TATA AIG

# CRITI MediCare

TATA AIG INSURANCE

WITH YOU ALWAYS

## Policy Wordings

Tata AIG General Insurance Company Limited (We, Our or Us) will provide the insurance cover, described in this Policy and any endorsements thereto, during the Policy Period, as defined in the Policy schedule. The insurance cover provided under this Policy is only with respect to such and so many of the benefits up to the Sum Insured as mentioned in the Policy Schedule. Commencement of risk cover under the policy is subject to receipt of premium by us.

The statements and declarations contained in the Proposal signed by the Policyholder (You) and/or medical reports shall be the basis of this Policy and are deemed to be incorporated herein. The insurance cover is governed by and subject to, the terms, conditions and exclusions of this Policy.

For **Tata AIG General Insurance Company Limited**

Authorized Signatory

**TATA AIG General Insurance Company Limited**
**Registered Office:**
Peninsula Business Park, Tower A,
15th Floor, G. K. Marg,
Lower Parel, Mumbai- 400013, Maharashtra, India
24x7 Toll Free No. 1800 266 7780 or
1800 22 9966 (Senior Citizen)
Visit us at www.tataaig.com
IRDA of India Registration No.:108
CIN: U85110MH2000PLC128425
UIN: TATHLIP22176V012122

Insurance is the subject matter of solicitation. For details on risk factors, terms and conditions, please read policy document carefully before concluding a sale.

## *Section 1 – General Definitions*

The terms defined below and at other junctures in the Policy Wording have the meanings ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same:

### i. Standard Definitions

**1. Accident**

An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

**2. Cashless facility**

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.

**3. Condition Precedent**

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

**4. Congenital Anomaly:**

Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

i. a) Internal Congenital Anomaly

Congenital anomaly which is not in the visible and accessible parts of the body.

ii. b) External Congenital Anomaly

Congenital anomaly which is in the visible and accessible parts of the body

**5. Day Care Centre**

A 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.

**6. Day Care Treatment**

Day care treatment means medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 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

**7. Dental Treatment**

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

**8. Deductible**

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.

**9. Domiciliary Hospitalization**

Domiciliary hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

ii. the patient takes treatment at home on account of non-availability of room in a hospital.

**10. Grace 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.

**11. Hospital**

A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;

ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

iii. has qualified medical practitioner(s) in charge round the clock;

iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;

v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

**12. Hospitalization**

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


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**13. Illness**

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

iii. (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

iv. (b) Chronic condition

A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests

ii. it needs ongoing or long-term control or relief of symptoms

iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it

iv. it continues indefinitely

v. it recurs or is likely to recur

**14. Injury**

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.

**15. Inpatient Care**

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

**16. Intensive Care Unit:**

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.

**17. Medical Advice**

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

**18. Medical Expenses:**

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.

**19. Medical Practitioner**

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



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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.

**20. Medically Necessary 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.

**21. Migration**

"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.

**22. Network Provider**

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.

**23. Notification of Claim:**

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

**24. OPD treatment**

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.

**25. Pre-Existing Disease**

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

**26. Pre-hospitalization Medical Expenses**

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

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

ii. The In-patient Hospitalization claim

for such Hospitalization is admissible by the Insurance Company.

**27. Portability**

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

**28. Post-hospitalization Medical Expenses**

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

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

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

**29. Qualified Nurse**

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.

**30. Reasonable and Customary Charges**

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

**31. Renewal**

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.

**32. Room Rent**

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

**33. Surgery or Surgical Procedure**

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.

**34. Unproven/Experimental treatment**

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.

**Standard Definitions for Covered Critical Illness(s) in the Product**

**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.


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The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded –

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

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

**2. Kidney Failure requiring regular dialysis**

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

**3. Major organ/Bone Marrow Transplant**

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.

The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

**4. Open Heart Replacement/Repair of Heart Valves**

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-



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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.

**5. Open Chest Coronary Artery Bypass Graft**

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 key hole 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

**6. Myocardial Infarction (First Heart Attack of specific severity)**

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

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

ii. New characteristic electroca-rdiogram changes

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

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.

**7. Stroke resulting in permanent symptoms**

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

II. The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic Injury of the brain

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

vestibular functions.

**8. Permanent Paralysis of Limbs**

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

**9. 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.

**10. End Stage Lung Failure**

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and

ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

iii. Arterial blood gas analysis with partial oxygen pressures of 55mmHg or less (PaO2 <55 mm Hg); and

iv. Dyspnea at rest.

