Kotak Mahindra General Insurance Company Ltd.
Registered Office: 27 BKC, C 27, G Block, Bandra Kurla Complex, Bandra East, Mumbai – 400051. Maharashtra, India.

23-24/v1

Kotak COVID-19 Secure
Policy Wording

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 this Policy. This Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided by You/ the Policyholder 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.

Standard Definitions

Accident	Means sudden, unforeseen and involuntary event caused by external, visible and violent means
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
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.
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.
Cashless Facility	Means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved
Condition Precedent	Means a policy term or condition upon which the Insurer's liability under the policy is conditional upon
Congenital Anomaly	Means a condition which is present since birth, and which is abnormal with reference to form, structure or position a) **Internal Congenital Anomaly** Congenital anomaly which is not in the visible and accessible parts of the body. b) **External Congenital Anomaly** Congenital anomaly which is in the visible and accessible parts of the body.
Co-Payment	means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
Day care centre	Means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum 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. Deductible shall be applicable per year, per life or per event as stated in the Policy Schedule/ Certificate of Insurance and specific benefit/ cover based deductible shall be applied if specified in the Policy Schedule/ Certificate of Insurance.
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 Care	Means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health
Grace Period	Means the specified period of time immediately following the premium due date during which 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 at-least 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.
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.
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 your rehabilitation or for you to be specially trained to cope with it 4. it continues indefinitely 5. it recurs or is likely to recur
Injury	Means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner
Inpatient care	Means treatment for which the insured person has to stay in a Hospital for more than 24 hours for a covered event.
Intensive Care Unit	Means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
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, dependent children, brother(s), sister(s) and parent(s).
Migration	Means the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.
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.
Nominee	Means the person(s) named in the Policy Schedule/ Certificate of Insurance who is nominated by You to receive the insurance benefits under this Policy payable on the death of the Insured Person.
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.
Portability	Means the right accorded to individual health insurance policyholder (including all members under family cover) to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
Pre-existing Disease	Means any condition, ailment, injury or disease: a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
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
Surgery or Surgical Procedure	Means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a Medical Practitioner
Unproven / Experimental Treatment	Means any treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

Standard Definitions

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
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
Associated Medical Expenses	Means Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioners (including surgeons, anesthetists and specialists).
AYUSH Treatment	Refers to the medical and/ or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.
Certificate of Insurance	Means the certificate We issue to the Insured Person confirming the Insured Person's cover under the Policy
Claim	Means a demand made by You for payment of any benefit under the Policy in respect of an Insured Person
COVID-19	Means the disease as defined by the World Health Organisation (WHO) and caused by a novel coronavirus called severe acute respiratory syndrome coronavirus 2 (SARS CoV-2).
Daily Cash Amount	Means the per day cash benefit opted for and specified in the Policy Schedule/Certificate of Insurance.

Diagnosis	Means the determination of the presence of COVID-19. For the purpose of this Policy, only diagnosis or the test carried out by laboratories authorised by Union Health Ministry of India and/or State Government and/or Union Territory for COVID-19 testing shall be considered valid.
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.
Family Floater	Means a Policy described as such in the Policy Schedule where You and Your family members [as mentioned in Eligibility (Part III)] 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. Daily Cash Benefit: The maximum number of days covered for a Family Floater means the number of days shown in the Schedule which represents Our maximum liability with respect to the number of days for any and all claims made by You and/or all of Your family members mentioned in the Policy Schedule during each Policy Period.
Franchise	Means a cost sharing requirement under a health insurance policy that provides that the Company will not be liable for a specified number of days/hours (specified period) in case of hospital cash policies or for a specified rupee amount in case of indemnity policies. On completion of the specified period/ utilisation of specified amount, the Insured Person is eligible for the benefits from the first day of hospitalisation subject to the Benefit payable as per terms and conditions.
Infection	Caused by pathogenic microorganisms such as bacteria, viruses, parasites or fungi. The disease can be spread directly or indirectly from one person to another.
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/Certificate of Insurance.
Insured Person(s)	Means the person(s) named in the Policy Schedule/Certificate of Insurance, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium received.
Nominee	Means the person(s) named in the Policy Schedule/ Certificate of Insurance who is nominated by You to receive the insurance benefits under this Policy payable on the death of the Insured Person.
Policy	Means these Policy wordings, the Policy Schedule/ Certificate of Insurance 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/ Certificate of Insurance and terminating at midnight on the Policy End Date as specified in Policy Schedule/ Certificate of Insurance
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/ Certificate of Insurance.
Quarantine	Means the isolation of an individual either due to diagnosis or suspected infection of COVID-19. For the purpose of this Policy, Quarantine shall mean isolation which is prescribed either by the Union Health Ministry- approved testing centre or the Central or State Government and in a place arranged and approved as a Quarantine centre by the Central or State Government. Self-isolation without the advise or directive of any State or Central Government Authority is not Quarantine for the purposes of this Policy.
Sum Insured	a. For Individual sum insured basis , the amount specified in the Policy Schedule or Certificate of Insurance against an Insured Person which is Our maximum, total and cumulative liability for any and all claims arising during the Period of Cover in respect of that Insured Person. b. For Family Floater sum insured basis, the amount specified in the Policy Schedule or Certificate of Insurance which is Our maximum, total and cumulative liability for any and all claims arising during the Period of Cover in respect of any one and/or all Insured Persons.
Third Party Administrator (TPA)	Means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulations,2016 notified by the Authority, and is engaged, for a fee or remuneration for providing health services as defined in those Regulations
You / Your / Policyholder	Means the policyholder / insured persons named in the Policy Schedule / Certificate of Insurance
We / Our / Us / Insurance Company	Means the Kotak Mahindra General Insurance Company Limited.

