Iv) In case of delay beyond stipulated 45 days, the company shall be liable to pay interest to the policyholder at a rate 2 % above the

bank rate from the date of receipt of last necessary document to the date of payment of claim.
(Explanation: "bank rate" shall mean the rate fixed by the reserve bank of India (rbl) at the beginning of the financial year in which claim has fallen due)

3. Cancellation/termination

i) the policyholder may cancel this policy by giving 15 days' written notice and in such an event, the company shall refund premium for the unexpired policy period as detailed below.

	Refund Percentage		
Cancellation period	**1 Year Policy**	**2 Year Policy**	**3 Year Policy**
Up to 1 month	75%	87.50%	92.00%
Up to 3 months	50%	75.00%	83.00%
Up to 6 months	25%	62.50%	75.00%
Up to 9 months	NIL	50.00%	67.00%
Up to 12 months	NIL	42.00%	55.00%
Up to 15 months	NIL	25.00%	50.00%
Up to 18 months	NIL	12.50%	42.00%
Up to 24 months	NIL	NIL	30.00%
Up to 30 months	NIL	NIL	8.00%
Up to 36 months	NIL	NIL	NIL

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

ii) the company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.
1. In case of demise of the policyholder,
i. Where the policy covers only the policyholder, this policy shall stand null and void from the date and time of demise of the policyholder. The premium would be refunded for the unexpired period of this policy at pro-rata basis.
ii. Where the policy covers other insured persons, this policy shall continue till the end of policy period for the other insured persons. If the other insured persons wish to continue with the same policy, the company will renew the policy subject to the appointment of a policyholder provided that:
a) written notice in this regard is given to the company before the policy period end date; and
b) a person of age 18 years or above, who satisfies the company's criteria applies to become the policyholder.

4. Complete discharge

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

5. Disclosure to information norm

The policy shall be void and all premium paid thereon shall be forfeited to the company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(Explanation: "material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

6. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per irdai guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an indian general/health insurer, the proposed insured person will get the accrued continuity bene-

fits in waiting periods as per irdai guidelines on portability.

For detailed guidelines on portability, kindly refer the link .....
Https://www.Irdai.Gov.In/admincms/cms/frmguidelines_layout.Aspx?Page=pageno3987&flag=1

7. Free look period

The free look period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the free look period, the insured shall be entitled to
ii. A refund of the premium paid less any expenses incurred by the company on medical examination of the insured person and the stamp duty charges or
ii. Where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

8. Nomination

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

9. Multiple policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. Ln all such cases the insurer chosen by the insured person shall be obliged to settle the claim as
Long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

10. Renewal of policy

The policy shall ordinarily be renewable except on grounds of fraud misrepresentation by the insured person.,
i. The company shall endeavor to give notice for renewal. However, the company is not under obligation to give any notice for renewal
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the grace period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v) No loading shall apply on renewals based on individual claims experience

11. Migration:
the insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast30 days before the policy renewal date as per irdai guide lines on migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per irdai guidelines on migration.

For detailed guidelines on migration, kindly refer the link .. . .
Https://www.Irdai.Gov.In/admincms/cms/frmguidelines_layout.Aspx?Page=pageno3987&flag=1

12) fraud
If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
D) any such act or omission as the law specially declares to be fraudulent

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

13) withdrawal of policy
i. In the likelihood of this product being withdrawn in future, the company will intimate the insured person about the same 90 days prior to expiry of the policy.
ii. Insured person will have the option to migrate to similar health insurance product available with the company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. As per irdai guidelines, provided the policy has been maintained without a break.

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

15. Condition precedent to admission of liability
The terms and conditions of the policy must be fulfilled by the insured person for the company to make any payment for claim(s) arising under the policy.

16. Moratorium period
After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of moratorium period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however b be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

17. Grievance mechanism

In case of any grievance the insured person may contact the company through
· website: www.hizuno.Com, link:https://www.hizuno.Com/documents/20143/1081704/service+parameters+and+ grievance+mechanism+15-04-21.Pdf/114fd592-ad87-457a-d8c6-2e6cc6b9fd91?T=1618577820419
· toll free: 1800120216216 / 1800 12000
· e-mail: grievance@hizuno.Com
· courier: 2nd Floor, tower 3, Kohinoor city mall, Kohinoor City, Kirol Road, Kurla (West), Mumbai 400 070:

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

If insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at 1800120216216 and grievance@hizuno.Com.