**11. 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.

**12. Angioplasty**

I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of

minimum 50% of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

II. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

III. Diagnostic angiography or investigation procedures without angioplasty / stent insertion are excluded.

The Sum Insured payable for this particular critical illness under the policy is limited to 50% or Rs 20 Lacs ,whichever is lower.

**13. 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.

**14. Motor Neuron Disease with Permanent Symptoms**

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.

**15. 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


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skull bones and tumors of the spinal cord.

**16. Major Head Trauma**

Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

The Activities of Daily Living are:

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

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

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

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

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

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

The following are excluded:

i. Spinal cord injury;

**17. Deafness**

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.

**18. 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.

**19. Loss of limbs**

The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This shall include medically necessary


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amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded

**20. Blindness**

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

II. The Blindness is evidenced by

i. corrected visual acuity being 3/60 or less in both eyes or;

ii. the field of vision being less than 10 degrees in both eyes.

III. The diagnosis of blindness must be confirmed and must not be correctable by aides or surgical procedure.

**21. Third Degree Burns**

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

**22. 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:

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

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

c. 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.

**ii. Specific Definitions(Definitions other than as mentioned under Section 1 (i) above)**

**1. Activities of Daily Living**

Means below mentioned activities:

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

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

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

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

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

vi. Feeding: the ability to feed oneself


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once food has been prepared and made available.

2. **Age**

Means the completed age of the Insured Person on his / her most recent birthday as per the English calendar, regardless of the actual time of birth.

3. **Home Care Treatment** means treatment availed by the Insured Person at home for Cancer which in normal course would require care and treatment at a hospital but is actually taken at home provided that:

a) The Medical practitioner advices 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

4. **Policy**

Policy means the contract of insurance including but not limited to Policy Schedule, Endorsements and Policy Wordings.

5. **Policy period**

Policy Period means the time during which this Policy is in effect. Such period commences from Commencement Date and ends on the Expiry Date and specifically appears in the Policy Schedule.

6. **Policy Schedule**

Policy Schedule means the Policy Schedule attached to and forming part of Policy

7. **Policy year**

Policy Year means a period of twelve months beginning from the date of commencement of the Policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the Policy Expiry date

**Specific Definitions for Covered Critical Illness(s) in the Product (Definitions other than those mentioned under section 1-(i) above)**

1. **Refractory heart failure**

Refractory heart failure must be diagnosed by a Cardiologist and optimal therapy must have been established for at least 6 months. The diagnosis of heart failure to be evidence by at least any 4 following criteria:

a. Class 3 (or above) of the New York Heart Association classification's of functional capacity (heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain)

b. Presence of third heart sound

c. Jugular venous pressure above 6 cms



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d. Persistent presence of Rales in both bases on auscultation

e. Cardiomegaly on chest x-ray PA view

f. Grade 3, or gross ascites, associated with marked abdominal distension and/ or peripheral oedema

g. 2-D echocardiography report suggestive of LVEF of 40% or less

h. Markedly Elevated biomarkers – B-type natriuretic peptide (BNP)/N-terminal pro-BNP(NT-proBNP)

The following are excluded:

- Heart Failure due to Auto-immune disorders
- Heart Failure secondary to drug or alcohol abuse

**2. Cardiomyopathy**

An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association Classification Class III or Class IV, or its equivalent, based on the following classification criteria:

- Class III NYHA - Marked functional limitation. Affected patients are comfortable at rest but performing activities involving less than ordinary exertion will lead to symptoms of congestive cardiac failure.
- Class IV NYHA - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echocardiographic findings of compromised systolic ventricular performance.

Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

**3. Parkinson's disease**

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

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

a. the disease cannot be controlled with medication

b. signs of progressive impairment; and

c. inability of the Insured Person to perform at least 3 of the 6 Activities of Daily Living as defined under section 3(General Definitions) for a continuous period of at least 6 months

Parkinson's disease secondary to drug and/or alcohol abuse is excluded.

**4. Rabies**

Rabies is a Viral disease characterized by and evidenced by at least 2 or more of the following:

1. Convulsions, delirium or paralysis
2. Detection of rabies viral antigens by direct fluorescent antibody test on skin biopsy (ante-mortem)
3. Detectable rabies-neutralizing



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antibody titre in the serum or the CSF of an unvaccinated person

4. Histological evidence of Negri bodies in brain (post-mortem)

The Diagnosis must be confirmed by a medical practitioner or specialist physician.

**5. Chronic Aplastic Anemia**

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

a. Blood product transfusion;

b. Marrow stimulating agents;

c. Immunosuppressive agents; or

d. Bone marrow transplantation.

