ZURICH kotak
General Insurance

Zurich Kotak General Insurance Company (India) Limited
(Formerly known as Kotak Mahindra General Insurance Company Limited)
Registered & Corporate Office: 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai - 400063. Maharashtra, India.

ZK - 24-25/v1

HEALTH 360
Policy Wording

Preamble

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

PART I

Definitions

For the purposes of this Policy, the terms specified below shall have the meaning set forth wherever appearing/specified in this Policy or related Endorsements:

Where the context so requires, references to the singular shall also include references to the plural and references to any gender shall include references to all genders. Further any references to statutory enactment include subsequent changes to the same.

Accident	means sudden, unforeseen and involuntary event caused by external, visible and violent means
Admission	means the Insured Person's admission to a Hospital as an inpatient for the purpose of medical treatment of an Injury and/or Illness
Alternative Treatment (AYUSH)	refers to the medical and/ or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems
Ambulance	means a road vehicle operated by a healthcare/ ambulance service provider and equipped for the transport and paramedical treatment of the person requiring medical attention
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
Associated Medical Expenses	means expenses incurred during hospitalization which vary due to the differential billing system as per room rent category including but not limited to • Room Rent, • nursing charges, • operation theatre charges, • fees of Medical Practitioners (including surgeons, anesthetists and specialists) • In-patient Physiotherapy Charges Associated medical expenses shall not include: a. Cost of pharmacy and consumables, b. Cost of implants and medical devices, c. Cost of diagnostics
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.
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.

Base Sum Insured	a. For Individual sum insured basis (Individual Policy), the amount specified in the Policy Schedule against an Insured Person which is Our maximum, total and cumulative liability for any and all claims arising during a Policy Year in respect of that Insured Person. b. For Family Floater sum insured basis (Floater Policy), the amount specified in the Policy Schedule which is Our maximum, total and cumulative liability for any and all claims arising during a Policy Year in respect of any one and/or all Insured Persons. If the Policy Period is more than one year, then the Base Sum Insured will apply afresh to each Policy Year in the Policy Period, but any portion of the Base Sum Insured which remains un-utilised in any Policy Year shall not be carried forward to any subsequent Policy Year in the Policy Period.
Break in policy	means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
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
Claim	means a demand made by You for payment of any benefit under the Policy in respect of an Insured Person
Condition Precedent	means a policy term or condition upon which the Insurer's liability under the policy is conditional upon
Congenital Anomaly	means a condition which is present since birth, and which is abnormal with reference to form, structure or position **a) Internal Congenital Anomaly** Congenital anomaly which is not in the visible and accessible parts of the body. **b) External Congenital Anomaly** Congenital anomaly which is in the visible and accessible parts of the body.
Co-Payment	means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
Cumulative Bonus	means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium
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
Day Care Treatment	means medical treatment, and/or surgical procedure which is: i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and ii. which would have otherwise required hospitalization of more than 24 hours Treatment normally taken on an out-patient basis is not included in the scope of this definition
Deductible	means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
Dental treatment	means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery
Disclosure to information norm	The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
Domiciliary Hospitalisation	means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances: i.The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or ii.The patient takes treatment at home on account of non-availability of room in a hospital.
Emergency	means a serious medical condition or symptom resulting from Injury or sickness which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an emergency anymore.
Emergency Care	means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health
Family Floater	means a Policy described as such in the Policy Schedule where You and Your family members as mentioned in Eligibility (Part III) and named in the Schedule are insured under this Policy as at the Policy Period Start Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your family members mentioned in the Policy Schedule during each Policy Period.
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.

Hospital	means any institution established for in-patient care and day care treatment of illness and / or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulations) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act Or complies with all minimum criteria as under: i. has qualified nursing staff under its employment round the clock; ii. has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places; iii. has qualified medical practitioner (s) in charge round the clock; iv. has a fully equipped operation theatre of its own where surgical procedures are carried out v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel
Hospitalisation	means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours
Illness	means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment (a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery. (b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics: 1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests 2. it needs ongoing or long-term control or relief of symptoms 3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it 4. it continues indefinitely 5. it recurs or is likely to recur
Injury	means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner
Inpatient care	means treatment for which the insured person has to stay in a Hospital for more than 24 hours for a covered event
Instalment Premium	Shall mean the defined proportion of the applicable annual premium with respect to the Insured Person(s) payable at regular frequency as defined in the Policy Schedule.
Insured Person(s)	means the persons named in the Policy Schedule, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium received
Intensive Care Unit	means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
ICU Charges	ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
Maternity expenses	Maternity expenses means; a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization); b) expenses towards lawful medical termination of pregnancy during the policy period
Medical Advice	means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription
Medical Expenses	means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
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
Medical Practitioner	means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license The term Medical Practitioner would include physician, specialist, anaesthetist and surgeon but would exclude You and Your Immediate Family. "Immediate Family would comprise of Your spouse, children, brother(s), sister(s) and parent(s).
Migration	means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credit gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer

Network Provider	means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility
New Born Baby	New born baby means baby born during the Policy Period and is aged upto 90 days.
Non-Network Provider	means any Hospital, day care centre or other provider that is not part of the network
Notification of Claim	means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication
OPD treatment	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.
Plan	means the Plan stated in the Policy Schedule which is applicable to all Insured Persons and specifies the amounts of benefits available
Policy	means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to You, what is excluded from the cover and the terms & conditions on which the Policy is issued to You.
Policy Period	means the period commencing from Policy Start Date and time as specified in Policy Schedule and terminating at midnight on the Policy End Date as specified in Policy Schedule
Policy Schedule	means the schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
Policy Year	means a period of twelve months beginning from the Policy Period Start Date and ending on the last day of such twelve-month period. For the purpose of subsequent years, "Policy Year" shall mean a period of twelve months beginning from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Policy Period End Date, as specified in the Policy Schedule.
Portability	means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer
Pre-existing Disease	means any condition, ailment, injury or disease: a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer or b) for which medical advice or treatment was recommended by, or received from, a physician not more than 36 months prior to the date of commencement of the policy.
Pre-Hospitalisation 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.
Post Hospitalisation 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.
Qualified Nurse	means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India
Reasonable& Customary Charges	means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.
Renewal	means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods
Room Rent	means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses
Shared Room	means a hospital room where at least two patients are accommodated at the same time. Such room shall be the most basic and the most economical of all accommodation available as twin sharing rooms in that hospital
Single Private AC Room	means an air conditioned room in a Hospital where a single patient along with the attendant 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.
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
Third Party Administrator (TPA)	means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services
Unproven/ Experimental Treatment	means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven
You/Your/Policyholder	means the policyholder/Insured Person named in the Policy Schedule
We/ Our/Us	means Zurich Kotak General Insurance Company (India) Limited

PART II

2. WHAT WE WILL PAY (COVERS AVAILABLE UNDER THE POLICY)

The Covers available under this Policy are described below. Covers will be available to the Insured Person, only if that particular cover is specifically mentioned in the Policy Schedule as per the Plan and Sum Insured opted by You, subject to

(a) availability of Sum Insured

(b) for any single Claim during a Policy Year, the maximum Claim amount payable shall be sum of Base Sum Insured, Cumulative Bonus, Cumulative Bonus Booster (if applicable), Double Cover (if applicable), Unlimited Restoration Benefit

(c) any sum insured or sub-limits specified in respect of that Cover for the Insured Person or sub-limits as specified in the Policy Schedule and

(d) the terms, conditions and exclusions of this Policy

I. Base Covers

A. Hospitalisation Expenses

1. In-patient Treatment

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

(a) The Hospitalisation is for a minimum and continuous period of 24 hours

(b) the Hospitalisation is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;

(c) the Medical Expenses incurred are Reasonable and Customary and may be for one or more of the following:

i. Room Rent and other boarding charges;

ii. ICU Charges;

iii. Operation theatre expenses;

iv. Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;

v. Qualified Nurses' charges;

vi. Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;

vii. Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized

viii. Anaesthesia, blood, oxygen and blood transfusion charges;

ix. Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

x. Inpatient physiotherapy charges;

In case of Individual Policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis.

2. Day Care Treatment

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

(a) the Day Care Treatment is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;

(b) the Medical Expenses incurred are Reasonable and Customary;

Further,

(a) We will not cover any OPD Treatment under this Benefit.

In case of Individual Policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis.

3. Modern Treatment

We will indemnify the Medical Expenses incurred on the following advance technology methods (wherever medically indicated) either as In-patient or as part of Day Care Treatment in a Hospital during the Policy Period upto the limit specified in policy schedule:

(i) Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

(ii) Balloon Sinuplasty

(iii) Deep Brain stimulation

(iv) Oral chemotherapy

(v) Immunotherapy- Monoclonal Antibody to be given as injection

(vi) Intra vitreal injections

(vii) Robotic surgeries

(viii) Stereotactic radio surgeries

(ix) Bronchial Thermoplasty

(x) Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

(xi) IONM - (Intra Operative Neuro Monitoring)

(xii) Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

In case of Individual Policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis.

4. Pre-Hospitalization Medical Expenses

We will indemnify the Insured Person's Pre-Hospitalisation Medical Expenses following an Illness or Injury that occurs during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under this Policy and the Pre-Hospitalisation Medical Expenses relate to the same Illness/medical condition;

Further,

(a) We will pay Pre-Hospitalisation Medical Expenses up to the number of days as mentioned in the Policy Schedule preceding the Insured Person's Admission to Hospital for In-patient Care or Day Care Treatment;

5. Post-Hospitalization Medical Expenses

We will indemnify the Insured Person's Post-Hospitalisation Medical Expenses following an Illness or Injury that occurs during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under this Policy and the Post-Hospitalisation Medical Expenses relate to the same Illness/medical condition;

Further,

(a) We will pay Post-Hospitalisation Medical Expenses up to the number of days as mentioned in the Policy Schedule immediately following the Insured Person's discharge from Hospital following In-patient Care or Day Care Treatment.

6. AYUSH Treatment

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

(a) The AYUSH Treatment is administered by a Medical Practitioner; who holds a valid practicing license in respect of such AYUSH Treatments;

(b) The Insured Person is admitted to AYUSH Hospital for Inpatient Treatment or Day Care Treatment

(c) In case of Individual Policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis.

7. Domiciliary Hospitalisation

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

(a) We will cover medical expenses of an Insured person for treatment of a disease, Illness or Injury taken at home which would otherwise have required hospitalisation or since the Insured person's condition did not allow a hospital transfer or a hospital bed was unavailable.

(b) The domiciliary hospitalisation is Medically Necessary and follows the written advice of a Medical Practitioner

(c) The Medical Expenses incurred are Reasonable and Customary Charges;

(d) The Insured Person's Domiciliary Hospitalisation extends for at least 3 consecutive days in which case We will pay Medical Expenses from the first day of Domiciliary Hospitalisation;

Further,

(a) We shall not indemnify for any Medical Expenses incurred for the treatment of any of the following Illnesses/conditions under this Cover:

i. Asthma;

ii. Bronchitis;

iii. Chronic Nephritis and Chronic Nephritic Syndrome;

iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis;

v. Diabetes Mellitus and Insipidus;

vi. Epilepsy;

vii. Hypertension;

viii. Influenza, cough and cold;

ix. psychiatric or psychosomatic disorders as mentioned below;

a. 2021 ICD-10-CM Diagnosis Code F32: Major depressive disorder, single episode

b. 2021 ICD-10-CM Diagnosis Code F41: Other anxiety disorders

c. ICD-10-CM Diagnosis Code F34: Persistent mood [affective] disorders

d. ICD-10-CM Diagnosis Code F31: Bipolar disorder

e. ICD-10-CM Diagnosis Code F20: Schizophrenia

f. ICD-10-CM Diagnosis Code F50: Eating disorders

g. ICD-10-CM Diagnosis Code F84: Autistic disorder

h. ICD-10-CM Diagnosis Code F79: Unspecified intellectual disabilities

i. ICD-10-CM Diagnosis Code F90: Attention-deficit hyperactivity disorders

j. ICD-10-CM Diagnosis Code F42: Obsessive-compulsive disorder

x. Pyrexia of unknown origin for less than 10 days;

xi. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;

xii. Arthritis, Gout and Rheumatism.

In case of Individual Policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis.

8. Organ Donor Cover

We will indemnify the In-patient Hospitalisation Medical Expenses towards the donor for harvesting the organ provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the Insured Person;

(b) The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules;

(c) The organ donated is for the use of the Insured Person who has been asked to undergo an organ transplant on Medical Advise;

Further,

(a) In case of Individual Policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis.