PART II

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

The Benefits available under this Policy are described below. The customer may opt for any one or more of the Base Benefits available. Optional Benefit may be opted only if the Base Benefit has been opted for. The Policy Schedule/ Certificate of Insurance will specify which of the following Benefits are applicable and in force for the Insured Person. Benefits will be payable subject to the terms, conditions and exclusions of this Policy and subject to Sum Insured/ Sub-limits/ Deductible/ Franchise/ Co-payment, if any and applicability specified in respect of that Benefit in the Policy Schedule/ Certificate of Insurance.

1.1 Base Benefit: Covid-19 Diagnosis Cover

We will pay the Sum Insured as specified in the Policy Schedule/ Certificate of Insurance as a lumpsum benefit to the Insured Person(s) provided that:

- The Insured Person(s) Diagnosis test confirms the presence of Coronavirus Disease (COVID-19)
- The date of Quarantine or Diagnosis (whichever is earlier) lies within the Policy Period and after the Initial Waiting Period as specified in the Policy Schedule/ Certificate of Insurance.

We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy Year.

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

1.2 Base Benefit: In-patient Hospitalisation Cover

We will indemnify the Medical Expenses incurred on the Insured

Person's Hospitalisation due to COVID-19 for a minimum and continuous period of 24 hours that occurs during the Policy Period provided that:

a) The Hospitalisation is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
b) The Medical Expenses incurred are Reasonable and Customary 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 and drugs prescribed by the treating Medical Practitioner;
   vii. Other allowable consumables and disposables prescribed by the treating Medical Practitioner upto ₹5,000 per day or the actual expenses whichever is lower;
   viii. Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized and conducted within the same Hospital where the Insured Person is admitted;
   ix. Anaesthesia, blood, oxygen and blood transfusion charges;
   x. Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

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.

1.3 Optional Benefit: Pre & Post Hospitalization Medical Expenses

We will indemnify the Insured Person's Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses due to COVID-19 that occurs during the Policy Period provided that:

a) We have accepted a Claim for In-patient Hospitalisation Cover under this Policy and the Pre-Hospitalisation Medical Expenses and/or Post Hospitalisation Medical Expenses relate to the same Illness/medical condition;
b) We will be liable to pay Pre-Hospitalisation Medical Expenses up to the number of days as specified in the Policy Schedule/Certificate of Insurance prior to the Insured Person's Admission to Hospital for In patient Care;
c) We will be liable to pay Post-Hospitalisation Medical Expenses up to the number of days as specified in the Policy Schedule/Certificate of Insurance immediately following the Insured Person's discharge from Hospital following In-patient Care.

The payment under this benefit is within the In-patient Hospitalisation Cover Sum Insured, subject to limits specified, if any.

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.

1.4 Optional Benefit: Room Rent Capping

We will pay for the room rent charges as per the limits set out in the Policy Schedule/ Certificate of Insurance for Normal and ICU room category and also based on the location of the hospital.

If the Insured Person incurs Room Rent that is higher than the eligible Room Rent as per the limits specified under this Benefit 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.

Optional Benefit 1.3 and 1.4 can be opted for only if Base Benefit: 1.2 In-patient Hospitalisation Cover is opted.