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

a. Absolute neutrophil count of 500/ $mm^3$ or less

b. Platelets count less than 20,000/ $mm^3$ or less

c. Absolute Reticulocyte count of 20,000/$mm^3$ or less

Temporary or reversible Aplastic Anaemia is excluded.

In this condition, the bone marrow fails to produce sufficient blood cells or clotting agents.

**6. Cerebral Aneurysm with Specified Surgery**

Cerebral aneurysm is a weakness in a blood vessel that balloons out and fills with blood within the brain causing increased pressure on nerves and surrounding brain tissue. The diagnosis must be confirmed by a specialist physician/neurologist and must be evidenced by any of the following:

a. Cerebral angiography/ Digital Substraction Angiography (DSA);

b. CT scan of brain;

c. MRI Angiography scan of brain

Surgery should be either of:

- Aneurysmal clipping
- Endovascular coiling
- flow diverter

**7. Hemiplegia**

The total and permanent loss of the use of one side of the body through paralysis caused by Illness or Injury (muscle power Grade II or below), except when such Injury is self-inflicted. Evidence of permanent changes on neuroimaging i.e. relevant and clinically corelated infarct should also be available.

The diagnosis has to be confirmed by a Specialist Medical Practiotioner/ Neurologist.

**8. Chronic Relapsing Pancreatitis**

An unequivocal diagnosis of Chronic Relapsing Pancreatitis, made by a registered Medical Practitioner who is a specialist in gastroenterology and confirmed as a continuing inflammatory disease of the pancreas characterised by relapses in the form of sub lethal


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attacks of acute pancreatitis, irreversible morphological change and typically causing pain and/or permanent impairment of function. The condition must be confirmed by elevated levels of pancreatic function tests including serum amylase, serum lipase, and radiographic and imaging evidence.

Relapsing Pancreatitis caused directly or indirectly, wholly or partly, by alcohol is excluded.

**9. Infective Endocarditis**

Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:

- Positive result of the blood culture proving presence of the infectious organism(s);
- Presence of at least moderate heart valve incompetence (meaning regurgitant fraction of 20% or above) or moderate heart valve stenosis (resulting in heart valve area of 30% or less of normal value) attributable to Infective Endocarditis; and
- The Diagnosis of Infective Endocarditis and the severity of valvular impairment are supported by Echocardiographic evidence, confirmed by a registered Medical Practitioner who is a cardiologist

**10. Pericardectomy**

The undergoing of a pericardectomy as a result of pericardial disease. Surgical Procedure must be certified to be absolutely necessary by a specialist in the relevant field.

**11. Percutaneous Heart Valve Replacement**

The actual undergoing of procedure to replace one or more heart values, 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 in the relevant field.

**12. Pneumonectomy**

I. The undergoing of Surgery on the advice of an appropriate Specialist Medical Practitioner to remove an entire lung for disease or traumatic Injury.

II. The following conditions are excluded:

   i. Removal of a lobe of the lungs (Lobectomy)

   ii. Partial Lung resection or incision

**13. Bariatric Surgery**

Insured Person undergoing Bariatric surgery and fulfillment of following conditions:

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

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

iii. Body Mass Index (BMI) greater than or equal to 40 or

iv. BMI greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of


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weight loss:

a. Obesity-related cardiomyopathy

b. Coronary heart disease

c. Severe sleep apnea

d. Uncontrolled Type2 Diabetes

Please note: Subsequent to this coverage, medical Exclusion (Code -Excl06) stands deleted.

**14. Percutaneous Transluminal Angioplasty of Renal Artery**

Renal angioplasty is a percutaneous intervention to renal arteries by way of balloon angioplasty with or without stenting for treatment of narrowing or blockage of minimum 50% of one or more renal arteries. This intervention must be determined to be medically necessary by a nephrologist, supported by renal angiogram and confirmed by the interventional specialist.

Diagnostic renal angiography or investigation procedures without angioplasty/stent insertion are excluded.

The claim is admissible once the procedure is done.

**15. Severe Progressive Supranuclear Palsy**

A diagnosis of progressive supranuclear palsy by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical impairment of eye movements and motor function for a minimum period of 30 days and progressive nature evident.

**16. Surgical Removal of One Kidney**

I. The undergoing of Surgery on the advice of a Specialist Medical Practitioner to remove an entire kidney for disease/illness or Injury.

II. The following conditions are excluded:

i. Partial resection of kidney

ii. In case the insured person is kidney donor and surgery undertaken as part of Organ donation

**17. Total Glossectomy**

The undergoing of surgery on the advice of a Specialist Medical Practitioner for removal of the entire tongue including the base of the tongue necessitated due to an illness/disease or injury.