(b) We will not cover expenses towards the donor in respect of:

(i) Any Pre-Hospitalization Medical Expenses or Post-Hospitalization Medical Expenses;

(ii) Costs directly or indirectly associated to the acquisition of the organ;

(iii) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

9. Road Ambulance Cover

We will indemnify the amount incurred up to the limit specified in the Policy Schedule for the reasonable expenses incurred by You on availing ambulance services offered by a healthcare or Ambulance service provider for your necessary transportation to the Hospital for treatment of an Illness or Injury following an Emergency provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy and the Ambulance service relates to the same illness / medical condition

(b) The necessity of the use of the Ambulance is certified by the treating Medical Practitioner;

Further

(a) We will also provide cover under this benefit if the Insured Person is required to be transferred from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital or the Insured Person is required to be moved to a better Hospital facility due to lack of available/adequate treatment facilities at the existing Hospital.

(b) In case of Individual Policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.

10. Air Ambulance Cover

We will indemnify the amount up to the limit specified in the Policy Schedule for the reasonable expenses incurred by You for ambulance transportation in an airplane or helicopter for emergency life threatening health conditions which require immediate and rapid ambulance transportation from the site of first occurrence of the Illness /Accident to the nearest hospital provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy and the air ambulance service relates to the same Illness / medical condition

(b) The necessity of the use of the Air Ambulance is certified by the treating Medical Practitioner;

Further,

(a) We will also provide cover under this Benefit if the Insured Person is required to be moved to a better Hospital facility due to lack of available/adequate treatment facilities at the existing Hospital.

(b) Return transportation to Your home by air ambulance is excluded

(c) In case of Individual policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis.

(d) Air ambulance providing the services, should be duly licensed to operate as such by a competent government authority

11. Bariatric Surgery

We will indemnify the Insured Person up to the amount as specified in Policy Schedule for expenses incurred on Bariatric Surgery during the Policy year on the advice of a Medical Practitioner because of Conditions mentioned below

1. The insured person is unable to lose weight through traditional methods like diet and exercise.

2. Insureds aged 18 years or older, presence of severe obesity documented in contemporaneous clinical records defined as any of the following:

3. BMI greater than and equal to 40 in conjunctions with any of the following severe comorbidities

i. Coronary heart disease; or

ii. Medically refractory hypertension (blood pressure greater than 140 mm Hg systolic and/or 90 mm Hg diastolic despite concurrent use of 3 anti-hypertensive agents of different classes);

iii. Type 2 diabetes mellitus

Special Conditions applicable to Bariatric Surgery Cover

i. Bariatric surgery performed for any other reason not listed above shall not be covered.

ii. The indication for the procedure should be found appropriate by two qualified surgeons

iii. To avail this Benefit Insured person shall obtain prior approval from Us.

Room Rent Conditions applicable for I.A Hospitalisation Expenses:

The eligible Room rent or Room category coverage under the Policy is "No limit" or as opted for and specified in the Policy Schedule, subject to maximum of Sum Insured opted. For ICU accommodation, we will cover up to Sum Insured opted or as specified in the Policy Schedule.

B. Other Base Covers

12. Cumulative Bonus

We will increase Your Base Sum Insured by 50% subject to the maximum limit of 100% at the end of the Policy Year if the Policy is renewed with Us provided that:

(a) Cumulative Bonus under a Family Floater Policy will be available only to those Insured Persons who were Insured Persons in the immediately completed Policy Year;

(b) If the Base Sum Insured is increased at the time of Renewal, then the Cumulative Bonus will be calculated on the Base Sum Insured of the immediately completed Policy Year;

(c) If the Base Sum Insured is reduced at the time of Renewal, then the applicable Cumulative Bonus will be applicable on the renewed policy Base Sum Insured.

(d) Cumulative Bonus will be carried forward to the next Policy Year, provided the Insured Person renews the Policy before the expiry of the Grace Period.

(e) If the Policy Period is more than one year, then any Cumulative Bonus that has accrued for the Policy Year will be credited at the end of the Policy Year and shall be available for any claims made in the subsequent Policy Year.

(f) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest among all the Insured Persons.

(g) If the Insured Persons in the expiring Policy are covered on a floater basis and such Insured Persons renew their expiring Policy with Us into two or more floater/individual policies then the Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Base Sum Insured of each Renewed Policy.

(h) The 'Unlimited Restoration Benefit' amount shall not be considered while calculating 'Cumulative Bonus'.

(i) Accrued 'Cumulative Bonus' can be utilized for 'Base Covers – A. Hospitalisation Expenses', 'Consumables Cover", 'Home Nursing Benefit', 'Home Care Treatment cover under the Policy.

13. Unlimited Restoration Benefit

If a Claim is payable under the Policy, We will provide restoration up to the Base Sum Insured unlimited times in a Policy Year, only after the Base Sum Insured, the Cumulative Bonus (if any), Cumulative Bonus Booster (if any), Double cover (if any) are insufficient in a policy year , provided that:

(a) A Claim will be admissible under the Unlimited Restoration Benefit only if the Claim is admissible under Cover 'Hospitalization Expenses'.

(b) The restored sum insured can be utilised in respect of any illness (related as well as different) and its complications except for claim under "Any one Illness" condition.

(c) All Insured Persons will be eligible to utilize the restored amount for any Illness or Injury pertaining to that Policy Year.

(d) Applicable Cumulative Bonus/ Cumulative Bonus Booster (if opted for) shall not be considered while calculating Unlimited Restoration Benefit.

(e) No Cumulative Bonus/ Cumulative Bonus Booster (if opted for) will apply on the restored sum insured;

(f) The restored sum insured will apply to all Insured Persons on the same basis as the Base Sum Insured i.e. individual sum insured in case of Individual Policy and floater sum insured in case of Floater Policy;

(g) Any restored sum insured which is not utilized in a Policy Year shall not be carried forward to any subsequent Policy Year;

'(h) Unlimited Restoration Benefit' can be utilized for 'Base Covers – A. Hospitalization Expenses'

(i) The restoration of sum insured shall not apply to the first claim in that Policy Year

Illustration –

Policy for single Individual with Sum Insured 5 lakhs

Policy Period	Sum Insured	Claim	Hospitalization Period	Ailment	Claim Amount	Paid Amount	Remark
1/1/2023-31/12/2024	500000	Claim 1	01/04/2024-04/04/2024	Cancer	700000	500000	1st claim hence Unlimited Restoration not triggered
		Claim 2	09/04/2024 - 13/04/2024	Cancer	200000	200000	Base Sum Insured exhausted. Paid from Unlimited Restoration.
		Claim 3	25/04/2024 - 28/04/2024	Cancer	400000	300000	Base Sum Insured exhausted. Paid from Balance Unlimited Restoration amount
		Claim 4	08/05/2024-10/05/2024	Cancer	100000	0	Any one Illness hence Unlimited restoration not triggered.
		Claim 5	15/05/2024-18/05/2024	Dengue	700000	500000	Base Sum Insured exhausted. Unlimited Sum Insured triggered upto Base Sum Insured

14. Consumables Cover

We will cover the cost of Non-Medical items, listed under Annexure II List 1 of the Policy, incurred towards Medically Necessary Hospitalization of the Insured Person, arising out of Disease/ Illness or Injury.

The cover is available subject to the claim being admissible under In-patient Treatment and/ or Day Care Treatment cover under this Policy and the expenses on Non-medical items are related to the same Illness/ Injury.

The payment under this benefit is within the Base Sum Insured & Cumulative Bonus (if any) i.e. Cumulative Bonus booster, Double Cover, Unlimited Restoration Benefit will not be applicable for this Benefit.

15. Shared Accommodation Benefit

We will pay the daily cash amount specified in the Policy Schedule for this Benefit for each and every completed day of the Insured Person's Hospitalization in shared room during the Policy Period provided that:

- The Company has accepted the Insured Person's claim under In-patient Treatment
- The benefit will not be applicable where the hospitalisation is based on package rates.
- Accommodation for intensive care unit (ICU) or high dependency units/wards will not be considered for this purpose.

- The payment under this benefit is over and above the Base Sum Insured.

16. Home Care Treatment

We will indemnify the Insured Person up to the amount as specified in Policy Schedule, for the Medical Expenses incurred by the Insured Person on availing treatment at home which in normal course would require care and treatment at a Hospital but is actually taken at home provided that:

a) The Medical Practitioner advises the Insured person to undergo treatment at home

b) There is a continuous active line of treatment with monitoring of the health status by a Medical practitioner for each day through the duration of the home care treatment

c) Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained

d) Insured can avail "Home Care Treatment" on cashless basis provided it pre-authorized by the Company

List of Conditions covered under Home Care treatment

a. Fever and Infectious diseases which can be managed as Inpatient

b. Uncomplicated Urinary tract infections but needing Parenteral Antibiotics

c. Asthma and COPD -Mild Exacerbations needing Home Nebulization

d. Acute Gastritis/Gastroenteritis

e. I.V. Chemotherapy [Where advised by the doctor]

f. Palliative Cancer care requiring medical assistance

g. Acute Vertigo

h. Diabetic foot and Cellulitis

i. IVDP [Cervical and Lumbar disc diseases]

j. Major Surgeries/Arthroplasties needing IV Antibiotics Post Discharge

k. Care for Brain and Spinal Injury Cases Post Discharge

l. Post CVA Care at Home after Discharge

m. Chronic Severe Refractory Asthma (by Advanced Medicine)

Note –

- This Cover is not available on reimbursement basis.
- The payment under this benefit is within the Base Sum Insured & Cumulative Bonus i.e. Cumulative Bonus Booster (if opted), Double Cover (if opted), Unlimited Restoration Benefit will not be applicable for this Benefit.
- Claim under this benefit will impact the Base Sum Insured and Premium Secure Benefit

17. Premium Secure Benefit

You will pay the premium based on your first policy inception age till a claim is paid under the Policy. Post the claim is paid, the premium charged will be as per your current age and will continue to change as per the age slabs at each renewal.

- In case of multi tenure policies, the premium for the entire tenure will be charged as per the entry age. No additional premium will be charged in the middle of the tenure in case of claims.
- At the time of renewal (in case of a claim), the premium will be charged as per the current age of the customer at renewal.
- If you add a member to the floater plan, then the premiums will be charged as per the entry age of the eldest member and will lock the premium at that age, till a claim is paid.
- If you add a member to an individual plan and convert it into a Floater plan, then the premiums will be charged as per the entry age of the eldest member and will lock the premium at that age, till a claim is paid.
- If the eldest member is no longer part of the Floater plan, then the Floater premium will be calculated as per the original entry age of the eldest member in the policy amongst the remaining members and lock at that age, till a claim is paid.
- If a floater plan, splits into multiple policies, then we will carry forward the locked age at which the floater policies were taken by individuals (as per the claim history) in the policies carried forward, till a claim is paid.
- In a multi individual policy, the age will unlock only for the individuals who claim.
- In a floater policy, if a claim is paid for anyone in the plan then we will unlock the age for the entire policy.
- If any underwriting loading is applied in the policy, the premium with loading will be continued till a claim is made
- We will consider a claim, if a claim is paid under the following - Hospitalisation Expenses, Home Care Treatment, Global Cover for the purpose of premium change under this Benefit.
- In case of any modification in the product pertaining to revision in premium rates, the new rates will be applicable under this cover as per the age at the time of first policy inception provided no claim under the policy

18. Annual Health Check-up

On the Insured Person's request, We will arrange for the Insured Person's Annual health check-up at Our Network Provider on cashless basis for the specified tests listed below subject to:

- This Benefit shall be available only once during a Policy Year per Insured Person.
- Availing the Annual Health Check-up will not impact the Base Sum Insured, Cumulative Bonus, Cumulative Bonus Booster (if any), Cash Bag (if any) or the Premium Secure Benefit

Medical Tests applicable for Insured Persons who are of Age 18 years or above on the Policy Period Start Date

Sum Insured	List of Medical tests
<=10 lacs	Complete Blood Count (CBC), Urine Routine, ESR, ABO Group & Rh Type, Blood Sugar Fasting, Cholesterol, Cholesterol Direct LDL, Cholesterol-HDL, Triglycerides, Total Cholesterol/HDL Ratio, Creatinine, Blood Urea Nitrogen, Bun/ Creatinine Ratio, Uric Acid
> 10 lacs	Complete Blood Count (CBC), Urine Routine, ESR, ABO Group & Rh Type, Blood Sugar Fasting, Cholesterol, Cholesterol Direct LDL, Cholesterol-HDL, Triglycerides, Total Cholesterol/HDL Ratio, Creatinine, Blood Urea Nitrogen, Bun/ Creatinine Ratio, Uric Acid, Treadmill Test

Medical Tests applicable for Insured Persons who are of Age below 18 years on the Policy Period Start Date

List of Medical tests
Physical Examination (Height, Weight and Body Mass Index (BMI)), Eye Examination, Dental Examination and Scoring, Growth Charting, Doctor Consultation, Urine Examination (Routine and Microscopic)

19. Wellness Program

The Benefit listed below shall be available to the Insured Persons covered as Adult aged 18 years and above in the Policy via mobile application/ health portal:

- Discount on renewal premium under our Wellness Benefit wherein You need to complete number of steps per day as per the table given below, that will help You in improving Your well-being.