For updated details of grievance officer, kindly refer the link.....

Https://www.hizuno.Com/documents/20143/1081704/service+parameters+and+grievance+mechanism+15-04-21.Pdf/114fd592-ad87-457a-d8c6-2e6cc6b9fd91?T=1618577820419

If insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of insurance ombudsman of the respective area/region for redressal of grievance as per insurance ombudsman rules 2017.

Grievance may also be lodged at irdai integrated grievance management system - https://igms.irda.gov.in

Ombudsman and addresses

Mentioned below are contact details of Ombudsman:

Office details	Jurisdiction of office union territory, district
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh, Chattisgarh
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar-751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Tamil Nadu PuducherryTown and Karaikal (which are part of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.

JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@ecoi.co.in	Rajasthan
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Ballia, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Mau, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Deoria, Kushinagar, Gorkhpur, Ghazipur, Chandauli, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001 Tel.: 0612-2547068 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Ii. Specific terms and clauses

1. Alterations in the policy

A. This policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the company, which approval shall be evidenced by a written endorsement signed and stamped by the company. However, change or alteration with respect to increase/ decrease of the sum insured shall be permissible only at the time of renewal of the policy. On renewal, the policy could be subject to certain changes in terms and conditions including change in premium rate.

B. Where an individual is added to this policy either by way of endorsement or at the time of renewal, the pre-existing disease clause, exclusions and waiting periods will be applicable considering such policy year as the first year of the policy with us.

2. Electronic transactions

The policyholder and/or insured person agree to adhere to and comply with all such terms and conditions as the company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centres, tele-service operations

(Whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the company, for and in respect of the policy or its terms, or the company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the company's terms and conditions for such facilities, as may be prescribed from time to time.

3. Limitation of liability

Any claim under this policy for which the notification or intimation of claim is received 12 calendar months after the event or occurrence giving rise to the claim shall not be admissible, unless the policyholder proves to the company's satisfaction that the delay in reporting of the claim was for reasons beyond his control.

4. Material change

It is a condition precedent to the company's liability under the policy that the policyholder shall immediately notify the company in writing of any material change in the risk. The company may adjust the scope of cover and / or the premium paid or payable accordingly.

5. Notices

Any notice, direction or instruction given under this policy shall be in writing and delivered by hand, post, or facsimile to:
1. You/the insured person at the address specified in the policy schedule or at the changed address of which the company must receive written notice.
2. Us at the following address: :- Zuno General Insurance Limited, Registered Office: 2nd Floor, Tower 3, Wing B, Kohinoor City Mall, Kohinoor City, Kirol Road, Kurla (West), Mumbai - 400 070,
Toll free no.: 180012000.
3. No insurance agents, brokers or other person/entity is authorized to receive any notice on the company's behalf.
4. In addition, the company may send you/the insured person other information through electronic and telecommunications means with respect to your policy from time to time.
6. No constructive notice
Any knowledge or information of any circumstance or condition in relation to the policyholder or insured person which is in possession of the company other than that information expressly disclosed in the proposal form or otherwise in writing to the company, shall not be held to be binding or prejudicially affect the company.
7. Obligations in case of a minor
If an insured person is less than 18 years of age, the legal guardian (in case of all other adult insured person's demise in a floater basis) shall be completely responsible for ensuring compliance with all the terms and conditions of this policy on behalf of that minor insured person.
8. Observance of terms and conditions
The due observance and fulfilment of the terms and conditions of this policy (including the realization of premium by their respective due dates and compliance with the specified procedure on all claims) in so far as they relate to anything to be done or complied with by the policyholder or any insured person, shall be condition precedent to the company's liability under the policy
9. Overriding effect of policy schedule
In case of any inconsistency in the terms and conditions in this policy vis-a-vis the information contained in the policy schedule, the information contained in the policy schedule shall prevail.
10. Proximate clause
The company covers the policyholder / insured person only to the extent of proximity cause which means active and efficient cause that sets in motion a chain of events which brings about a result, without the intervention of any force started and working actively from a new and independent source.
11. Premium loading
1. Based on the company's discretion, upon the disclosure of the health status of the persons proposed for insurance and declarations made in the proposal, the company may apply a risk loading on the premium payable (excluding statutory levies and taxes) or special conditions on the policy. The maximum risk loading applicable shall not exceed more than 100% of the premium.
2. These loadings will be applied from inception date of the first policy including subsequent renewal(s) with us.
3. The company may apply a specific personal waiting period on a medical condition/ailment depending on the past history or additional waiting periods on pre-existing diseases as part of the special conditions on the policy.
12. Policy disputes
Any and all disputes or differences under or in relation to the validity, construction, interpretation and effect to this policy shall be determined by the indian courts and in accordance with indian law.