**18. Budd–Chiari syndrome**

Budd-Chiari syndrome is a disorder characterized by narrowing and obstruction (occlusion) of the veins of the liver (hepatic veins). This disorder should be evidenced by following:

a) Portal hypertension

b) Hepatomegaly

c) Ascites

The diagnosis should be made by a Specialist Medical Practitioner and supported by way of:

a. Abdominal Ultrasonography

b. CT/MRI scan of Abdomen

**19. Carotid Angioplasty**

I. Carotid Angioplasty is defined as percutaneous neurological intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or



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blockage of minimum 50% of one of the carotid arteries. The intervention must be determined to be medically necessary by an interventional radiologist/neurologist and supported by a Cerebral angiogram.

II. Diagnostic angiography or investigation procedures without angioplasty / stent insertion are excluded.

**20. Polycystic Kidney Disease**

Diagnosis of Polycystic Kidney Disease confirmed and evidenced by radiological investigations such as ultrasonography, MRI or CT scan. Diagnosis must be confirmed by a Specialist medical practitioner.

**21. Primary Biliary Cirrhosis/Primary Biliary Cholangitis (PBC)**

PBC is a type of liver disease caused by damage to the bile ducts in the liver and characterized by:

- Jaundice
- Ascites
- Variceal bleeding
- Hepatomegaly

Diagnosis should be confirmed by a Specialist medical practitioner and evidenced by both of the below mentioned:

a. Ultrasonography findings (abdomen) suggestive of PBC

b. Liver Biopsy

**22. Cardiac Rupture**

Cardiac Rupture is a medical condition to be confirmed and diagnosed by a Specialist medical practitioner. The diagnosis must be supported by 2-D echocardiography/ post-mortem in case of fatal rupture.

**23. Total Laryngectomy**

I. The undergoing of Surgery on the advice of a Specialist Medical Practitioner to remove the entire larynx for disease/illness or Injury.

II. Surgery undergone for partial resection of larynx is excluded

**24. Cerebral Artery Bypass Surgery**

I. The actual undergoing of cerebral surgery to correct blockage or narrowing in one or more cerebral artery(s), by cerebral artery bypass grafting done via a craniotomy or minimally invasive key hole cerebral artery bypass procedures. The diagnosis must be supported by a cerebral angiography and the realization of surgery has to be confirmed by a neurosurgeon.

II. Angioplasty and/or any other intra-arterial procedures are excluded.

**25. Pulmonary Thromboembolism (PTE)**

PTE is a condition characterized by obstruction of either part or whole of the pulmonary artery by a thrombus. The diagnosis must be supported by pulmonary angiography or Ventilation-Perfusion lung scan and confirmed by a specialist medical practitioner.Pulmonary embolism under claim should fall in Class III or more of PESI (Pulmonary Embolism Severity Index)

**26. Carotid endarterectomy Surgery**

The actual undergoing of Surgery on the advice of a Specialist Medical Practitioner for treatment of carotid artery disease where the carotid artery narrowing is 50% or more. The narrowing should be supported by carotid angiogram.

**27. Spinal Surgery in case of Trauma**

The actual undergoing of reparative surgery in case of major blunt trauma on the advice of a specialist medical practitioner. Spinal surgeries due to illness/diseases are excluded.

**Category B:**

**28. Alzheimer's disease**

Alzheimer's disease is a progressive degenerative Illness of the brain, characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.

Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a specialist Medical Practitioner (Neurologist) and supported by Our appointed Medical Practitioner, evidenced by findings in cognitive and neuro radiological tests (e.g. CT scan, MRI, PET scan of the Brain). The disease must result in a permanent inability to perform three or more Activities with Loss of Activities of Daily Living(as defined under Section 1;General Definitions) or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days

The following conditions are however not covered:

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

b. alcohol related brain damage; and

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

**29. Apallic syndrome**

Apallic Syndrome or Persistent vegetative state (PVS) or unresponsive wakefulness syndrome (UWS) is a universal necrosis of the brain cortex with the brainstem remaining intact. The patient should be in a vegetative state for a minimum of four weeks in order to be classified as UWS, PVS, Apallic Syndrome.

The diagnosis must be confirmed by a Neurologist acceptable to Us and the condition must be documented for at least one month.

In this condition, the patient with severe brain damage progresses who was in coma, progresses to a wakeful conscious state, but not in a state of true awareness.

**30. Loss of independent existence**

Loss of independent existence means inability of the insured person to perform at least 3 of the 6 Activities of Daily Living (as defined under Section 1, General

Definitions)for a continuous period of at least 6 months, due to disease/injury.