Number of Healthy Days (10,000 Steps and above per day)	Discount on Renewal Premium
270 days and above	30%
240 – 269 days	20%
180 –239 days	15%
120 – 179 days	10%
< 120 days	Nil

Conditions applicable to this benefit:

a) The number of days specified in the table above should fall within Policy Year. The activities undertaken towards this benefit during the last 3 (three) months of the Policy tenure shall not be considered for reward calculation. The same shall carry forward and will be considered in next Policy Period.

b) In Individual sum insured policy This wellness benefit is available only for the adult members with age 18 years and above. However, in a Floater policy, this program shall be available only to the independent adult members (Self / Spouse / Dependent parent / Parent in laws if any) and shall not be available to dependent children.

c) The above benefit will be applicable on Individual basis. In case of floater, average of number of Healthy days earned by all Insured Members shall be considered for calculating renewal discount. For example,' A' has attained 260 Healthy days and ' B' has attained 230 Healthy days, average of the Healthy days is 245 and accordingly the discount calculated is 20%. In case of multi tenure, average of number of Healthy days earned over the policy tenure shall be considered for discount.

d) Redemption against renewal premium will be available only at the time such renewal is due. Any earned rewards will lapse at the end of the grace period if the policy is not renewed with us.

e) In case of instalment premium mode is opted, then discount shall be considered only post payment of first 6 months of premium.

f) Vouchers of value equivalent to renewal discount amount can also be provided to Insured in case he/she does not wish for discount on renewal premium.

The notifications related to Wellness Program will be communicated via SMS, email and the program specific mobile application. Details about reward points will be available on the program app or would be shared through SMS and/or Renewal Notice which would be sent to customers. The mobile app must be downloaded within 30 days of the policy risk start date to avail this benefit. The average step count completed by an Insured member would be tracked on our mobile application/ portal. We reserve the right to remove or reduce any count of steps if found to be achieved in unfair manner by manipulation.

20. Unlimited E-consultations

We shall offer unlimited e consultations with qualified General Physicians at our network during the Policy Year through any digital mode of communication (Voice/Video Call /Chat/ Email Chat/ etc.)

- Availing the unlimited E-consultations will not impact the Base Sum Insured, Cumulative Bonus or the Premium Secure Benefit.
- This will be offered regardless of any claim admitted/ registered under the Policy.

21. Health Services

The Benefits listed below shall be available to the Insured Persons.

Health Portal: The insured may access health related information and services such as Health Risk Assessment (HRA), Wellness Sessions/ Videos/ Podcasts, Healthy tips reminder as available on Company's website/ Mobile application.

The Insured Person may access discounted OPD, Diagnostics, Pharmacy etc. through Network as available on the Company's website/ Mobile application.

II. Optional Covers

1. Global Cover (Not Applicable for Silver and Gold Plan)

By Opting for this cover, if Insured is hospitalized on the advice of a Medical Practitioner because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then We will indemnify You against Reasonable and Customary Medical Expenses incurred outside India for

- Planned treatment where diagnosis was made in India and the insured travels abroad for Planned treatment only
- Emergency Care where the Injury or Illness should occur while the Insured Person is outside India

Medical Expenses during hospitalization are covered as specified below up to the Base Sum Insured subject to a maximum of INR 2 crore:

i. Room and Boarding expenses as per the limit/category specified on the Policy Schedule. If admitted in ICU, the Company will pay up to ICU expenses at actuals.

ii. Nursing Expenses as provided by the Hospital.

iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees.

iv. Anesthesia, Blood, Oxygen, Operation Theatre Charges, surgical appliances.

v. Medicines & Drugs, Medical Consumables prescribed to manage the emergency condition.

vi. Equipment if implanted internally like pacemaker during a surgical process.

vii. Relevant laboratory diagnostic tests, X-ray and such similar expenses that are medically necessary prescribed by the treating Medical Practitioner.

Conditions applicable to Global Cover –

- This cover is payable within the Base Sum insured i.e. Cumulative Bonus, Cumulative Bonus booster (if opted), Double Cover (if opted), Unlimited Restoration Benefit will not be applicable for this Benefit.
- This cover can be availed by Insured Person(s) up to the age of 65 years and who are resident(s) of India and are within the geographical boundaries of India during Policy issuance. Non-disclosure or misrepresentation with respect to the above will impact claims admissibility under this Cover and lead to Policy Cancellation.
- Global cover cannot be availed by Non Resident Indians/Overseas Citizens of India.
- There will be a waiting period of 2 years for any claim under this cover. There will be no waiting period for Accidental Emergencies.
- In case of addition of any new members to the Policy, the waiting period of 2 years will be applicable before availing any coverage under Worldwide Cover.
- Pre-existing disease waiting period will be applicable to global cover. Optional cover of waiting period modification will not be applicable for this cover
- The Medical Expenses payable shall be limited to Inpatient treatment/ Day Care Treatment.
- Expenses incurred for Pre and Post Hospitalization Medical Expenses, Out- patient Treatment or any other Basic Covers/Optional Covers under this Policy shall not be covered under Global cover.
- The payment of any claim under this benefit will be in Indian Rupees based on the rate of exchange as on the date of invoice, published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian Rupees for claims payment. If these rates are not published on the date of invoice, the exchange rate next published by RBI shall be considered for conversion
- The Medical Expenses payable shall be limited to Hospitalization only on reimbursement basis. Cashless facility may be arranged on case to case basis. Insured person can contact us for any claim assistance.
- The treatment should be taken in a registered Hospital, as per law, rules and/ or regulations applicable to the country, where the treatment is taken.
- In case of Migration, continuity benefit shall be offered provided In-patient treatment outside India is available under expiring policy
- The Company may not be liable to make any payment under this Policy, wherein the Government of India has laid down territorial restriction regarding travel to specific countries.
- There is no separate Sum Insured for this optional cover and any claim triggered under this benefit shall reduce the Sum Insured of the opted plan

Conditions applicable for Planned Treatment

a. We shall require the following additional documents supporting the claim under this benefit:
   - Proof of diagnosis in India
   - Insured's Passport and Visa

b. The Insured person has to take prior approval atleast 7 days in advance for Medical Treatment under global cover.

c. The Hospitalisation is for a minimum and continuous period of 24 hours as an Inpatient or Day care procedure will be covered under planed treatment

Conditions applicable Emergency Care

a. The Injury or Illness should occur while the Insured Person is outside India.

b. The treatment must commence immediately on diagnosis of the Illness or occurrence of the Injury.

c. The benefit is available for 45 continuous days from date of travel in a Single trip and 90 days on a cumulative basis as whole in a Policy year.

d. The Insured person has to inform us within 24 hours of occurrence of the emergency condition and take prior approval for Medical Treatment.

e. We will not cover the treatment or part of treatment for any condition which is not Life threatening in nature and can be safely postponed till the Insured Person returns to India

f. Permanent Exclusion 3.5 (27) of the Policy Wordings stands deleted to the extent of this Benefit only.

2. Cumulative Bonus Booster

By opting this cover Insured will get an extension to Cumulative Bonus benefit and all provisions stated under the Cumulative Bonus benefit will be applicable to Cumulative Bonus Booster in addition to the below mentioned terms and conditions:

a) If no claim has been made in the expiring Policy Year and the Policy is renewed with the Company without any break, the Insured Person would receive a flat 100% increase in the Base Sum Insured on a cumulative basis as Cumulative Bonus Booster for each completed and continuous Policy Year.

b) Cumulative Bonus Booster will be over and above the Base Sum Insured and Cumulative Bonus accrued under the Policy.

c) In any Policy Year, the accrued Cumulative Bonus Booster shall not exceed 10 times of the Base Sum Insured available in the expiring policy or renewed Policy, wherever the sum insured is lower.

d) In the event of a claim there is no impact on the accrual of Cumulative Bonus Booster

e) The Unlimited Restoration Benefit, Double Sum Insured amount will not be considered while calculating Cumulative Bonus Booster.

f) In case no claim is made in the particular Policy Year, Cumulative Bonus Booster would be credited automatically to the subsequent Policy year, even in case of multi-year Policies.

g) At the time of Policy renewal if the Policyholder chooses not to renew this Optional Benefit, then the Cumulative Bonus Booster under the expiring Policy shall be forfeited.

h) This Cover is applicable only for Benefits mentioned under Hospitalisation Expenses

3. Double Cover

In case this Cover is opted for, We will provide an additional 100% of Base Sum Insured as Double Cover, which can be utilized for claims incurred under the Policy, for the particular Policy Year, provided that:

i. The benefit shall be available only if the Company has accepted a Claim for In-patient Treatment or Day Care Treatment under this Policy

ii. The benefit shall be available only after full exhaustion of Base Sum Insured, cumulative bonus (if any), cumulative bonus booster under the Policy.

iii. The Company's overall liability for all claims, in aggregate, within a Policy Year under this benefit shall be limited to 100% of the Base Sum Insured

iv. While calculating Cumulative Bonus, Cumulative Bonus Booster, Double Cover shall not be considered.

v. Any unutilized Double Cover Sum Insured, in whole or in part shall not be carried forward to subsequent Policy Years.

vi. The Double Cover will be available on individual basis for individual policies and on floater basis for floater policies.

vii. This Cover is applicable only for Benefits mentioned under Hospitalisation Expenses

4. Cash Bag

By opting for this Benefit for each claim free year You will get an amount equal to 10% of the premium to be paid on 1st Renewal and 5% thereafter on each renewal from 2nd renewal onwards.

This amount can be used for

- Payment of deductibles in this Policy (if any)
- Payment of co-payment in this Policy (if any)
- Non-payable items (If any)
- Payment of OPD expenses (if any)

Further-

- Amount available under this Benefit will be over and above the Base Sum insured.
- Claim under this Benefit will not impact the Base Sum Insured, Cumulative Bonus, Cumulative Bonus Booster (if any), or the Premium Secure Benefit

5. Step Up Benefit (Applicable for Silver and Gold Plan Only)

By Opting for this Cover, when multiyear policy is purchased, the Base Sum Insured operates on annual basis. i.e. Base Sum Insured of multiple years tenure opted is combined and is available for the entire policy tenure.

Further

- This Benefit will be applicable only for policies with tenure more than 1 year
- While calculating the Cumulative Bonus & Unlimited Restoration Benefit, the Base sum insured (single year) will be considered
- This cover is not applicable for Unlimited sum insured policy.

Illustration 1 with Base Cover and No Cumulative Bonus

Policy Year	Base Sum Insured	2 years Policy (without Step Up Benefit)	3 years Policy (without Step Up Benefit)	Policy With Step Up Benefit 2 years	Policy With Step Up Benefit 3 years
1	1000000	1000000	1000000	2000000	3000000
2	1000000	1000000	1000000		
3	1000000	1000000	1000000	2000000	
4	1000000	1000000	1000000		
5	1000000	1000000	1000000	2000000	3000000
6	1000000	1000000	1000000		

Illustration 2 with Base Cover and Cumulative Bonus

Policy Period	Sum Insured Opted	Policy With Step Up (2 years)	CB	Claim	Hospitalisation Period	Ailment	Claim Amount	Amount Paid	Remarks
1-1-2022 to 31-12-2023	500000	1000000	0	No	NA	NA	NA	NA	NA
1-1-2024 to 31-12-2025	500000	1000000	50000	Yes	1-05-2024 to 8-05-2024	Cancer	2200000	1500000	Paid in Step Up Sum insured + Cumulative Bonus, Restoration not triggered as 1st claim
					31-05-2024 to 2-6-2024	Cancer	1200000	500000	Step Up (Base) SI & Cumulative Bonus SI exhausted, paid INR 500000 from Restoration
					8-6-2024 to 10-6-2024	Cancer	200000	0	Any One Illness hence unlimited SI not triggered
					10-6-2024 to 12-06-2024	Dengue	100000	100000	Unlimited Restore Paid (Any one Illness not applicable)
					12-4-2025 to 13-04-2025	Cancer	1200000	1000000	Step Up (Base) SI exhausted, paid from Cumulative Bonus 500000 & 500000 from Restoration

6. One Plus Benefit

By Opting for this cover, You can add your Future Spouse to the Policy, and waiting periods as mentioned below completed by You will be passed on to your Future Spouse, when they are added in the Policy:

- Initial Waiting Period

- Pre-Existing Disease Waiting Period
- Specified disease/procedure Waiting Period

Further-

- This Optional Benefit can be opted at the time of new policy inception or at any renewal.
- You can ONLY add your newly married spouse to the plan.
- We will need the marriage certificate to add the spouse.
- The spouse can be added anytime during the policy tenure or at Renewal.
- Newly Married spouse must be added within 90 days of the marriage.
- Addition of Future Spouse will be subject to Underwriting guidelines of the Company

7. Convalescence Benefit

By opting this Benefit, we will pay the amount specified in the Policy Schedule for this Benefit if the Insured Person is admitted in Hospital for a minimum period of 10 consecutive days provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalization;

Further,

(a) We shall not be liable to make payment under this Benefit in respect of an Insured Person more than once during the Policy Year.