13. Grievance mechanism:

in case of any grievance of the complainant sent in a written communication to the company at any of the touch points as mentioned, shall be addressed within 14 days of the receipt of the complaint

· for easy and faster response, please feel free to contact us on
Call us at: 180012000 (toll free) or 02242312000 (call charges applicable)
email us at: support@hizuno.Com

· please feel free to contact our grievance cell on
Call us at: 1800120216216
Email: grievance@hizuno.Com
Contact details for senior citizens:
· contact number: 02242312001
· email id: senior.Citizen@hizuno.Com
Address: zuno general insurance company limited, kohinoor city mall, tower 3, kirol road, kurla west, mumbai 400070

· the grievance redressal officer
Email: grievanceofficer@hizuno.Com
Call us at: 022 4931 4422
Address: zuno general insurance company limited, kohinoor city mall, tower 3, kirol road, kurla west, mumbai 400070

If you are not satisfied with the response or do not receive a response from the company, within 14 days of your complaint, you may approach the grievance cell of the insurance regulatory and development authority of india ('irdai') on the following contact details:

Irdai grievance call centre (igcc) toll free no: 155255
Email id: complaints@irda.Gov.In
Register online at: http://www.Igms.Irda.Gov.In/

Address for communication for complaints by fax/paper:
consumer affairs department
Insurance regulatory and development authority of india
Sy. No. 115/1, financial district, nanakramguda, gachibowli
Hyderabad – 500032

In case you are not satisfied with the response provided by the company or no response is received, you may approach the insurance ombudsman in your region for the resolution post 30 days from the date of registration of the complaint.

Details of the insurance ombudsman offices are available on the link http://www.Policyholder.Gov.In/addresses_of_ombudsmen.Aspx

The complainant may approach the office of the insurance ombudsman established by the central government of india as per rule 13 and rule 14 of the insurance ombudsman rules, 2017 ('ombudsman rules').
The following complaints can be lodged with the insurance ombudsman:
1. Any partial or total repudiation of claims by an insurer;
2. Any dispute in regard to premium paid or payable in terms of the policy;
3. Any dispute on the legal construction of the policies in so far as such disputes relate to claims;
4. Delay in settlement of claims;
5. Non-issue of any insurance document to customers after receipt of premium.

Manner in which complaint is to be made rule 14 of the ombudsman rules:-
1. Any person who has a grievance against the company, may himself or through his legal heirs make a complaint in writing to the ombudsman within whose jurisdiction the branch or office of the company complained against is located.
2. The complaint shall be in writing duly signed by the complainant or through his legal heirs and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against which the complaint is made, the fact giving rise to the complaint.

3. No complaint to the ombudsman shall lie unless:
· the complainant had before making a complaint to the ombudsman, made a written representation to the company/insurer named in the complaint and either insurer had rejected the complaint or the complainant had not received any reply within a period of one month after the insurer concerned received his representation or the complainant is not satisfied with the reply given to him by the insurer;
· the complaint is made not later than one year after the insurer had rejected the representation or sent his final reply on the representation of the complainant; and
· the complaint is not on the same subject matter for which any proceedings before any court or consumer forum or arbitrator is pending or was so earlier.

Insurance ombudsman –the insured person may also approach the office of insurance ombudsman of the respective area/region for redressal of grievance.
The contact details of the insurance ombudsman offices have been provided as annexure-a.