Limitation: Please note that we shall pay only one claim related to Loss of Independent Existence, as an independent insured event or as a part of fulfillment of criteria laid down under Critical Illness definitions, during the lifetime of policy for a particular insured person.

**31. Chronic Rheumatoid Arthritis**

Unequivocal Diagnosis of systemic immune disorder of rheumatoid arthritis where all of the following criteria are met:

- Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis;
- Permanent inability to perform at least two (2) Activities of Daily Living(as defined under Section 1;General Definitions);
- Widespread joint destruction and major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet; and
- The foregoing conditions have been present for at least six (6) months.
- Presence of chronic rheumatoid arthritis should be supported by Elevated levels of anti-CCP (anti-cyclic citrullinated peptide), markedly elevated erythrocyte sedimentation rate (ESR) and high titres of RA factor (Rheumatoid Arthritis Factor) test

**32. Pheochromocytoma**

Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines requiring the actual undergoing of surgery to remove the tumour.

The Diagnosis of Pheochromocytoma must be supported by plasma metanephrine levels and / or urine catecholamines and metanephrines and confirmed by a registered doctor who is an endocrinologist.

**33. Eisenmenger's Syndrome**

Development of severe pulmonary hypertension and shunt reversal resulting from heart condition. The diagnosis must be made by a registered Medical Practitioner who is a specialist with echocardiography and cardiac catheterisation and supported by the following criteria:

- Mean pulmonary artery pressure > 40 mm Hg;
- Pulmonary vascular resistance > 3mm/L/min (Wood units); and
- Normal pulmonary wedge pressure < 15 mm Hg

**34. Chronic Adrenal Insufficiency**

An autoimmune disorder causing a gradual destruction of the adrenal gland resulting in the need for life long glucocorticoid and mineral corticoid replacement therapy. The disorder must be confirmed by a registered Medical Practitioner who is a specialist in endocrinology through one of the following:

- ACTH simulation tests;


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- Insulin-induced hypoglycemia test;
- Plasma ACTH level measurement;
- Plasma Renin Activity (PRA) level measurement.

Only autoimmune cause of primary adrenal insufficiency is included. All other causes of adrenal insufficiency are excluded.

**35. Cardiac Pacemaker insertion**

Insertion of a permanent cardiac pacemaker that is required as a result of serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be absolutely necessary by a specialist in the relevant field; or Insertion of a permanent cardiac defibrillator as a result of cardiac arrhythmia which cannot be treated via any other method. Documentary evidence of ventricular tachycardia or fibrillation must be provided.

**36. Surgical removal of an eyeball**

Surgical removal of an eyeball as a result of Injury or disease. For this definition, Self-inflicted Injuries is not covered:

**37. Wilson's disease**

Wilson's disease is a medical condition typically characterized by liver cirrhosis, degeneration of basal ganglia and peripheral corneal pigmentation. Diagnosis should be confirmed by a specialist medical practitioner and evidenced by:

a. Elevated levels of Serum Copper &

b. Deficiency of Serum Caeruloplasmin

c. Liver biopsy confirming elevated hepatic copper concentrations

d. Corneal pigmentation confirmed by an Ophthalmologist

**38. Guillain Barre Syndrome (GBS)**

- GBS is an acute, frequently severe, and fulminant polyradiculoneuropathy that is autoimmune in nature.
- Level 3 of Brighton Criteria for diagnosis of GBS should be met.
- This medical condition to be certified by a consultant neurologist or a specialist.

**39. Age Related Macular Degeneration (ARMD)**

I. Total, permanent and irreversible loss of central vision in one/both eyes as a result of age related macular degeneration.

The diagnosis of ARMD must be confirmed by an Ophthalmologist and supported by Fluorescein angiography/ Optical Coherence Tomography

**40. Surgery for Removal of Acoustic Neuroma**

The actual undergoing of surgery for removal of acoustic neuroma on advice of the Specialist medical practitioner.

**41. Major Brain Surgery**

The actual undergoing of Surgery to the brain arising from a disease process under general anesthesia during which a craniotomy / craniectomy is performed.

Exclusion:

Burr hole Surgery / brain Surgery on account of an Accident.

**42. Complete Splenectomy**

The actual undergoing of surgery for removal of entire spleen on the advice of a Specialist medical practitioner due to illness/disease or injury. Partial resection of the spleen and surgery undertaken for removal of spleen in view of alcoholic liver diseases is excluded.

**43. Whipple procedure**

The actual undergoing of Surgery which involves removal of head of pancreas, first part of small intestine (duodenum), the gallbladder along with bile duct. The surgery is undergone on the advice of a Specialist medical practitioner necessitated due to illness/disease or injury.