(b) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

The payment under this benefit is over and above the Base Sum Insured.

8. Home Nursing Benefit

By opting this Benefit, we will indemnify the amount specified in the Policy Schedule for this Benefit incurred for medical care services of a qualified nurse at the residence of the Insured Person following discharge from hospital after treatment for Illness/ Injury provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalisation;

(b) Such medical care services are confirmed as being necessary by the attending Medical Practitioner and the same relate directly to Illness/ Injury for which the Insured Person has undertaken treatment during the hospitalisation

Further,

(a) The cover is applicable for a maximum of 15 days during the Policy Year and after the completion of the number of days mentioned in the Post-Hospitalization Medical Expenses cover (2.I.A.5).

(b) In case of Individual policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.

(c) The payment under this benefit is within the Base Sum Insured & Cumulative Bonus.

9. Hospital Daily Cash

By opting this Benefit, we will pay the daily cash amount specified in the Policy Schedule for this Benefit for each and every completed day of the Insured Person's Hospitalization during the Policy Period provided that:

a) We have accepted a Claim for In-patient Treatment under the Policy;

b) The Insured Person's Hospitalization extends for at least 3 consecutive days, in which case We will make payment under this Benefit from the first day of Hospitalization;

c) We shall not be liable to make payment for more than the maximum number of days per Policy Year specified in the Policy Schedule for this Benefit.

Further,

(a) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

(b) The payment under this benefit is over and above the Base Sum Insured.

10. Daily Cash for Accompanying an Insured Child

By opting for this Benefit, we will pay the Daily Cash Amount specified in the Policy Schedule for this Benefit for each and every completed day of the Insured Person's Hospitalization during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy;

(b) The Insured Person hospitalized is a Child aged 12 years or below

(c) We shall not be liable to make payment for more than the maximum number of days per Policy Year specified in the Policy Schedule for this Benefit.

Further,

(a) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

(b) The payment under this benefit is over and above the Base Sum Insured.

11. Compassionate Visit

By opting for this benefit we will indemnify the costs of a return journey undertaken by air/ rail/ road (to and fro) up to the limit specified in the Policy Schedule under this Benefit for one of the Insured Person's Immediate Relative to travel from the place of the Immediate Relative's residence to the Hospital where the Insured Person is hospitalized, in case Hospitalization of the Insured Person extends beyond 5 consecutive days provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy

Further,

(a) In case of Individual policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.

(b) The payment under this benefit is over and above the Base Sum Insured.

(c) For the purpose of this Benefit, the term “Immediate Relative” would mean the Insured Person's spouse, children or parents.

12. Essential Equipment Cover

By Opting for this Cover, we will indemnify the expenses upto limit specified in Policy Schedule towards the cost of buying or renting of Durable Medical Equipment as listed below, provided the same is prescribed to the Insured Person by the treating Medical Practitioner, during or after hospitalization for a Medically Necessary treatment.

The cover is available subject to below conditions:

i. Hospitalization claim is admissible under 'In-patient Treatment' and/ or 'Day Care Treatment cover' under the Underlying Policy and the expenses on Durable Medical Equipment are related to the same Illness/ Injury.

ii. The need for Durable Medical Equipment is prescribed by an authorised Medical Practitioner during hospitalization or within 30 days post discharge of the insured from the hospital.

iii. Any purchase/ renting of the Durable Medical Equipment should be done within 30 days of such recommendation.

iv. For the purpose of this benefit, Durable Medical Equipment shall mean

1	CPAP machine
2	Ventilator
3	Wheelchair
4	Prosthetic device
5	Suction Machine
6	Commode Chairs
7	Infusion pump
8	Continuous Passive motion devices in case of Knee Replacement
9	Oxygen concentrator

v. For the purpose of this cover, a Prosthetic device means an

- externally applied device used to replace wholly or partly an absent or deficient body part (limited to arm or leg or auditory system)

vi. Exclusion clause number 3.5 (17) Underlying Policy with respect to any of the above listed Durable Medical Equipment shall not be applicable for this benefit.

vii. The payment under this benefit is over and above the Base Sum Insured.

13. Maternity Benefit

13.i Maternity Expenses

By Opting this Cover, we will indemnify the Medical Expenses incurred up to the Maternity Benefit Sum Insured specified in the Policy Schedule for the delivery of the Insured Person's child (including cesarean section) or the Medically Necessary and lawful medical termination of pregnancy during the Policy Period provided that:

(a) The treatment is taken as an In-patient in a Hospital;

(b) Waiting period as mentioned on the Policy Schedule which would apply from the date of inception & continuous cover of this benefit

Further,

(a) We shall not be liable to pay for more than 2 events of deliveries across all Policy Periods with Us;

(b) We will cover pre-natal and post-natal expenses up to the amount specified in the Policy Schedule for this Benefit provided that We have accepted a Claim for delivery/termination under this Benefit;

(c) Ectopic pregnancy shall not be covered under this Benefit, but any Claims will be considered under In-patient Treatment;

(d) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

(e) The payment under this benefit is over and above the Base Sum Insured.

(f) In case of Portability or cover opted at renewal, all waiting periods shall apply afresh for any treatment taken outside India

(g) In case of Migration continuity benefit shall be offered provided maternity benefit is opted under expiring policy

(h) This cover is applicable for female Insured with relationship as self / spouse

(i) Cover will available for Beneficiary above 18 years (at the time of claim).

Permanent Exclusion 3.5(15) of the Policy Wordings stands deleted to the extent of this Benefit only.

13.ii New Born Baby Cover

We will indemnify the Medical Expenses incurred on the Hospitalization of the Insured Person's New Born Baby during the Policy Period within the limits of the Maternity Sum Insured subject to the following:

(a) We have accepted a Claim for Maternity Benefit under the Policy.

(b) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

(c) Any pre and post hospitalization expenses for the new born shall not be covered under this benefit.

You can cover the New Born Baby beyond 90 days on payment of requisite premium for the New Born Baby by way of an endorsement or at the next Renewal, whichever is earlier subject to underwriting guidelines of company.

13.iii Vaccination Expenses

We will cover the Vaccination Expenses incurred on the Insured Person's Baby during the Policy Period up to the limit specified in the Policy Schedule subject to the following:

(a) We have accepted a Claim for Maternity Benefit under the Policy.

(b) The Insured Person whose maternity claim has been accepted by Us continues to renew the Policy with Us subsequently.

Further,

(a) The expenses will be covered from the birth till the Baby completes two years.

(b) Reimbursement claims for vaccination expenses can be submitted once during a Policy Year.

(c) The payment under this benefit is over and above the Base Sum Insured.

Permanent Exclusion 3.5 (22) of the Policy Wordings stands deleted to the extent of this Benefit only

14. Critical Illness Cover

If the Insured Person is first diagnosed to be suffering from any of the following Critical Illnesses during the Policy Period, We will pay sum insured upto the limit specified in the Policy Schedule for this Cover, subject to the following:

(a) On payment of additional premium, cover would be provided to each individual for the Policy Period.

(b) We shall not be liable to accept any Claim under this Cover if it pertains to any Critical Illness diagnosed within 90 days of the commencement of the first Policy Period of this Cover with Us;

(c) We shall not be liable in case any of the Critical Illnesses is a consequence of or arises out of any Pre-Existing Condition(s)/Disease.

(d) We shall not be liable to make payment under this Cover for more than once in respect of any Insured Person across all Policy Periods;

Further,

(a) This cover is applicable on an individual basis irrespective of type of policy (Individual/ Floater) and available for Insured Persons aged 18 years or above.

(b) The payment under this benefit is over and above the Base Sum Insured upto limit specified in Policy Schedule and will not impact the Base Sum Insured or the Cumulative Bonus (if any).

(c) Once a Claim has been accepted and paid for any of the listed Critical Illness, this benefit shall cease in respect of that Insured Person, but shall continue to be in force for other Insured Persons.

(d) Notwithstanding any provision to the contrary in the Policy, this Cover will be applicable on a worldwide basis;

(e) In the event of a Claim arising under this Cover, We shall be given written notice of the Claim within 30 days from the date of the first diagnosis of the Critical Illness and We shall be provided the following information and documentation:

(i) The Claim documents stated in the Policy, provided that We will accept duly certified copies of the listed documents if the originals are required to be submitted to any other insurance company;

(ii) Written confirmation of the diagnosis of the Critical Illness from the treating Medical Practitioner;

"Critical Illness" for the purpose of this Cover is as mentioned below:

- First diagnosis of the below-mentioned Illnesses more specifically described below

1. Cancer of specified severity
2. Kidney failure requiring regular dialysis;
3. Multiple Sclerosis with persisting symptoms;
4. Motor Neurone Disease with Permanent Symptoms
5. Benign Brain Tumor
6. Primary Pulmonary Hypertension
7. End Stage Liver Failure

- Undergoing for the first time of the following surgical procedures, more specifically described below:

1. Major Organ / Bone Marrow Transplant;
2. Open heart replacement or repair of heart valves
3. Open chest CABG
4. Aorta Graft Surgery

- Occurrence for the first time of the following medical events more specifically described below:

1. Coma of Specified Severity
2. Stroke resulting in permanent symptoms;
3. Permanent Paralysis of Limbs;
4. First Heart Attack of specified severity.

5. Third Degree (or Major) Burns
6. Deafness
7. Loss of Speech

The Critical Illnesses and the conditions applicable to the same are more particularly described in Annexure III.

15. Personal Accident Cover

We will pay Sum Insured upto the limit specified in the Policy Schedule for this Cover, subject to the following:

(a) On payment of additional premium, cover would be provided to each individual for the Policy Period.

(b) We shall not be liable to make payment under this Cover for more than once in respect of any Insured Person across all Policy Periods;

Further,

(a) This cover is applicable on an individual basis irrespective of type of policy (Individual/ Floater)

(b) The payment under this benefit is over and above the Base Sum Insured upto limit specified in Policy Schedule and will not impact the Base Sum Insured or the Cumulative Bonus (if any).

(c) Notwithstanding any provision to the contrary in the Policy, this Cover will be applicable on a worldwide basis;

- **Accidental Death**

We will pay the Sum Insured upto the limit specified in the Policy Schedule if the Insured Person dies solely and directly due to an Injury sustained in an Accident which occurs during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of that Accident.

Once a Claim has been accepted and paid under this Benefit then this Policy will automatically terminate in respect of that Insured Person only.

- **Permanent Total Disablement (PTD)**

We will pay the Sum Insured upto the limit specified in the Policy Schedule if the Insured Person suffers Permanent Total Disablement of the nature specified below solely and directly due to an Accident which occurs during the Policy Period provided that the Permanent Total Disablement occurs within 12 months from the date of that Accident:

(i) Loss of Use of both eyes, or Physical Separation/ Loss of Use of two entire hands or two entire feet, or one entire hand and one entire foot, or of such Loss of Use of one eye and such Physical Separation/ Loss of Use of one entire hand or one entire foot.

(ii) Physical Separation/ Loss of Use of two hands or two feet, or of one hand and one foot, or of Loss of Use of one eye and Loss of Use of one hand or one foot.

(iii) If such Injury shall as a direct consequence thereof, permanently, and totally, disable the Insured Person from engaging in any employment or occupation of any description whatsoever.

Once a Claim has been accepted and paid under this Benefit then the Personal Accident Cover will automatically terminate in respect of that Insured Person only.

16. Pre-existing Diseases Waiting Period Modification

In case this Cover is opted for, the applicable Pre-existing Diseases waiting period of 36 months shall be modified to specific time period as mentioned in the Policy Schedule.

This option is available only at the time of first purchase (at the inception) of Policy.

Cover once opted cannot be withdrawn from the Policy.

17. Specified disease/ procedure Waiting Period Modification

In case this Cover is opted for, the applicable Specified disease/ procedure waiting period of 24 months shall be modified to 12 months.

This option is available only at the time of first purchase (at the inception) of Policy

Cover once opted cannot be withdrawn from the Policy.

18. Smart Select

In case, this Cover is opted, the policyholder is entitled for a discount subject to following conditions.

(a) If the Insured Person takes the Medical Treatment in hospitals other than those listed in Annexure IV to the Policy wordings (please refer to website – www.zurichkotak.com for the updated list of Hospitals), then the Policyholder/Insured Person shall bear a co-payment of 20% on each and every Claim arising in such regard which will be in addition to any other co-payment (if any) applicable in the policy.

(b) However, no such additional co-payment shall be applicable if treatment is availed in the hospitals listed in Annexure IV to the policy terms and conditions.