G. Other terms and conditions

Claims procedure and management
A. Pre-requisite for admissibility of claim
Any claim being made by an insured person or attendant of insured person during hospitalization on behalf of the insured person, should comply with the following conditions:
1. The condition precedent clause has to be fulfilled.
2. The medical condition caused, medical expenses incurred, subsequently the claim being made, should be with respect to the insured person only. The company will not be liable to indemnify the insured person for any loss other than the covered benefits and any other person who is not accepted by the company as an insured person.
3. The holding policy should be in force at the event of the claim. All the policy terms and conditions, waiting periods and exclusions are to be fulfilled including the realization of premium by their respective due dates.
4. All the required and supportive claim related documents are to be furnished within the stipulated timelines. The company may call for additional documents wherever required.

B. Duties of a claimant/ insured person in the event of claim:-
On the occurrence of any loss, within the scope of cover under the policy
You shall:
1. The policyholder / insured person shall check the updated list of network provider before submission of a pre-authorization request for cashless facility.
2. Forthwith file/submit a claim form in accordance with 'claim procedure' clause as provided in the policy.
3. Assist and not hinder or prevent us or any of our representative from taking any reasonable steps in pursuance of their duties for ascertaining the admissibility of the claim under the policy.
4. The company's medical practitioner and representatives shall be given access and co-operation to inspect the insured person's medical and hospitalization records and to investigate the facts and examine the insured person and shall be provided with complete necessary documentation and information to establish company's/ its liability for the claim, its circumstances and its quantum.
5. If you do not comply with the provisions of this clause or other obligations cast upon you under this policy, in terms of the other clauses referred to herein or in terms of the other clauses in any of the policy documents, all benefits under the policy shall be forfeited, at our option.

C. Claims procedure
Intimation must be given at least 72 hours prior to planned hospitalization. In case of emergency hospitalization, intimation must be given within 48 hours of hospitalization or before discharge whichever is earlier.
We may consider the delay in extreme cases of hardship where it is proved to our satisfaction that under the circumstances in which the insured person was placed it was not possible from him/her or any other person to intimate/ notify / submit / file claim within the prescribed time limit.

I. Cashless facility

The company extends cashless facility as a mode to indemnify the medical expenses incurred by the insured person at a network provider. In order to avail cashless facility, the following process must be followed:

1. Submission of pre-authorization form: a pre-authorization form which is available on the company's website or with the network provider, has to be duly filled and signed by the insured person and the treating medical practitioner, as applicable, which has to be submitted electronically by the network provider to the company for approval. Only upon due approval from the company, cashless facility can be availed only at network hospital. A health card issued to the insured person at the time of policy purchase, should be preserved and produced at any of the network providers in the event of claim being made, to avail cashless facility.

I. For planned treatment: the company must be contacted to pre-authorize cashless facility for planned treatment at least 72 hours prior to the proposed treatment. Once the request for pre-authorization has been granted, the treatment must take place within 10 days of the pre-authorization date at a network provider.

Ii. In emergencies: if the insured person has been hospitalized in an emergency, the company must be contacted to pre-authorize cashless facility within 48 hours of the insured person's hospitalization or before discharge from the hospital, whichever is earlier.

Iii. Identification documents: health card issued by the company and valid photo identification like voter id card, driving license, passport, pan card, aadhaar card or any other identification proof.

2. Company's approval: the company will confirm in writing, authorization or rejection of the request to avail cashless facility for the insured person's hospitalization.

3. Please note that rejection of a pre-authorization request is in no way construed as rejection of coverage or treatment. The insured person can proceed with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.

4. The company may modify the list of network providers or modify or restrict the extent of cashless facilities that may be availed at any particular network provider.