**44. Loss of sight of one eye and loss of one limb**

Total and irrecoverable loss of sight of one eye and loss of a Limb.

For the purpose of this Benefit:

1. Limb means a hand at or above the wrist or a foot above the ankle;
2. In this benefit, Loss means the physical separation of a body part, or the total loss of functional use of a body part or organ provided this has continued for at least 365 days from the onset of such disablement and provided further that We are satisfied based on a written confirmation by a Medical Practitioner at the expiry of the 365 days that there is no reasonable medical hope of improvement.

**45. Embolization of Acquired AV fistula**

Embolization is a procedure which uses materials such as gelfoam sponges, metal coils, balloons etc. to block a blood vessel.

Undergoing the procedure of embolization of acquired AV (arterio-venous) fistula on the advice of specialist medical practitioner. Embolization carried out in case of AV fistulas created in case of hemodialysis is excluded.

**46. Myxomas**

Myxomas are cardiac tumors which commonly present with obstructive signs/ symptoms. The condition should be confirmed by a Specialist medical practitioner and evidenced by 2D echocardiography or CT/MRI scan.

**47. Diabetes Insipidus**

Diabetes insipidus is a medical condition characterized by the production of abnormally large volumes of dilute urine. The diagnosis of this condition has to be confirmed by a Specialist medical practitioner and fulfils the following criteria:

a. 24- hour urine exceeds 50 mL/kg body weight per day;

b. Urine osmolarity is below 300 mOsmol/L; and

c. Polyuria

Gestational diabetes insipidus is excluded.

**48. Full dental reconstruction due to accident**

Undergoing of full mouth/dental reconstruction surgery as part of an inpatient care necessitated due to an

accident. Reconstructive surgery should be on the advice of a Specialist Dental surgeon.

The claim should be supported by all relevant medico legal compliances viz. FIR/ MLC/ police report and relevant imaging / clinical reports.

Full dental reconstruction done for full mouth rehabilitation in view of any disease, replacement of missing teeth, secure implant/ ill-fitting denture, treating multiple teeth with caries needing root canal treatment / extraction of treatment of periodontal problems is specifically excluded.

**49. Keyhole Craniotomy**

The actual undergoing of Surgery to the brain via keyhole surgery ("Keyhole Craniotomy"). Surgery must be considered medically necessary by a consultant neurologist.

Exclusion:

Burr hole Surgery / brain Surgery on account of an Accident.

**50. Terminal Illness**

The conclusive diagnosis of an illness, which in the opinion of a Medical Practitioner who is an attending Consultant and agreed by our appointed Registered Medical practitioner, life expectancy is no greater than twelve (12) months from the date of notification of claim, regardless of any treatment that might be undertaken.

**<u>Category C</u>**

51. Creutzfeldt-Jakob disease

Creutzfeldt-Jacob disease is an incurable brain infection that causes rapidly progressive deterioration of mental function and movement. A registered doctor who is a neurologist must make a definite diagnosis of Creutzfeldt-Jacob disease based on clinical assessment, EEG and imaging. There must be objective neurological abnormalities on examination along with severe progressive dementia.

**52. Progressive Scleroderma**

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve some organ system i.e heart, lungs or kidneys etc.

The following conditions are excluded:

- Localised scleroderma (linear scleroderma or morphea);
- Eosinophilicfascitis; and
- CREST syndrome

**53. Medullary Cystic Disease**

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

**54. Muscular dystrophy**

A group of hereditary degenerative diseases of muscle characterised by

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

a. Family history of muscular dystrophy;

b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;

c. Characteristic electromygram; or

d. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living(as definied under section 1 ;General Definitions) as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months.

**55. Poliomyelitis**

The unequivocal diagnosis of infection with the polio virus must be established by a Consultant Neurologist. The infection must result in irreversible paralysis as evidenced by impaired motor function or respiratory weakness. Expected permanence and irreversibility of the paralysis must be confirmed by a Consultant Neurologist after at least 6 months since the beginning of the event.

Exclusions:

Cases not involving irreversible paralysis shall not be eligible for a claim

Other causes of paralysis such as Guillain-Barré Syndrome are specifically excluded.

**56. Systemic lupus erythematosus with renal involvement**

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

a. Class I: Minimal change – Negative, normal urine.

b. Class II: Mesangial – Moderate proteinuria, active sediment.

c. Class III: Focal Segmental – Proteinuria, active sediment.

d. Class IV: Diffuse – Acute nephritis with active sediment and/or nephritic syndrome.

e. Class V: Membranous – Nephrotic Syndrome or severe proteinuria.