1.5 Base Benefit: Ambulance Cover

We will indemnify the Reasonable and Customary Charges incurred up to the limit specified in the Policy Schedule/ Certificate of Insurance towards transportation of the Insured Person by a healthcare or Ambulance service provider to a Hospital due to COVID-19 following an Emergency provided that:

a) The necessity of the use of the Ambulance is certified by the treating Medical Practitioner;
b) 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.
c) The limit under Ambulance cover is applicable for each claim admitted under the policy.

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.

1.6 Base Benefit: Hospital Daily Cash Benefit

We will pay the Daily Cash Amount, subject to Deductible/ Franchise, as specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation for Inpatient Care due to COVID-19 during this Policy Period.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/ per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

1.7 Base Benefit: ICU Daily Cash Benefit

We will pay the Daily Cash Amount, subject to Deductible/ Franchise, as specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation for Inpatient Care due to COVID-19 in an ICU during this Policy Period.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/ per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

Note:

- In case the Policyholder opts for both 1.6 Hospital Daily Cash Benefit and 1.7 ICU Daily Cash Benefit, the maximum number of days under each Benefit will be considered individually as mentioned in the Policy Schedule/ Certificate of Insurance.
- In case the Insured Person's Hospitalisation covers both Hospital Daily Cash Benefit and ICU Daily Cash Benefit, the highest of the Daily Cash Amount applicable will be paid in respect of each and every completed day. There will be no cumulative payout under these 2 Benefits and only the highest of the payout applicable will be paid.

1.8 Base Benefit: OPD Benefit

We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule/ Certificate of Insurance towards out patient medical expenses in respect of Insured person due to COVID-19 towards:

a) Diagnostic procedures like laboratory tests, MRI's, CAT Scan, Pathology tests
b) Medical Practitioners consultations
c) Pharmacy expenses
d) Any others expenses specifically approved by the Medical Practitioner

Provided that:

- The Medical Expenses incurred are Reasonable and Customary Charges
- Co-payment, as mentioned in the Policy Schedule / Certificate of Insurance is applicable in respect of this benefit.

General Exclusion 2.3 and 2.36 of the Policy Wordings stands deleted to the extent of this Cover only.

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.

1.9 Base Benefit: Convalescence Benefit

We will pay the Sum Insured specified in the Policy Schedule/Certificate of Insurance for this Benefit if the Insured Person is admitted in a Hospital due to COVID-19 for a minimum period as specified in the Policy Schedule/ Certificate of Insurance.

We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy Year.

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

SPECIFIC CONDITIONS APPLICABLE TO THE POLICY

A. The Benefits shall be applicable after an Initial Waiting Period of 15 days or as mentioned in the Policy Schedule / Certificate of Insurance
B. The Insured must have tested positive for COVID-19 as per report from laboratories authorised by Union Health Ministry of India

and/or State Government and/or Union Territory for COVID-19 testing.

C. The Insured should not have traveled to travel restricted countries against travel advisory whether in force or freshly issued by Government of India at any time during the Policy Period

D. The Insured Person(s) should not violate any of the directives issued by the Government of India or any other government authorities with respect to Novel Coronavirus Disease (COVID-19) including the Lock Down orders issued by the State Government(s).

E. **Unauthorised testing centre:** Testing done at a diagnostic centre which is not recognised and authorised by the Union Health Ministry of India and/or State Government and/or Union Territory shall not be covered under this Policy.

F. **Negative or Inconclusive Reports:** If the test report is negative or if Insured Person is "Patient under investigation" with inconclusive reports, it will not be covered under the Policy.

2. WHAT WE WILL NOT PAY (GENERAL 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:

Standard Exclusions

2.1 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 48 months of continuous coverage after the date of inception of the first policy with insurer.

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

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

d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

The above Pre-Existing Diseases condition will be applicable to all Benefits except 1.1 Base Benefit: Covid-19 Diagnosis Cover

Pre-existing diseases (applicable to 1.1 Base Benefit: Covid-19 Diagnosis Cover): Any Pre-existing condition whether declared or not declared is not covered.

2.2 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.

2.3 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.

2.4 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

2.5 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.

2.6 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.

2.7 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.

2.8 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.

2.9 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.

2.10 Code- Excl12

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

2.11 Code- Excl13

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

2.12 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.

2.13 Refractive Error (Code – Excl15)

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

2.14 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.

2.15 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

2.16 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.