Ii. Re-imbursement facility

1. It is agreed and understood that in all cases where intimation of a claim has been provided under reimbursement facility and/or the company specifically states that a particular coverage is payable only under reimbursement facility, the following information details should be provided to the company within 48 hours of admission to the hospital or before discharge from the hospital, whichever is earlier:

i. The policy number

Ii. Name of the policyholder

Iii. Nature of illness or injury and the treatment/surgery taken

Iv. Hospital where treatment/surgery was taken

V. Date of admission and date of discharge.

2. In the event of death of the policyholder, the company will pay the nominee and in case of no nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

D. Documents to be submitted for filing a valid claim

The company shall be provided with the following necessary information and documentation in respect of all claims at your/insured person's expense within 15 days of the insured person's discharge from hospital (in the case of pre-hospitalization medical expenses and hospitalization medical expenses) or within 15 days of the completion of the post-hospitalization medical expenses period (in the case of post-hospitalization medical expenses). For those claims for which the use of cashless facility has been authorized, the company will be provided these documents by the network provider immediately following the insured person's discharge from hospital as follows.

Indicative check list of enclosures for submission of claim

1. In-patient treatment /day care procedures
2. Duly filled and signed claim form.
3. Photocopy of id card / photocopy of current year policy.
4. Original detailed discharge summary / day care summary from the hospital. Original consolidated hospital bill with bill no and break up of each item, duly signed by the insured.
5. Original payment receipt of the hospital bill with receipt number
6. First consultation letter and subsequent prescriptions. Original bills, original payment receipts and reports for investigation supported by the note from attending medical practitioner / surgeon demanding such test.

7. Surgeons certificate stating nature of operation performed and surgeons bills and receipts
8. Attending doctors/ consultants/ specialist's/ anesthetist bill and receipt and certificate regarding same
9. Original medicine bills and receipts with corresponding prescriptions.
10. Original invoice/bills for implants (viz. Stent /phs mesh/ iol etc.) with original payment receipts.
11. Hospital registration number and pan details from the hospital
12. Doctors registration number and qualification from the doctor
13. Road traffic accident
14. In addition to the in-patient treatment documents:
15. Copy of the first information report from police department / copy of the medico-legal certificate.
16. In non medico legal cases
17. Treating doctor's certificate giving details of injuries (how, when and where injury sustained)
18. In accidental death cases
19. Copy of post mortem report (if conducted) & death certificate.
20. Pre and post-hospitalisation expenses
21. Duly filled and signed claim form.
22. Photocopy of id card / photocopy of current year policy.
23. Original medicine bills, original payment receipt with prescriptions.
24. Original investigations bills, original payment receipt with prescriptions and report.
25. Original consultation bills, original payment receipt with prescription.
26. Copy of the discharge summary of the main claim.
We may call for additional documents/ information as relevant to the claim.

E. Claim assessment

1. The company shall scrutinize the claim and supportive documents, once received. In case of any deficiency, the company may call for any additional documents or information as required, based on the circumstances of the claim.
2. All admissible claims under this policy shall be assessed by the company in the following progressive order:
i. If the provisions in clause f.9 (multiple policies) are applicable, the company's liability to make payment under that claims shall first be apportioned accordingly.
3. The claim amount assessed in clause g.E.(2) above would be deducted from the following amounts in the following progressive order:
i. Sum insured
Ii. No claims bonus (if applicable)
iii. Additional sum insured for critical illness (if applicable)
iv. Restoration (if applicable)
v. Recharge (if applicable)

F. Payment terms

1. This policy covers only medical treatment taken entirely within india. All payments under this policy shall be made in indian rupees and within india.
2. The company shall have no liability to make payment of a claim under the policy in respect of an insured person during the policy period, once the total sum insured for that insured person is exhausted.
3. The company shall settle the claim within 30 days from the date of receipt of last necessary document in accordance with the provisions of regulation 27 of irdai (health insurance) regulations, 2016. In the case of delay in the payment of a claim, the company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate. However, where the circumstances of a claim warrant an investigation in the opinion of the company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the company shall settle the claim within 45 days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days, the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

G. Tax benefit

The premium amount paid under this policy qualifies for deduction under section 80d of the income tax act.