**57. Myasthenia gravis**

An acquired autoimmune disorder of neuromuscular transmission leading to fluctuating muscle weakness and


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fatigability, where all of the following criteria are met:

- Presence of permanent muscle weakness categorized as Class IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification below; and
- The Diagnosis of Myasthenia Gravis and categorization are confirmed by a registered Medical Practitioner who is a neurologist.

Myasthenia Gravis Foundation of America Clinical Classification:

Class I: Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere.

Class II: Eye muscle weakness of any severity, mild weakness of other muscles.

Class III: Eye muscle weakness of any severity, moderate weakness of other muscles.

Class IV: Eye muscle weakness of any severity, severe weakness of other muscles.

Class V: Intubation needed to maintain airway.

**58. Good pastures syndrome with lung or renal involvement**

Goodpasture's syndrome is an autoimmune disease in which antibodies attack the lungs and kidneys, leading to permanent lung and kidney damage. The permanent damage should be for a continuous period of at least thirty (30) days. The Diagnosis must be proven by Kidney biopsy and confirmed by a Specialist Medical Practitioner.

**59. 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. Following 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.

The aorta is the main artery carrying blood from the heart. Aortic graft surgery benefit covers Surgery to the aorta wherein part of it is removed and replaced with a graft.

**60. Bacterial Meningitis**

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks resulting in permanent inability to perform three or more

Activities for Loss of Independent Living(as defined under section 1;General Definitions)

This diagnosis must be confirmed by:

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

b. A consultant neurologist certifying

the diagnosis of bacterial meningitis.

Bacterial Meningitis in the presence of HIV infection is excluded.

**61. Encephalitis**

Severe inflammation of the brain tissue due to infectious agents like viruses or bacteria which results in significant and permanent neurological deficits for a minimum period of 30 days, certified by a specialist Medical Practitioner (Neurologist)

The permanent deficit should result in permanent inability to perform three or more Activities of Daily Living(as defined under Section 1,General Definitions).

Exclusions:

Encephalitis in the presence of HIV infection is excluded.

Exclusions:

Encephalitis in the presence of HIV infection is excluded.

**62. Fulminant Viral Hepatitis**

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

a. Reduction in liver size;

b. Necrosis involving entire lobules, leaving only a collapsed reticular framework; to be supported by imaging/ biopsy evidence.

c. Rapid deterioration of liver function tests;

d. Deepening persistent jaundice; and

e. Hepatic encephalopathy.

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

**63. Crohn's Disease**

Crohn's Disease is a chronic, transmural inflammatory disorder of the bowel. To be considered as severe, there must be evidence of continued inflammation in spite of optimal therapy, with all of the following having occurred:

- Stricture formation causing intestinal obstruction requiring admission to Hospital, and
- Fistula formation between loops of bowel, and
- At least one bowel segment resection.

The diagnosis must be made by a registered medical practitioner who is a specialist Gastroenterologist and be proven histologically on a pathology report

**64. Ulcerative Colitis**

Acute fulminant ulcerative colitis with life threatening electrolyte disturbances. All of the following criteria must be met:

- the entire colon is affected, with severe bloody diarrhoea; and
- the necessary treatment is total colectomy and ileostomy; and
- the diagnosis must be based on histopathological features and confirmed by a registered Medical Practitioner who is a specialist in gastroenterology

**65. Autoimmune Hepatitis**


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Autoimmune hepatitis is a chronic disorder and diagnosis includes:

a. Hepatocellular necrosis

b. Hypergammaglobulinemia

c. Liver biopsy abnormalities

Diagnosis has to be confirmed by a specialist medical practitioner.

**66. Total Pancreatectomy**

The actual undergoing of Surgery which involves removal of pancreas. The surgery is undergone on the advice of a Specialist medical practitioner necessitated due to illness/disease or injury. Removal of pancreas due to alcoholic diseases are excluded.

**67. Tuberculosis Meningitis**

Meningitis caused by tubercle bacilli. Such a diagnosis must be supported by all of i) and ii) and iii)

i. Confirmatory Findings in the cerebrospinal fluid (CSF) report

ii. Presence of acid fast bacilli in the cerebrospinal fluid or growth of M. Tuberculosis demonstrated in the culture report or Nucleic acid amplification tests like PCR

iii. Certification by a registered doctor who is a specialist in neurology, or a physician with a degree of MD

**68. Dissecting Aortic aneurysm**

A condition where the inner lining of the aorta (intima layer) is interrupted so that blood enters the wall of the aorta and separates its layers. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The diagnosis must be made by a registered Medical Practitioner who is a specialist with computed tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiograph (MRA) or angiogram. Emergency surgical repair is required.