Smart Select will not be applicable for Global Cover.

19. Cap on Room Rent

If We have accepted a Claim for In-patient Hospitalization under the Policy and if the Insured Person incurs Room Rent that is higher than the eligible Room Rent as specified in the Policy Schedule then We will be liable to pay only a rateable proportion of the Associated Medical Expenses incurred in the proportion of the difference between the eligible Room Rent and the Room Rent actually incurred, provided that Reasonable and Customary costs incurred on medicines/pharmacy, medical consumables, medical implants and diagnostic costs will be reimbursed based on the actual amounts incurred.

Proportionate deductions will not be 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. Further, proportionate deductions will not be applied in respect of ICU Charges.

In case this Cover is not opted for, Insured will get the eligible Room Rent and Associated Medical Expenses subject to Base Sum Insured including Cumulative Bonus and Restoration Benefit, if applicable.

Under this Cover, the Insured is entitled for a discount in the premium on opting for Cap on Room Rent.

This Cover is only applicable only for Silver plan for 5 lacs Base Sum Insured

20. Room Category Modification

Notwithstanding anything to the contrary in the Policy, if this Optional Benefit is opted, the Company agrees to modify the Room Rent / Room Category to Single Private AC Room / Shared Room as specified in Policy schedule.

If the Insured Person is admitted in a Hospital room where the Room Category opted or Room Rent incurred is higher than the eligible Room Category/ Room Rent as specified in the Policy Schedule, then We will be liable to pay only a ratable proportion of the Associated Medical Expenses (including applicable surcharge and taxes thereon) in the proportion of the difference between the Room Rent actually incurred and the Room Rent specified in the Policy Schedule or the Room Rent of the entitled Room Category to the Room Rent actually incurred.

20.i Shared Room Cover

In case, this Cover is opted, We will restrict the Room category coverage up to 'Shared Room' subject to maximum of Total Sum Insured under the Policy.

Under this Cover, the Insured is entitled for a discount in the premium on opting for Cap on Room Rent.

The "Room Rent Conditions" as mentioned under I.A Hospitalization Expenses will be applicable to this cover.

Payment under Shared Accommodation Benefit will not applicable in case this Cover is opted for.

20.ii Single Private Room Cover

In case, this Cover is opted, We will restrict the Room category coverage up to 'Single Private AC Room' subject to maximum of Total Sum Insured under the Policy.

Under this Cover, the Insured is entitled for a discount in the premium on opting for Cap on Room Rent.

The "Room Rent Conditions" as mentioned under I.A Hospitalization Expenses will be applicable to this cover.

Note:

- The nomenclature of Room 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.

- Further, proportionate deductions will not be applied in respect of ICU Charges.

21. Deductible

You can opt for a Deductible in the Policy which will be specified in the Policy Schedule. Wherever a Deductible is selected such amount will be applied for each Policy Year on the aggregate of all Claims in that Policy Year.

Deductible is applicable on the Benefits namely Hospitalization Expenses, Road Ambulance Cover, Consumables Cover, Double Cover and Air Ambulance Cover.

For the purpose of calculating the deductible and assessment of admissibility all claims must be submitted in accordance with Section 5 Claims Procedure.

All other terms, conditions, waiting periods and exclusions shall apply.

Deductible once opted can be Changed / withdrawn only at renewal subject to Underwriting.

Illustration for applicability of Deductible in the same Policy Year:

Sr No	Sum Insured	Deductible Opted	Claim Amount	Deductible Exhaustion	Balance Deductible	Claim Payable
At Inception	1000000	200000	0	0	0	0
Claim 1	1000000		150000	150000	50000	0
Claim 2	1000000		200000	150000+ 50000	0	150000
Claim 3	1000000		500000	200000	0	500000

22. Voluntary Co-pay

If this Optional Benefit is opted, then the Insured Person will have an option to bear a Co-payment, as specified in the Policy Schedule, and the Company's liability shall be restricted to the balance amount payable.

The Co-payment proportion (If opted) shall be borne by the Insured Person on each Claim which will be applicable on the Benefits namely Hospitalization Expenses, Consumable cover , Home Care Treatment , Global Cover, Compassionate Visit & Essential Equipment.

The Co-payment shall be applicable to each claim for each Insured member as defined in the Policy

Co-pay once opted can be Changed / withdrawn only at renewal subject to Underwriting

3. WHAT WE WILL NOT PAY (EXCLUSIONS APPLICABLE UNDER THE POLICY)

We shall not be liable to make any payment under this Policy directly or indirectly for/ caused by/ based upon/ arising out of or howsoever attributable to any of the exclusions listed below. All waiting periods will apply individually to each Insured Person:

3.1 Pre-Existing Diseases (Code – Excl01)

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

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

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

d) Coverage under the policy after the expiry of 36 months (or as mentioned in the Policy Schedule) for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

3.2 30 Day Waiting Period (Code – Excl03)

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

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

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

3.3 Specified disease/ procedure waiting period (Code – Excl02)

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months (or as mentioned in the Policy Schedule) 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

1. Any treatment related to Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism, Spinal Disorders, Joint Replacement Surgery, Arthroscopic Knee Surgeries/ACL Reconstruction/Meniscal and Ligament Repair
2. Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal
3. Septum Deviation, Sinusitis and related disorders
4. Benign Prostatic Hypertrophy
5. Cataract
6. Dilatation and Curettage
7. Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers
8. Surgery of Genito-urinary system unless necessitated by malignancy
9. All types of Hernia & Hydrocele
10. Hysterectomy for menorrhagia or Fibromyoma or prolapse of uterus unless necessitated by malignancy
11. Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant
12. Kidney Stone / Ureteric Stone /Lithotripsy / Gall Bladder Stone
13. Myomectomy for fibroids
14. Varicose veins and varicose Ulcers
15. Parkinson's or Alzheimer's disease or Dementia

3.4 Maternity Benefit Waiting Period

Any treatment arising from or traceable to pregnancy, childbirth including caesarean section will not be covered until 24 months of continuous coverage has elapsed for that particular Insured Person since the inception of the Maternity Expenses Benefit under the Policy for that Insured Person.

3.5 Permanent Exclusions

We will not be liable under any circumstances, for any Claim in connection with or with regard to any of the following permanent exclusions as specified below:

1. Investigation & Evaluation (Code- Excl04)

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

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

2. Rest Cure, rehabilitation and respite care (Code – 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.

3. 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

4. Change-of- Gender treatments (Code – Excl07)

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

5. Cosmetic or plastic Surgery (Code – Excl08)

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

6. Hazardous or Adventure sports: (Code- Excl09)

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

7. Breach of law (Code – Excl10)

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

8. Excluded Providers: (Code- Excl11)

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

9. Code- Excl12

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof

10. Code- Excl13

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

11. Code- Excl14

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.

12. Refractive Error (Code- Excl15)

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

13. Unproven Treatments (Code – Excl16)

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

14. Sterility and Infertility (Code- Excl17)

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization

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

iii. Gestational Surrogacy

iv. Reversal of sterilization

15. Maternity (Code- Excl18)

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

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

16. Costs of routine medical, eye or ear examinations preventive health check-ups, spectacles, laser surgery for correction of refractory errors, contact lenses, hearing aids, dentures or artificial teeth;

17. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively;

18. Any expenses incurred on personal comfort, erectile dysfunction, cosmetics, convenience and hygiene related items and services, medical supplies including elastic stockings, diabetic test strips, and similar products.

19. Expenses incurred on all dental treatment unless necessitated due to an Accident and treatment is taken in in-patient department of hospital or day care centre;

20. Non-Allopathic Treatment (other than AYUSH), Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or treatment related to any unrecognized systems of Medicine

21. Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident;

22. All preventive care (except eligible and entitled for Benefit: 'Annual Health Check-up'), Vaccination including Inoculation and Immunizations (except in case of post-bite treatment) and tonics

23. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)

24. Screening, counseling or treatment of any external Congenital Anomaly, Illness or defects or anomalies or treatment relating to external birth defects.

25. Any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition;

26. Costs incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose;

27. Any treatment taken outside India unless specifically opted for

28. Any treatment taken from anyone not falling within the scope of definition of Medical Practitioner. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council;

29. Any consequential or indirect loss arising out of or related to Hospitalization;

30. Any Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or

under the order of any government or public local authority;

31. Any Illness or Injury directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel;

32. All non-medical expenses other than listed in Annexure II (List I) of the Policy.

33. Any OPD treatment

34. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.

35. Treatment such as External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), and Hyperbaric Oxygen Therapy will not be covered unless it forms a part of In-Patient Treatment in case of hospitalisation or part of discharge advice upto the Post hospitalisation period as specified in the Policy Schedule.

36. Hormone replacement therapy.

37. Alopecia wigs and/or toupee and all hair or hair fall treatment and products.

38. Any physical, medical condition or treatment that is specifically excluded in the Policy Schedule under Important Conditions

4. CLAIM ADMINISTRATION

The fulfillment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the following in relation to claims, shall be Condition Precedent to admission of Our liability under this Policy:

a. On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed;

b. If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the facts surrounding the Claim. Such medical examination will be carried out only in case of reimbursement claims with prior consent of the Insured Person;

c. We/Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of such Claim;

d. If the Insured Person suffers a relapse within 45 days of the date of discharge from Hospital for a Claim that has been made, then such relapse shall be deemed to be part of the same Claim and all limits for Any One Illness under this Policy shall be applied as if they were part of a single claim.

5. CLAIMS PROCEDURE

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

5.1 For Cashless Facility

Cashless Facility will be available at a Network Provider of the Company. The complete list of Providers is available on Our website (The list is updated as and when there is any change in the Network Provider) or can be obtained from Our call centre. In order to avail of Cashless Facility, the following procedure shall be followed:

(a) Pre-authorization for Planned Hospitalization:

At least 48 hours prior to a planned Hospitalization, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that planned Hospitalisation. Each such request must be accompanied by all the following details:

(i) Pre-authorization form available at the hospital helpdesk to be duly filled in and signed by Insured and treating doctor

(ii) Copy of the Health Card We have issued to the Insured Person;

(iii) Proposed date of Admission.

(iv) Medical papers viz. All prescriptions, medical investigation reports etc.

(v) Photo ID

(vi) Address proof, and photo to comply with KYC norms

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/Our TPA will request additional information or documentation in respect of that request.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.

Turn Around Time (TAT) for issue of Pre-Authorization within 1 hours from receipt of complete documents for initial and within 3 hours from receipt of complete documents for final approval at the time of discharge.

In Case of Claim Contact Us at:

24x7 Toll Free number: 1800 266 4545 or may write an e- mail at care@zurichkotak.com

In the event of claims, please send the relevant documents to:

Family Health Plan (TPA) Ltd,

Srinilaya – Cyber Spazio

Suite # 101,102,109 & 110, Ground Floor,

Road No. 2, Banjara Hills,

Hyderabad, 500 034.

(b) Pre-authorization for Emergency Care:

If the Insured Person has been admitted into Hospital for Emergency Care, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that Emergency Care within 24 hours of commencement of Hospitalisation. Each such request must be accompanied by all the following details:

(i) Pre-authorization form available at the hospital helpdesk to be duly filled in and signed by Insured and treating doctor

(ii) Copy of the Health Card We have issued to the Insured Person;

(iii) Medical papers viz. All prescriptions, medical investigation reports etc.

(iv) Photo ID

(v) Address proof, and photo to comply with KYC norms

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/ Our TPA will request additional information or documentation in respect of that request with the provider.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection. In circumstances where We/Our TPA refuse the request for pre-authorisation as there is insufficient Base Sum Insured or there is insufficient information to determine the admissibility of the request for pre-authorisation, a claim for reimbursement may be submitted to Us in accordance with the procedure set out below and We will consider the Claim in accordance with the policy terms, conditions and exclusions.

We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities in Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers on Our website or by calling Our call centre.

5.2 For Reimbursement Claims

We shall be given written notice of the Claim for reimbursement along with the following details at least within 30 days of the Insured Person's discharge from Hospital:

(i) The Policy Number;

(ii) Name of the Policyholder;

(iii) Name and address of the Insured Person in respect of whom the request is being made;

(iv) Nature of Illness or Injury and the treatment/surgery taken;

(v) Name and address of the attending Medical Practitioner;

(vi) Hospital where treatment/surgery was taken;

(vii) Date of Admission and date of discharge;

(viii) Approximate claim amount (if available)

(ix) Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

If the Claim is not notified to Us within 30 days of the Insured Person's discharge from Hospital, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

Turn Around Time (TAT) for settlement of Reimbursement is within 15 days from the date of receipt of claim along with claim form (and necessary documents).