Specific Exclusions

2.17 Initial Waiting Period

a) Any Diagnosis, Quarantine or expenses related to Coronavirus Disease (COVID-2019) arising within 15 days or number of days as specified in the Policy Schedule/ Certificate of Insurance from the first policy commencement date shall be excluded

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.

2.18 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;

2.19 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 and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra operatively;

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

2.21 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;

2.22 Acupressure, acupuncture, magnetic and such other therapies;

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

2.24 Vaccination or inoculation of any kind, unless it is post animal bite and there is hospitalisation as an in-patient;

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

2.26 Treatment relating to Congenital external Anomalies;

2.27 Any treatment related to sleep disorder or sleep apnoea syndrome

2.28 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

2.29 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;

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

2.31 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;

2.32 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;

2.33 Non-medical expenses as listed in Annexure II (List I) of the Policy.

2.34 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.

2.35 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.

2.36 Any OPD treatment will not be covered.

2.37 Any hospitalisation treatment taken outside India

3. CLAIMS PROCESS

3.1 Claim Administration

The fulfilment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule/ Certificate of Insurance) 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, We may conduct Medical examination by any Medical Practitioner for this purpose when and so often as We may reasonably require. Such medical examination will be carried out only in case of reimbursement claims with prior consent of the Insured Person and We/Our representatives must be permitted to inspect the medical and Hospitalisation records pertaining to the Insured Person's treatment and to investigate the facts surrounding the Claim;

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.

3.2 Claims Intimation

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:

a) For Cashless Facility

Cashless Facility is only available at a Network Provider. The complete list of Network 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:

- **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. The Health Card We have issued to the Insured Person;
  ii. The Policy Number;
  iii. Name of the Policyholder;
  iv. Name and address of Insured Person in respect of whom the request is being made;
  v. Nature of the Illness and the treatment required;
  vi. Name and address of the attending Medical Practitioner;
  vii. Hospital where treatment is proposed to be taken;
  viii. Proposed date of Admission.

  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 6 hours from receipt of complete documents

  In Case of Claim Contact Us at:

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

- **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. The Health Card We have issued to the Insured Person;
  ii. The Policy Number;
  iii. Name of the Policyholder;
  iv. Name and address of Insured Person in respect of whom the request is being made;
  v. Nature of the Illness and the treatment required;
  vi. Name and address of the attending Medical Practitioner;
  vii. Hospital where treatment is being taken;
  viii. Date of Admission.

  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. In circumstances where We/Our TPA refuse the request for pre authorisation as there is insufficient Base Annual Sum Insured 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.

Turn Around Time (TAT) for settlement of Reimbursement is within 30 days from the receipt of the complete documents.

b) For Reimbursement Claims

We shall be given a written notice within 10 days of the Insured Person being first diagnosed with Coronavirus Disease (COVID-19) and We shall be provided the following necessary information and documentation in respect of all Claims atleast within 30 days of the Insured Person's diagnosis/ discharge from quarantine/ hospital (as applicable):

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 and the treatment taken;
v. Name and address of the attending Medical Practitioner;
vi. Hospital where treatment was taken/ Details of the Quarantine Facility;
vii. Date of Admission and date of discharge;
viii. 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.

Kindly note that Company may de-list few of the hospitals and the Company shall not service any claims including re imbursement claims for the treatment undertaken at these hospitals other than in case of a medical Emergency. List of de-listed hospitals would be available on our website and is subject to updates from time to time.

3.3 Claims 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) Original Pre – authorization request
c) Copy of Pre – authorization approval letter
d) Copy of the photo identity document of the Insured Person;
e) Address Proof of Insured / nominee;
f) KYC documents and 2 recent coloured passport size photographs of Insured/ nominee;
g) Signed NEFT mandate along cancelled cheque copy of Insured/ nominee;
h) Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner;
i) Original bills from chemists supported by proper prescription;
j) A positive virology report from laboratories authorised by Union Health Ministry of India for COVID-19 testing shall be considered valid.
k) Original investigation test reports (including CT/MR/USG/ECG, as applicable) and payment receipts;
l) Indoor case papers (if available);
m) Medical Practitioner's referral letter advising Hospitalization in non Accident cases and referral slip for all investigations carried out;
n) Hospital discharge summary;
o) Copy of passport with Entry/ exit stamp (If has insured has travel history)
p) Post mortem report (if applicable and conducted);
q) Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

Cover-wise Additional Documents:

Pre & Post Hospitalization Medical Expenses	Original copies of Consultations, bills & receipts towards medical expenses, investigation reports & bills, prescriptions and invoices.
Ambulance Cover	Ambulance Cover Original Bill from a certified Ambulance Service Provider or Hospital Doctor's advice for Ambulance
Hospital Daily Cash Benefit / ICU Daily Cash Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill.
OPD Benefit	Consultations bills, receipts, investigation reports & bills, prescriptions and invoices.
Convalescence Benefit	Hospital discharge card / summary

PART III

General Terms and Clauses

Standard 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. Cancellation

i. The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.
For Policyholder's initiated cancellation, the Company would compute refund amount as pro-rata (for the unexpired duration) premium. This would further be deducted by 25% of computed refundable premium.
Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.
ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

7. 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.
For Detailed Guidelines on Migration, kindly refer:
IRDAI/HLT/REG/ CIR/003 /01/2020

8. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.
The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured shall be entitled to
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;

9. 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.

10. 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 would be given to pay the instalment premium due for the policy.
ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged 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.

11. Moratorium Period

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

12. 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.

13. Grievances

In case of any grievance the insured person may contact the company through
Website: www.kotakgeneral.com
Toll free: 18002664545
E-mail: care@kotak.com
Fax: 022-28401823
Courier: Kotak General Insurance 8th Floor, Zone IV, Building No.21, Infinity IT park, Off Western Express Highway, Goregaon, Mulund Link Road, Malad (E), Mumbai - 400097.
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@kotak.com.
For updated details of grievance officer, kindly refer the link:
https://www.kotakgeneral.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@kotak.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.kotakgeneralinsurance.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 at IRDAI Integrated Grievance Management System: https://bimabharosa.irdai.gov.in/.

14. Claim Settlement (Provision For Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such

investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

Specific Terms and Clauses

1. Eligibility

Minimum Entry Age	1 day
Maximum Entry Age	No Limit

Insured Person will include Self (Group member) and the following relationships of the Group member: Lawfully wedded spouse (more than one wife)/ Partner (including same sex partners) and Live-in Partner, children (biological/ adopted/others), parents (biological/ foster), siblings (biological/ step), mother in-law, father in-law, son in-law, daughter in-law, brother in law, sister in-law.

For the purpose of this Policy, Partner shall be taken as declared at the time of Start of the Policy Period and no change in the same would be accepted during a Policy Period. However, an Insured Person may request for change at the time of Renewal of the cover.

2. Material Change

Material information to be disclosed to Us includes every matter that You are aware of 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.

3. 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.

4. Terms and condition of the Policy

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

5. 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.

6. 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.

7. Role of Group Administrator/ Policyholder

a) The Policy holder should provide the complete list of members to Us at the time of policy issuance and renewal. Further intimation should be provided to Us on the entry and exit of the members at periodic intervals. Insurance will cease once the member leaves the group except when it is agreed in advance to continue the benefit even if the member leaves the group.

b) In case of employer-employee policies, the employer may issue confirmation of insurance protection to the individual employees with clear reference to the Group Insurance policy and the benefits secured thereby.

c) In case of such policies, claims of the individual employees may be processed through the employer

d) In case of non-employer-employee policies, We shall generally issue the Certificate of Insurance. However, We may provide the facility to the Group Administrator to issue the Certificate of Insurance to the members.

e) In case of such policies, the Group Administrator may facilitate the claims process for the members however the payment will be made only to the beneficiary which is the Insured Person

8. Renewal of Policy

Renewal notice for policies issued on Auto Renewal Basis:

- The Insurance Company shall automatically renew the Policy annually for the period it has been issued for. However on expiry of the Policy after completing its entire auto renewal period the Insurance Company shall not deduct any renewal premium nor give notice that such renewal premium is due.
- Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein before mentioned and that nothing is known to the Insured Person that may result to enhance the risk of the Insurance Company under the guarantee hereby given.
- No renewal receipt shall be valid unless it is on the printed form of the Insurance Company and signed by an authorised official of the Insurance Company. Any change in the risk will be intimated to the Insurance Company by the Insured Person. Nothing herein or otherwise shall affect the Company's right to impose any additional terms and conditions on renewal or restrict any renewal terms as to premium or otherwise.
- The Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to the Insurance Company on or before the date of expiry of the Policy and in no case later than Grace Period of at least 30 days or as informed by Insurer from time to time.