Appendix I - List I - Items for which coverage is not available in the policy

The details of the excluded items can also be viewed on our website: www.hizuno.com
Link: https://www.hizuno.com/contact-us

Sl. No.	Item	Sl. No.	Item
1	Baby food	39	Steam inhaler
2	Baby utilities charges	40	Armsling
3	Beauty services	41	Thermometer
4	Belts/braces	42	Cervical collar
5	Buds	43	Splint
6	Cold pack/hot pack	44	Diabetic foot wear
7	Carry bags	45	Knee braces (long/ short/ hinged)
8	Email/ internet charges	46	Knee immobilizer/shoulder immobilizer
9	Food charges (other than patient's diet provided by hospital)	47	Lumbo sacral belt
		48	Nimbus bed or water or air bed charges
10	leggings	49	Ambulance collar
11	Laundry charges	50	Ambulance equipment
12	Mineral water	51	Abdominal binder
13	Sanitary pad	52	Private nurses charges- special nursing charges
14	Telephone charges	53	Sugar free tablets
15	Guest services	54	Creams powders lotions (toiletries are not payable, only prescribed medical pharmaceuticals payable)
16	Crepe bandage		
17	Diaper of any type	55	ECG electrodes
18	Eyelet collar	56	Gloves
19	Slings	57	Nebulisation kit
20	Blood grouping and cross matching of donors samples	58	Any kit with no details mentioned [delivery kit, orthokit, recovery kit, etc
21	Service charges where nursing charge also charged	59	Kidney tray
		60	Mask
22	Television charqes	61	Ounce glass
23	Surcharges	62	Oxygen mask
24	Attendant charges	63	Pelvic traction belt
25	Extra diet of patient (other than that which forms part of bed charge)	64	Pan can
		65	Trolly cover
26	birth certificate	66	Urometer, urine jug
27	Certificate charges	67	Ambulance
28	Courier charges	68	Vasofix safety
29	Conveyance charges		
30	Medical certificate		
31	Medical records		
32	Photocopies charges		
33	Mortuary charges		
34	Walking aids charges		
35	Oxygen cylinder (for usage outside the hospital)		
36	Spacer		
37	Spirometre		
38	Nebulizer kit		

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

Sl. No.	Item
1	Baby charges (unless specified/ indicated)
2	Hand wash
3	Shoe cover
4	Caps
5	Cradle charges
6	Comb
7	Eau-de-cologne/ room freshners
8	Foot cover
9	Gown
10	Slippers
11	Tissue paper
12	Tooth paste
13	Tooth brush
14	Bed pan
15	Face mask
16	Flex! Mask
17	Hand holder
18	Sputum cup
19	Disinfectant lotions
20	Luxury tax
21	Hvac
22	House keeping charges
23	Air conditioner charges
24	Im iv injection charges
25	Clean sheet
26	Blanket/warmer blanket
27	Admission kit
28	Diabetic chart charges
29	Documentation charges/ administrative expenses
30	Discharge procedure charges
31	Daily chart charges
32	Entrance pass/ visitors pass charges
33	Expenses related to prescription on discharge
34	File opening charges
35	Incidental expenses/ misc. Charges (not explained)
36	patient identification band/ name tag
37	Pulseoxymeter charges

Day Care Treatment: All the day care treatments are covered which falls under the definition of Day care treatment mentioned in the policy.

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

Sl. No.	Item
1	Hair removal cream
2	Disposables razors charges (for site preparations)
3	Eye pad
4	Eye sheild
5	Camera cover
6	Dvd, cd charges
7	Gause soft
8	Gauze
9	Ward and theatre booking charges
10	Arthroscopy and endoscopy instruments
11	Microscope cover
12	Surgical blades, harmonicscalpel, shaver
13	Surgical drill
14	Eye kit
15	Eye drape
16	X-ray film
17	Boyles apparatus charges
18	Cotton
19	Cotton bandage
20	Surgical tape
21	Apron
22	Torniquet
23	Orthobundle, gynaec bundle

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

Sl. No.	Item
1	Admission/registration charges
2	Hospitalisation for evaluation/ diagnostic purpose
3	Urine container
4	Blood reservation charges and ante natal booking charges
5	Bipap machine
6	Cpap/ capo equipments
7	Infusion pump- cost
8	Hydrogen peroxide\spirit\ disinfectants etc
9	Nutrition planning charges - dietician charges- diet charges
10	HIV kit
11	Antiseptic mouthwash
12	Lozenges
13	Mouth paint
14	Vaccination charges
15	Alcohol swabes
16	Scrub solutionisterillium
17	Glucometer& strips
18	Urine bag