6. CLAIM DOCUMENTS

We shall be provided the following necessary information and documentation in respect of all Claims within 30 days of the Insured Person's discharge from Hospital. For Claims under which the use of Cashless Facility has been approved, We will be provided with these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:

(a) Duly completed Claim form signed by You and the Medical Practitioner (only for reimbursement claims);

(b) Hospital discharge summary;

(c) First consultation and follow up treatment papers;

(d) Original bills and receipts from the Hospital/Medical Practitioner;

(e) Original bills from chemists supported by proper prescription;

(f) Original investigation test reports (including CT/MR/USG/ECG, as applicable) and payment receipts;

(g) Indoor case papers, if available;

(h) Implant Invoice/ Sticker, if available;

(i) Ambulance Invoice, if applicable;

(j) FIR (if done) or MLC (if conducted) for Accident cases ;

(k) Post mortem report (if conducted);

(l) KYC documents viz. Photo ID and address proof along with duly completed form.

(m) Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

For claims under which cashless facility has been approved, following documents will be provided by the Network hospital along with the above:

(n) Original Pre – authorization request

(o) Copy of Pre – authorization approval letter

(p) Copy of the photo identity document of the Insured Person;

(q) KYC documents obtained at the time of cashless facility.

- **Additional Documents for Personal Accident Cover:**

Accidental Death

(a) Original Death certificate issued by the office of Registrar of Birth & Deaths;

(b) Death summary issued by a Hospital, if applicable;

Permanent Total Disablement (PTD) resulting from Accident

(a) Original treating Medical Practitioner's certificate describing the disablement;

(b) Photograph of the Insured Person reflecting the disablement;

(c) Prescriptions and consultation papers of the treatment;

(d) Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable

- **Critical Illness Claim Documents**

a. Common list of documents for all Critical Illness:

1) Duly completed claim form;

2) Certificate from the attending Medical Practitioner of the Insured Person confirming, inter alia,

i. Name of the Insured Person;

ii. Name, date of occurrence and medical details confirming the event giving rise to the Claim.

iii. Written confirmation from the treating Medical Practitioner that the event giving rise to the Claim does not relate to any Pre-Existing Disease or any Illness or Injury which was diagnosed within the first 90 days of commencement of first Policy Period with Us.

3) Original Policy document;

4) Original Discharge Certificate/Death Summary/Card from the hospital/ Medical Practitioner;

5) Original investigation test reports, indoor case papers;

6) In the cases where Critical Illness arises due to an Accident, FIR copy or medico legal certificate (if done/conducted) will also be required wherever conducted. We may call for any additional necessary documents/information as required based on the circumstances of the claim.

7) Any other documents as may be required by Us.

If the Claim is not notified to Us within the time period specified above, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

b. Specific Documentation Required for each of the Critical Illnesses Please note that the following are illustrative lists and we may seek additional documentation based on the facts and circumstances of the Claim and if done/conducted/available

1) CANCER OF SPECIFIED SEVERITY

i. Hospital Discharge Card photocopy

ii. Hospital Bills photocopy

iii. Pharmacy/Investigations Bills

iv. Investigations Report

v. Details of the treatment received by the Insured Person from the inception of the ailment.

vi. Letter from treating consultant stating presenting complaints with duration and the past medical history.

vii. Histopathology / Cytology / FNAC / Biopsy / Immuno-histochemistry reports.

viii. X-Ray / CT scan / MRI scan / USG / Radioisotope / Bone scan Reports.

ix. Blood Tests.

x. Any other specific investigation done to support the diagnosis like the PAP Smear/ Mammography, etc.

xi. Any other documents as may be required by Us.

2) KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

i. Hospital Discharge Card photocopy

ii. Photocopy Hospital Bills.

iii. Pharmacy/Investigations Bills

iv. Investigations Reports

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.

vi. Blood Tests- Renal Function Tests specifically: Serum Creatinine, Blood Urea Nitrogen, Serum Electrolytes done in the recent past (Not more than Two Week period from the date of intimation of Loss)

vii. Dialysis Papers/Receipts done in recent past.

viii. Renal scan

ix. Letter from the nephrologists stating the diagnosis of End Stage Kidney Failure.

x. Any other documents as may be required by Us.

3) MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

i. Hospital Discharge Card photocopy

ii. Photocopy Hospital Bills.

iii. Pharmacy/Investigations Bills

iv. Investigations Reports

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.

vi. MRI / CT Scan Report.

vii. Electro-myogram report

viii Biopsy / Cytology Report

ix. Specific Blood Tests: Creatinine Phosphokinase /Anti-nuclear antibodies, C- reactive protein /autoimmune work up

x. Any other relevant Blood investigations.

xi. Confirmation from the Central/State Government Hospital about diagnosis of Multiple Sclerosis and the duration of the same.

xii. Any other documents as may be required by Us.

4) MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS

i. Hospital Discharge Card photocopy (in case of Hospitalization)

ii. Investigations Reports like Blood tests, EEG, Nerve Conduction test, etc

iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment

iv. Electro-myogram Report

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.

vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit and the degree/current status

vii. Any other document as may be required by the company

5) BENIGN BRAIN TUMOR

i. Hospital Discharge Card photocopy

ii. Hospital Bills photocopy

iii. Pharmacy/Investigations Bills

iv. Investigations Reports

v. Details of the treatment received by the Insured Person from the inception of the ailment.

vi. Letter from treating consultant stating presenting complaints with duration and the past medical history.

vii. Histopathology / Cytology / FNAC / Biopsy / Immuno-histochemistry reports.

viii. X-Ray / CT scan / MRI scan / USG / Radioisotope / Bone scan Reports.

ix. Blood Tests.

x. Neurological examination report by Neurologist

xi. Any other documents as may be required by Us.

6) PRIMARY PULMONARY HYPERTENSION

i. Hospital Discharge Card photocopy

ii. Photocopy Hospital Bills.

iii. Pharmacy/Investigations Bills

iv. Investigations Reports

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.

vi. MRI / CT Scan Report.

vii. Echocardiography report

viii. Computed tomography (CT), magnetic resonance imaging (MRI), and lung scanning

ix. Pulmonary angiography

x. Any other documents as may be required by Us.

7) END STAGE LIVER DISEASE / FAILURE

i. Hospital Discharge Card photocopy

ii. Photocopy Hospital Bills.

iii. Pharmacy/Investigations Bills

iv. Investigations Reports

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.

vi. Ultrasound scan of liver

vii. CT and/or MRI scan of the liver

viii. X-ray and Liver function test

ix. Biopsy / FNAC (where applicable)

x. Any other documents as may be required by Us.

8) MAJOR ORGAN /BONE MARROW TRANSPLANT

i. Hospital Discharge Card photocopy

ii. Photocopy Hospital Bills.

iii. Pharmacy/Investigations Bills

iv. Investigations Reports

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.

vi. Scan / Histopathology / Cytology / FNAC / Biopsy report suggesting irreversible & non-compensatory changes of the particular organ. 8 Bone Marrow Biopsy Reports (Specifically In Case of Bone Marrow Transplant)

vii. Letter from a specialist Doctor confirming the need of transplantation (Organs Specified are: Heart, lung, Liver, pancreas, kidney, bone marrow)

viii. Any other documents as may be required by Us.

9) OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

i. Hospital Discharge Card photocopy

ii. Photocopy Hospital Bills.

iii. Pharmacy/Investigations Bills

iv. Investigations Reports

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.

vi. X-ray and 2D-Echocardiography Report.

vii. Letter from the Cardiologist / Cardiothoracic Surgeon suggesting valve replacement with the type of valve to be used.

viii. Any other documents as may be required by Us.

10) OPEN CHEST CABG

i. Photocopy Hospital Discharge Card

ii. Photocopy Hospital Bills.

iii. Pharmacy/Investigations Bills

iv. Investigations Reports

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.

vi. ECG at the time of detection of Coronary Artery Disease and Subsequent ECG's

vii. Stress test/ Tread Mill Test

viii. Letter from treating consultant suggesting Coronary Angiography and CABG

ix. Coronary Angiography report / CT Angiography Report

x. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT,

xi. LDH / Electrolytes

xii. X-ray / 2D-Echocardiography Report

xiii. Thallium Scan Report

xiv. Any other documents as may be required by Us.

11) AORTA GRAFT SURGERY

i. Photocopy Hospital Discharge Card

ii. Photocopy Hospital Bills.

iii. Pharmacy/Investigations Bills

iv. Investigations Reports

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.

vi. ECG at the time of detection of Coronary Artery Disease and Subsequent ECG's

vii. Stress test/ Tread Mill Test

viii. Letter from treating consultant suggesting Coronary Angiography and CABG

ix. Coronary Angiography report / CT Scan

x. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT,

xi. LDH / Electrolytes

xii. X-ray / 2D-Echocardiography Report

xiii. Thallium Scan Report

xiv. Bio-markers for Aortic dissection

xv. Any other documents as may be required by Us.

12) COMA OF SPECIFIED SEVERITY

i. Hospital Discharge Card photocopy

ii. Investigations Reports like Blood tests, EEG, etc

iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment

iv. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Glasgow coma scale grading.

v. Indoor case papers and / or ICU case papers indicating the history, signs, symptoms, line of treatment and daily charts like TPR, etc

vi. FIR / MLC / Panch nama for accident induced coma

vii. Any other document as may be required by the company

13) STROKE RESULTING IN PERMANENT SYMPTOMS

i. Hospital Discharge Card photocopy

ii. Photocopy Hospital Bills.

iii. Pharmacy/Investigations Bills

iv. Investigations Reports

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.

vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit.

vii. MRI / CT scan/ 2D Echocardiography Reports or any other Imaging technique Used during the diagnosis and treatment of the Stroke

viii. Blood tests (Lipid profile/Random Blood Sugar / Prothrombin Time/APTT/ Bleeding Time/ Clotting Time/Homocystiene levels)

ix. Any other documents as may be required by Us.

14) PERMANENT PARALYSIS OF LIMBS

i. Hospital Discharge Card photocopy

ii. Investigations Reports

iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment of the Stroke

iv. Electro-myogram Report

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.

vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit and the degree/current status and duration of the Paralysis.

vii. Any other document as may be required by the company

15) FIRST HEART ATTACK - OF SPECIFIED SEVERITY

i. Hospital Discharge Card photocopy

ii. Photocopy Hospital Bills.

iii. Pharmacy/Investigations Bills

iv. Investigations Reports

v. Casualty Medical Officers/Emergency room papers with all details of Presenting Complaints and the Medical Examination by the attending physician.

vi. Subsequent Consultation Papers with the treating Medical Practitioner and the treatment received

vii. ECG on admission and subsequent ECG's

viii. Stress test/ Tread Mill Test

ix. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT, LDH / Electrolytes

x. X-ray / 2D-Echocardiography Report

xi. Thallium Scan Report

xii. Any other documents as may be required by Us.

16) THIRD DEGREE (OR MAJOR) BURNS

i. Hospital Discharge Card photocopy

ii. Photocopy Hospital Bills.

iii. Pharmacy/Investigations Bills

iv. Investigations Reports, treatment papers

v. Certificate from the treating specialist Doctor indicating the classification / degree of burns

vi. Following medico-legal documents if applicable

(i) FIR

(ii) Panchanama

(iii) Inquest Panchanama

(iv) Police Final Report/Charge Sheet (Based on FIR)

vii. Any other documents as may be required by Us.

17) DEAFNESS OR LOSS OF HEARING

i. Hospital Discharge Card photocopy

ii. Photocopy Hospital Bills.

iii. Pharmacy/Investigations Bills

iv. Investigations Reports

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.

vi. Pure tone testing report

vii. Audiometry report

viii. Confirmation of Diagnosis by ENT specialist along with duration

ix. All treatment papers and medical investigation test reports

x. Any other documents as may be required by Us.

18) LOSS OF SPEECH

i. Hospital Discharge Card photocopy

ii. Photocopy Hospital Bills.

iii. Pharmacy/Investigations Bills

iv. Investigations Reports

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.

vi. Confirmation of Diagnosis by ENT specialist along with cause and duration

vii. All treatment papers and medical investigation test reports

Any other documents as may be required by Us.

- **Claims For Pre-Hospitalisation Medical Expenses And Post-Hospitalisation Medical Expenses**

a. All Claims for Pre-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the Insured Person's discharge from Hospital along with the following information and documentation:

(i) Duly Completed Claim Form

(ii) Investigation Payment Receipt

(iii) Original Investigation Report

(iv) Original Pharmacy Bills

(v) Original Pharmacy Prescription

(vi) Copy of Discharge Summary

b. All Claims for Post-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the completion of post hospitalisation period as mentioned in your plan. You need to send Medical Expenses being incurred along with the following information and documentation:

(i) Duly Completed Claim Form

(ii) Original bills and receipts from the Hospital/Medical Practitioner;

(iii) Investigation Payment Receipt

(iv) Original Investigation Report

(v) Original Pharmacy Bills

(vi) Original Pharmacy Prescription

(vii) Copy of Discharge Summary

PART III

General Terms and Clauses

1. Disclosure of Information

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

2. Condition Precedent to Admission of Liability

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

3. 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.