9. Auto Debit / ECS (Electronic Clearing System) Payment Facility:

You may opt for the Auto Debit/ECS payment facility for your premium payments under this Policy subject to such facility being specifically availed by the Master Policyholder for all its group members/beneficiaries under the Policy. This facility can be opted by you for automatic premium payment under this Policy by submitting a duly signed Auto Debit/ECS mandate form in physical or electronic form. It may be noted that:

a. The premium amount under the Policy may 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 Auto Debit/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 Auto Debit/ECS mandate by giving Us at least 15 days' notice before the due date of next premium due under the Policy

The Auto Debit/ECS payment facility shall be governed by the guidelines issued by the Reserve Bank of India (and as may be amended from time to time)

10. 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.

11. 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/ Certificate of Insurance.

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

12. 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/ Certificate of Insurance, during normal business hours or contact Our call centre.

13. 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.

14. Assignment Clause

An assignment of this policy of insurance, wholly or in part, whether with or without consideration, may be made only by an endorsement upon the policy itself or by a separate instrument, signed in either case by theassignor and attested by at least one witness, specifically setting forth the fact of transfer or assignment and the reasons thereof, the antecedents of the assignee and the terms on which the assignment is made. Such assignment shall be operative as against the Company effective from the date the Company receives a written notice of the assignment/request and endorses the same on the Policy.

The Company may, accept the assignment, or decline to act upon any endorsement, where it has sufficient reason to believe that such transfer or assignment is not bona fide or is not in the interest of the policyholder or in public interest or is for the purpose of trading of insurance policy. However, by recording the assignment the Company does not express any opinion upon the validity nor accepts any responsibility on the assignment.

15. 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.

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, Fax: 044 - 24333664, 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.
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
Items for which optional cover may be offered
List I - Optional Items

Sr. No.	Items	Suggestions
1	Baby Food	Not Payable
2	Baby Utilities Charges	Not Payable
3	Beauty Services	Not Payable
4	Belts/ Braces	Essential and Should be Paid at least Specifically 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	Essential in Bariatric and Varicose Vein Surgery and may be considered for at least these conditions where Surgery itself is Payable.
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 / Payable by the Patient
17	Diaper Of Any Type	Not Payable
18	Eyelet Collar	Not Payable
19	Slings	Reasonable costs for one sling in case of Upper Arm Fractures may be considered.
20	Blood Grouping and Cross Matching of Donors Samples	Part Of Cost Of Blood, Not Payable
21	Service Charges Where Nursing Charge Also Charged	Post Hospitalization Nursing Charges Not Payable
22	Television Charges	Payable Under Room Charges Not if separately levied
23	Surcharges	Part of Room Charge Not Payable Separately
24	Attendant Charges	Not Payable - Part of Room Charges
25	Extra Diet Of Patient (Other Than That Which Forms Part Of Bed Charge)	Not Payable. Patient Diet Provided by Hospital is 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

Sr. No.	Items	Suggestions
41	Thermometer	Not Payable (paid By Patient)
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	Essential and should be paid at least specifically for cases who have undergone Surgery of Lumbar Spine.
48	Nimbus Bed Or Water Or Air Bed Charges	Payable for any ICU Patient requiring more than 3 Days in ICU; All Patients with Paraplegia /Quadriplegia for any reason and at Reasonable Cost of approximately ₹ 200/Day.
49	Ambulance Collar	Not Payable
50	Ambulance Equipment	Not Payable
51	Abdominal Binder	Essential and should be Paid at least in 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	Post Hospitalization Nursing Charges Not Payable
53	Sugar Free Tablets	Payable -Sugar Free variants of admissible medicines are not Excluded
54	Creams Powders Lotions (Toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)	Payable when Prescribed
55	ECG Electrodes	Up to 5 Electrodes are Required for every case visiting OT or ICU. For longer stay in ICU, may Require a Change and at least one set every second day must be Payable.
56	Gloves	Sterilized Gloves Payable / Unsterilized Gloves not payable.
57	Nebulisation Kit	If used during Hospitalization is Payable Reasonably.
58	Any Kit With No Details Mentioned [Delivery Kit, Orthokit, Recovery Kit, Etc]	Not Payable
59	Kidney Tray	Not Payable
60	Mask	Not Payable
61	Ounce Glass	Not Payable
62	Oxygen Mask	Not Payable
63	Pelvic Traction Belt	Should be Payable in case of PIVD requiring traction as this is generally not reused.
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	Payable - Maximum of 3 in 48 Hrs and then 1 in 24 Hrs.

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

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