4. 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. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

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.

5. 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.

6. 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 thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

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

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

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

7. Cancellation

a. The Policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Insurer shall –

1. For 1 year Policy-

Refund proportionate premium for unexpired policy period subject to no claim(s) were made during the policy period.

2. For Multi Year Policy -

- For any policy year where the risk date has not yet started, the premium will be refunded without any deduction.
- For any policy year where the risk has started, the premium will be refunded on a pro-rata basis for that policy year, provided no claim has been made during the policy year and in full for future policy years.

Additional Deductions - Notwithstanding the above, if (i) the risk under the Policy has already commenced, or (ii) only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then expenses incurred by the Company on medical examination of the Policyholder will also be deducted before refunding of premium.

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

8. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability.

If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

9. Migration

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

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 atleast 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. 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.

12. Premium Payment in Instalments

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

i. Grace Period of 15 days (where premium is paid on monthly instalments) and 30 days (where premium paid in quarterly / half yearly/ annual instalments) would be given to pay the instalment premium due for the policy.

ii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also

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 If the instalment premium is not paid on due date.

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

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

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

13. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

14. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) under the policy no look back to be applied. This period of sixty months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 60 continuous months would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable on grounds of non-disclosure, misrepresentation, except on grounds of established fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

15. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the

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

16. Redressal of Grievance

In case of any grievance the insured person may contact the company through

Website: www.zurichkotak.com

Toll free: 18002664545

E-mail: care@zurichkotak.com

Courier: Zurich Kotak General Insurance Company (India) Limited, 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai- 400063. Maharashtra, India.

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 grievanceofficer@zurichkotak.com

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

https://www.zurichkotak.com/customer-support/grievance-redressal-process

For senior citizens, please contact the respective branch office of the Company or call at 18002664545 or may write an e- mail at seniorcitizen@zurichkotak.com

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.

The details of the Insurance Ombudsman is available at:

https://www.zurichkotak.com/customer-support/grievance-redressal-process

The updated details of Insurance Ombudsman offices are also available on the website of Council for Insurance Ombudsmen: www.cioins.co.in/ombudsman

The details of the Insurance Ombudsman is available at Annexure I

Grievance may also be lodged through the Bima Bharosa Portal – https://bimabharosa.irdai.gov.in

17. Claim Settlement (Provision for Penal Interest)

I. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of claim along with claim form (and necessary documents)

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 (RBI) at the beginning of the financial year in which claim has fallen due)

18. Eligibility

Family Floater policy - A family floater policy can cover a maximum of 2 adults and 3 dependent children under a single policy

Relationships covered -

i) Self,

ii) Spouse / Partner,

iii) Your natural or adopted dependent children

iv) Dependent Parents

v) Dependent Parents in law

Individual Policy - Self, Spouse / Partner, Your natural or adopted dependent children, Your parents, Your parents-in-law, Your siblings, Uncle, Aunt, Brother in Law, Sister in Law, Grandparents, Grandchild(ren).

Natural/ Appointed Guardian can also take insurance for minor under their guardianship.

In case of multiple Insured Person(s) covered under a Policy, the covers mentioned in Part II are applicable to all the Insured Person(s) in accordance with the premium paid and Plan opted unless specifically excluded as per the terms and conditions of the respective Cover.

19. Material Change

Material information to be disclosed to Us includes every matter that You are aware of or could reasonably be expected to know that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk and the terms of acceptance of the risk.

20. No constructive Notice

Any knowledge or information of any circumstances or condition in Your connection in possession of any of Our personnel and not specifically informed to Us by You shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

21. Terms and condition of the Policy

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

22. Zone Classification

Zone I - Delhi NCR, Nasik, Gujarat

Zone II - Kolkata, Mumbai, Palghar, Raigarh (MH), Thane, Chennai, Jaipur, Rest of Haryana

Zone III --Rest of India excluding location mentioned under Zone I &Zone II

- Identification of Zone will be based on the city of the Proposer.
- A single Zone shall be applicable to all members covered under the Policy.
- You also have an option of selecting another Zone from the applicable Zones of any of the Insured Person(s) in the Policy.
- Option to select a Zone higher than that of the actual Zone is available on payment of relevant premium at the time of buying the Policy or at the time of Renewal.
- Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalisation due to an Accident.

Co-payment

- Persons paying Zone I premium can avail treatment all over India without any Co-payment.
- Persons paying Zone II premium can avail treatment in Zone II and Zone III without any co-payment
- Persons paying Zone III premium can avail treatment in Zone III only without any co-payment

Co-payment for treatment in a Higher Zone

In case of treatment taken in a city, in a Zone higher than the eligible Zone for the Insured Person, the Co-payment percentages as below shall apply:

Applicable Zone	Treatment Taken at	Co-payment applicable
Zone II	Zone I	10%
Zone III	Zone I	20%
Zone III	Zone II	10%

- In Case Global cover is opted then zone 2 & 3 will not be applicable

23. Underwriting and Loadings

We may apply a risk loading up to a maximum of 200 % per Insured

Person on the premium payable (excluding statutory levies & taxes) based on the declarations made in the proposal form and the health status of the persons proposed for insurance.

Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s). There will be no loadings based on individual claims experience.

In case of loading on 2 or more ailments, the loadings shall apply in conjunction, however maximum risk loading per individual shall not exceed 200% of Premium excluding applicable Taxes.

We will inform You about the applicable risk loading or special condition through a counter offer letter and We will only issue the Policy once We receive your consent on the applicable additional premium.

In case policies are accepted with loadings, waiting period for Pre-Existing Disease Waiting Period (Section 3.1) as well as Specified disease/procedure Waiting Period (Section 3.3) shall continue to be applicable.

Alterations such as increase/ decrease in Base Sum Insured or change in covers or addition/deletion of Insured Persons will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy. Underwriting in relation to acceptance of request for changes will be based mainly as per underwriting policy of the company. The terms and conditions of the existing policy will not be altered. Increase/ Enhancement of Base Sum Insured shall be allowed up to maximum Base Sum Insured available under the Policy.

On Renewal of the Policy if an increased Base Sum Insured is requested then the elapsed period for existing diseases/ illness / injury shall be limited to the Base Sum Insured of the immediately completed Policy Period. Further, the waiting periods will apply afresh in relation to the amount by which the Base Sum Insured has been enhanced.

24. Cause of Action/ Currency for payments

No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Policy. All Claims shall be payable in India and shall be in Indian Rupees only.

25. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed by both You and Us to be adjudicated or interpreted in accordance with Indian law and only competent Courts of India shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

26. Special Provision for Insured Person who are Senior citizen

The premium charged for health Insurance products offered to Senior citizens shall be fair, justified, transparent and duly disclosed upfront. The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of policy.

27. Communications & Notices

Any communication, notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:

In Your case, at Your last known address per Our records in respect of this Policy.

In Our case, at Our address specified in the Policy Schedule.

No insurance agent, broker or any other person is authorised to receive any notice on Our behalf.

28. Customer Service

If at any time You require any clarification or assistance, You may contact Our offices at the address specified in the Policy Schedule, during normal business hours or contact Our call centre.

29. ECS/ Auto Debit Payment Facility:

You are eligible for availing the ECS / Auto Debit payment facility for your premium payments under this Policy. This facility can be opted for automatic premium payment under this Policy for such premium paying term as availed by you under this Policy by submitting a duly signed ECS / Auto Debit mandate form. You may opt for any premium payment term as per your convenience but in accordance with the Policy terms and conditions. Please note that this facility may not be available for all the Banks at present however and you are requested to kindly visit website: www.zurichkotak.com to check the updated list of all partner banks facilitating the ECS /Auto Debit facility from time to time. Additionally, the following conditions shall apply in case of ECS / Auto Debit facility opted by you –

a. The premium payment under the Policy shall be subject to change on renewal which would be in accordance with the terms and conditions of the Policy

b. The Policy shall get cancelled in the event of failure of ECS transaction towards payment of premium under the Policy and/or non-receipt of premium within the Grace Period under the Policy

c. The renewal premium amount under the Policy shall be communicated to you in advance i.e. minimum 45 days before the renewal date

d. You have the right to withdraw the ECS /Auto Debit mandate by giving Us at least 15 days' notice before the due date of next premium due under the Policy

The term ECS / Auto Debit herein shall be governed by the Electronic Clearing Service (Debit) Procedural Guidelines issued by the Reserve Bank of India (as may be amended from time to time) and shall mean an electronic facility for effecting periodic insurance premium payment transactions in an automated manner.

30. Electronic Transactions

You 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 centers, teleservice 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, 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.

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/confirmed by the Insured.

31. Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate in the case of any Insured Person's demise during the policy period/year:

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

32. Utilisation of Sum Insured

The sequence for utilisation of Total Sum Insured in the event of claim will be done as per below order depending on the terms and conditions of the respective Covers:

i. Base Sum Insured

ii. Cumulative Bonus (if any)

iii. Cumulative Bonus Booster (if opted)

iv. Double Cover (if opted)

v. Unlimited Restoration Benefit (Inbuilt)

33. Sanction Exclusion Clause

Notwithstanding any other terms under this agreement, no insurer shall be deemed to provide coverage or will make any payments or provide any service or benefit to any insured or other party to the extent that such cover, payment, service, benefit and/or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

ANNEXURE I

Details of Insurance Ombudsman

Office Details	Jurisdiction of Office Union Territory, District
Ahmedabad: Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
Bengaluru: Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
Bhopal: Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh and Chattisgarh.
Bhubneshwar: Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455; Email: bimalokpal.bhubaneswar@cioins.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, Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
Chennai: Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
Delhi: Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	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@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Hyderabad: Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122, Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
Jaipur: Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.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 Email: bimalokpal.ernakulam@cioins.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 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
Lucknow: Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.

Office Details	Jurisdiction of Office Union Territory, District
Mumbai: Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
Noida: Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253, Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
Patna: Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068, Email: bimalokpal.patna@cioins.co.in	Bihar and 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@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

ANNEXURE II

List I - List of non-medical expenses

Sr. No.	Items	Remarks
1	Baby Food	Not Payable
2	Baby Utilities Charges	Not Payable
3	Beauty Services	Not Payable
4	Belts/ Braces	Payable for cases who have undergone surgery of Thoracic or Lumbar Spine.
5	Buds	Not Payable
6	Cold Pack/Hot Pack	Not Payable
7	Carry Bags	Not Payable
8	Email / Internet Charges	Not Payable
9	Food Charges (other than Patient's Diet Provided by Hospital)	Not Payable
10	Leggings	Payable in case of Bariatric and Varicose Vein Surgery
11	Laundry Charges	Not Payable
12	Mineral Water	Not Payable
13	Sanitary Pad	Not Payable
14	Telephone Charges	Not Payable
15	Guest Services	Not Payable
16	Crepe Bandage	Not Payable
17	Diaper Of Any Type	Not Payable
18	Eyelet Collar	Not Payable
19	Slings	Not Payable
20	Blood Grouping and Cross Matching of Donors Samples	Not Payable
21	Service Charges Where Nursing Charge Also Charged	Post Hospitalization Nursing Charges Not Payable
22	Television Charges	Not Payable
23	Surcharges	Not Payable
24	Attendant Charges	Not Payable
25	Extra Diet Of Patient (Other Than That Which Forms Part Of Bed Charge)	Not Payable
26	Birth Certificate	Not Payable
27	Certificate Charges	Not Payable
28	Courier Charges	Not Payable
29	Conveyance Charges	Not Payable
30	Medical Certificate	Not Payable
31	Medical Records	Not Payable
32	Photocopies Charges	Not Payable
33	Mortuary Charges	Payable Up to 24 Hrs, Shifting Charges Not Payable
34	Walking Aids Charges	Not Payable
35	Oxygen Cylinder (For Usage Outside The Hospital)	Not Payable
36	Spacer	Not Payable
37	Spirometre	Not Payable
38	Nebulizer Kit	Not Payable
39	Steam Inhaler	Not Payable
40	Armsling	Not Payable
41	Thermometer	Not Payable
42	Cervical Collar	Not Payable
43	Splint	Not Payable
44	Diabetic Foot Wear	Not Payable
45	Knee Braces (Long/ Short/ Hinged)	Not Payable
46	Knee Immobilizer/ Shoulder Immobilizer	Not Payable
47	Lumbo Sacral Belt	Payable for cases who have undergone Surgery of Lumbar Spine
48	Nimbus Bed Or Water Or Air Bed Charges	Not Payable
49	Ambulance Collar	Not Payable
50	Ambulance Equipment	Not Payable
51	Abdominal Binder	Payable in case of post-surgery patients of Major Abdominal Surgery Including TAH, LSCS, Incisional Hernia Repair, Exploratory Laparotomy for Intestinal Obstruction, Liver Transplant Etc
52	Private Nurses Charges- Special Nursing Charges	Not Payable
53	Sugar Free Tablets	Not Payable

Sr. No.	Items	Remarks
54	Creams Powders Lotions (Toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)	Not Payable
55	ECG Electrodes	Not Payable
56	Gloves	Sterilized Gloves Payable / Unsterilized Gloves not payable
57	Nebulisation Kit	Not Payable
58	Any Kit With No Details Mentioned [Delivery Kit, Orthokit, Recovery Kit, Etc]	Not Payable
59	Kidney Tray	Not Payable
60	Mask	Not Payable

Sr. No.	Items	Remarks
61	Ounce Glass	Not Payable
62	Oxygen Mask	Not Payable
63	Pelvic Traction Belt	Payable in case of PIVD requiring traction
64	Pan Can	Not Payable
65	Trolly Cover	Not Payable
66	Urometer, Urine Jug	Not Payable
67	Ambulance	Payable - Ambulance from home to Hospital or inter-hospital shifts is Payable/ RTA - As Specific Requirement for critical injury is Payable
68	Vasofix Safety	Not Payable

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

Sr No	Item
1	Baby Charges (Unless Specified/Indicated)
2	Hand Wash
3	Shoe Cover
4	Caps
5	Cradle Charges
6	Comb
7	Eau-De-Cologne / Room Freshners
8	Foot Cover
9	Gown
10	Slippers
11	Tissue Paper
12	Tooth Paste
13	Tooth Brush
14	Bed Pan
15	Face Mask
16	Flexi Mask
17	Hand Holder
18	Sputum Cup
19	Disinfectant Lotions

Sr No	Item
20	Luxury Tax
21	Hvac
22	House Keeping Charges
23	Air Conditioner Charges
24	Im Iv Injection Charges
25	Clean Sheet
26	Blanket/Warmer Blanket
27	Admission Kit
28	Diabetic Chart Charges
29	Documentation Charges / Administrative Expenses
30	Discharge Procedure Charges
31	Daily Chart Charges
32	Entrance Pass / Visitors Pass Charges
33	Expenses Related To Prescription On Discharge
34	File Opening Charges
35	Incidental Expenses / Misc. Charges (Not Explained)
36	Patient Identification Band / Name Tag
37	Pulseoxymeter Charges

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

Sr 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

Sr No	Item
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

Sr No	Item
1	Admission/Registration Charges
2	Hospitalisation For Evaluation/ Diagnostic Purpose
3	Urine Container
4	Blood Reservation Charges And Ante Natal Booking Charges
5	Bipap Machine
6	Cpap/ Capd Equipments
7	Infusion Pump– Cost
8	Hydrogen Peroxide\Spirit\ Disinfectants Etc
9	Nutrition Planning Charges - Dietician Charges- Diet Charges

Sr No	Item
10	Hiv Kit
11	Antiseptic Mouthwash
12	Lozenges
13	Mouth Paint
14	Vaccination Charges
15	Alcohol Swabes
16	Scrub Solution/ Sterillium
17	Glucometer& Strips
18	Urine Bag

Annexure III

List of Critical Illness

1. Cancer Of Specified Severity

I. 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.

II. The following are excluded –

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

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

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

ii. 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

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

iv. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

2. Kidney Failure Requiring Regular Dialysis

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

3. Multiple Sclerosis With Persisting Symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Neurological damage due to SLE is excluded.

4. Motor Neurone Disease With Permanent Symptoms

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

5. Benign Brain Tumor

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

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

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

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

III. The following conditions are **excluded**:

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

6. Primary (Idiopathic) Pulmonary Hypertension

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

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

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

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

7. End Stage Liver Failure

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

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy.

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

8. Major Organ /Bone Marrow Transplant

I. The actual undergoing of a transplant of:

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

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

II. The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

9. Open Heart Replacement Or Repair Of Heart Valves

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

10. Open Chest CABG

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

II. The following are excluded:

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

11. Coma Of Specified Severity

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

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

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

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

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

12. Stroke Resulting In Permanent Symptoms

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

II. The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

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

13. Permanent Paralysis Of Limbs

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

14. Myocardial Infarction (First Heart Attack Of Specified Severity)

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

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

ii. New characteristic electrocardiogram changes

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

II. The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

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

15. Third Degree Burns

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

16. Deafness

I. Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

17. Loss Of Speech

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

18. Aorta Graft Surgery

The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.

(i) The following conditions are excluded:

a. Surgery performed using only minimally invasive or intra-arterial techniques.

b. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.

(ii) The diagnosis to be evidenced by any two of the following:

a. Computerized tomography (CT) scan

b. Magnetic Resonance Imaging (MRI) scan

c. Echocardigraphy (an ultrasound of the heart)

d. Angiography (Injecting X ray dye)

e. Abdominal ultrasound

Annexure IV
List of Hospitals where Co-payment of 20% is not applicable under the Cover "Smart Select"

Note: Below is a Non-exhaustive list of Network Hospitals under Smart Select Cover. Please check the latest list of Network Hospitals on www.zurichkotak.com

Hospital Name	Address
Chord Road Hospital Pvt Ltd.	100, Lic Colony Wc Road Basaveshwara Nagar B-79 Bangalore 560079 Dist Bangalore Karnataka
Trust Hospital	Kala Nagar,Near Benz Circle Benz Circle Vijayawada 520010 Dist Krishna Andhra Pradesh
Citizens Specialty Hospital (A unit of Artmed Health Care Pvt Ltd)	1/100/1/Cch, Nallagandla Serilingampally Hyderabad 500019 Dist Rangareddy Telangana
MPCT HOSPITAL A SURANA ASSOCIATE	Plot No 7,Sector 4 Sanpada Navi Mumbai
Aster RV Hospital	Ca 37 24 Main Road Iti Layout 1St Phase J.P Nagar, City: Bengaluru, Dist: Bengaluru, State: Karnataka-560078
Aster RV Hospital	Ca 37 24 Main Road Iti Layout 1St Phase J.P Nagar, City: Bengaluru, Dist: Bengaluru, State: Karnataka-560078 www.asterhospitals.in

Hospital Name	Address
BIG APOLLO SPECTRA HOSPITALS (A Unit Of Big Healthcare Pvt Ltd)	Agamkuan, Sheetla Mandir Road, City: Patna, Dist: Patna, State: Bihar - 800007.
Shri Bhavani Multispeciality Hospital & Research Institute	Plot No. 58, Mouza Punapur, Shri Bhavani Mata Mandir Road, Pardi, City: Nagpur, Dist: Nagpur, State: Maharashtra-440035
Batra Hospital & Medical Research Centre	1, Tughlaqabad Institutional Area, Mb Road, City: New Delhi, Dist: New Delhi, State: Delhi - 110006
Asian Fidelis Multi Speciality Hospital	RPS City, Sector-88, City: Faridabad, Dist: Faridabad, State: Haryana-121002
Sunshine Hospital	Laxmisagar Square, Cuttack - Puri Road, Budheswari Colony, City: Bhubaneswar, Dist: Khordha, State: Orissa-751006
Apollo Cradle And Apollo Spectra Hospital	NH-27 Pocket 7, Near Mitra Society, City: Greater Noida, Dist: G.B.Nagar, State: Uttar Pradesh-201308

Hospital Name	Address
Sardar Vallabhbhai Patel Institute Of Medical Sciences And Research	SVPIMSR, Ellisbridge, City: Ahmedabad, Dist: Ahmedabad, State: Gujarat-380006
Heart And General Hospital A Unit Of Cardiac Care And Allied Health Pvt Ltd	7 Vivekananda Marg C-Scheme Jaipur
Sehgal Neo Hospital (Previously Sehgal Nursing Home)	B-364, Meera Bagh Outer Ring Road Paschim Vihar New Delhi 110063 Dist New Delhi Delhi
ILS Hospital, Salt Lake City	Dd-6 Salt Lake City Sector-I Kolkata 700064 Dist Kolkata West Bengal
Chaitanya Eye Hospital, Andhra Pradesh	Near Siddhartha Arts College Tikkil Road Mogalrajpuram Vijayawada 520010 Dist Krishna Andhra Pradesh
Metro Multi Speciality Hospital	L-94, Sec-11, Gautam Buddh Nagar , City : Noida , Dist: Gautam Buddha Nagar State: Uttar Pradesh - 201301
ZENITH SUPER SPECIALIST HOSPITAL A UNIT OF JYOTISHMAN MULTI DISCIPLINARY HOSPITAL PVT LTD	9/3, Feeder Road, Belghoria Kolkata Kolkata 700056 Dist: 24 Parganas (NORTH) West Bengal
Noble Hospital Pvt. Ltd.	153, Magarpatta City Road, Hadapsar, City: Pune, Dist: Pune, State: Maharashtra - 411013
Tirath Ram Hospitals Pvt. Ltd	166/20, Basai Road Gurgaon Gurgaon 122001 Dist Gurgaon Haryana
Aditya Hospitals	4.1.16, Adjacent Endowments Tilak Road Abids Hyderabad 500001 Dist Hyderabad Telangana
Sarvodaya Hospital and Research Centre	Sector - 8, Ymca Road, Near Esi Hospital, Faridabad Faridabad 121005 Dist Faridabad Haryana
Apollo Speciality Hospital	Padma Complex 320, Anna Salai Chennai Chennai 600035 Dist Chennai Tamil Nadu
Poojan Children Hospital and Neonatal Centre	1st Floor, Vaibhav Comp, Near Nirnayanagar Underbridge Nirnayanagar Ahmedabad 382481 Dist Ahmedabad Gujarat
Kailash Hospitals Ltd	23, Institutional Area, Sector Alpha II,KP-1, Noida - 201310; Dist: Gautam Budh Nagar; State: Uttar Pradesh
Wockhardt hospital, Meera Road	Asmita ENolave Mira Road Thane 401107 Dist Thane Maharashtra
CIMET s Inamdar Multi Speciality Hospital	S No - 15, Next To Jain Square Fatimangar Pune 411040 Dist Pune Maharashtra www.inamdarhospital.com

Hospital Name	Address
Kauvery Hospital (Unit of Ms. Sri Kavery Medical Care Trichy Ltd.)	No.199/90, Nbc Towers, Church Road, Alwarpet Junction, Chennai 600018 Dist Chennai Tamil Nadu
Park Hospital	H-Block Palam Vihar Gurgaon 122017 Dist Gurgaon Haryana
Specialist Health Systems Pvt Ltd. (Specialist Hospital)	No.216, 7th Main, 80 Feet Road, 1st Block, Hrbr Layout, Kalyan Nagar, Bangalore 560043 Dist Bangalore Karnataka
Kalinga Institute Of Medical Science (KIMS)	Kiit-University, Patia, Bhubaneswar 751024 Dist Khurda Orissa
Paramitha Childrens Hospital Pvt. Ltd.	H.No:B&C,IN Sy.No: 7/D, Ward No: 11, Block No:13, Green Hills Colony, Saroor Nagar Hyderabad 500035 Dist Rangareddy Telangana www.paramithahospitals.com
Radha Hospital And Maternity Home	239, Bhagunagar Soc, Opp.Hans Soc, L.H. Road, Varachha, Surat 395006 Dist Surat Gujarat
Rahate Surgical Hospital	Telephone Exchange Square, Old Mangalwari Central Avenue Nagpur 440008 Dist Nagpur Maharashtra
Omni RK Hospital (A Unit of INCOR Hospitals Vizag Pvt. Ltd.)	Opp Lions Club, Ramnagar, Visakhapatnam 530002 Dist Visakhapatnam Andhra Pradesh
Sarvodaya Superspeciality Hospital and Heart Centre	Plot No D3, Kavi Nagar Industrial Area, Ghaziabad 201002 Dist Ghaziabad Uttar Pradesh
Aster Aadhar Hospital (Prerana Hospital Ltd.)	Rs No.628 B-Ward, Near Kmt Workshop, Shastri Nagar, Kolhapur Dist Kolhapur Maharashtra
Apollo Spectra (A unit of Apollo Specialty Hospitals Pvt Ltd)	No.41/42, 53/54, Sathyadey Avenue, Mrc Nagar, Ra Puram Chennai 600028 Dist Chennai Tamil Nadu
Neo Hospital	D-170a, Sector-50 Noida 201301 Dist Gautam Budh Nagar Uttar Pradesh
Durga Hospital (A unit of Smile Care Multispeciality Hospitals India Pvt. Ltd.)	36-91-108, Near Urvasi Junction, Kancharapalem, Visakhapatnam 530008 Dist Visakhapatnam Andhra Pradesh
Bharati Hospital And Research Centre	Katraj-Dhankawadi Pune 411043 Dist Pune Maharashtra
Kolekar Hospital	Omprakash Arcade, 2nd floor, Ambedkar Garden. Chembur, Mumbai 400071 Dist Mumbai Maharashtra
Mgm Hospital & Research Centre	1A,CBD, City: Belapur, Dist: Thane, State: Maharashtra-400614

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