**69. Elephantiasis**

Massive swelling in the tissues of the body as a result of destroyed regional lymphatic circulation by chronic filariasis infection. The unequivocal diagnosis of elephantiasis must be confirmed by a registered Medical Practitioner who is a specialist physician. There must be clinical evidence of permanent massive swelling of leg(s), arm(s), scrotum(s), vulva, or breast(s). There must also be laboratory confirmation of microfilariae infection. Swelling or lymphedema caused by infection with a sexually transmitted disease, trauma, post-operative scarring, congestive heart failure, or congenital lymphatic system abnormalities is excluded.

**70. Myelofibrosis**

A disorder which can cause fibrous tissue to replace the normal bone marrow and results in anaemia, low levels of white blood cells and platelets and enlargement of the spleen. The condition must have progressed to the point that it is permanent and the severity is such that the Insured Person requires a blood transfusion at least monthly. The diagnosis of myelofibrosis must be supported by bone marrow biopsy and confirmed by a registered Medical Practitioner who is a specialist.

Evidence of the blood transfusion for last

3 months should be available.

**71. Cystic Fibrosis**

Cystic fibrosis is a medical disorder which affects multiple epithelial tissues. Diagnosis has to be confirmed by a specialist medical practitioner and supported by CFTR (Cystic Fibrosis Transmembrane Conductance Regulator) mutation analysis/ Sweat test results.

**72. Total proctocolectomy**

The actual undergoing of removal of large intestine along with rectum on advice of a special medical practitioner and necessitated due to illness/disease or injury.

**73. Toxic epidermal necrolysis (TEN)**

TEN is a type of cutaneous (skin) disorder which results in large areas of denuded skin and caused due to ingestion of certain drugs. The diagnosis has to be confirmed by a specialist medical practitioner. Any self-inflicted act of drug ingestion leading to TEN is excluded.

**74. Chronic PAN (Polyarteritis Nodosa)**

PAN is a multisystem disorder which affects the arteries in which involvement of renal and visceral arteries is predominant. The diagnosis is evidenced by way of characteristic findings of vasculitis on biopsy or arteriogram and confirmed by a Specialist medical practitioner. The condition should have been present for six (6) months.

**75. Adult Polymyositis**

Adult Polymyositis represent a disorder which causes skeletal muscle weakness. The disorder has to be confirmed by a specialist medical practitioner supported by findings of all of the below:

- analysis of serum muscle enzymes,
- EMG findings and
- muscle biopsy.

**76. Giant Cell Arteritis**

Giant Cell Arteritis is a systemic disease which involves inflammation of arteries. The medical condition has to be diagnosed and confirmed by a Specialist medical practitioner which should be supported by findings of vasculitis in biopsy of artery or vascular imaging studies – Ultrasonography/MRI/CT scan.

**77. Multiple System Atrophy**

A Diagnosis of multiple system atrophy made by a Specialist Medical Practitioner (Neurologist). There must be evidence of permanent clinical impairment for a minimum period of thirty (30) days of bladder control with postural hypotension and any 2 of the following:

a. Rigidity

b. Cerebellar Ataxia

c. Peripheral Neuropathy

**78. HIV due to blood transfusion and occupationally acquired HIV**

I. Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:

a. The blood transfusion was medically necessary or given as part of a medical treatment;



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b. The blood transfusion was received in India after the Policy Commencement Date, Date of endorsement, whichever is the later;

c. The source of the infection is established to be from the Institution that provided the blood transfusion and the Institution is able to trace the origin of the HIV tainted blood; and

d. The Insured does not suffer from Thalassaemia Major or Haemophilia.

II. Infection with the Human Immunodeficiency Virus (HIV) which resulted from an Accident occurring after the Policy Commencement Date, date of endorsement or date of reinstatement, whichever is the later whilst the Insured was carrying out the normal professional duties of his or her occupation in India, provided that all of the following are proven to the Company's satisfaction:

1. Proof that the Accident involved a definite source of the HIV infected fluids;

2. Proof of sero-conversion from HIV negative to HIV positive occurring during the 180 days after the documented Accident. This proof must include a negative HIV antibody test conducted within 5 days of the Accident; and

3. HIV infection resulting from any other means including sexual activity and the use of intravenous drugs is excluded.

This benefit is only payable when the occupation of the Insured Person is a Registered Medical practitioner, housemen, medical student, registered nurse, medical laboratory technician, blood bank technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre, blood bank or clinic in India. This benefit will not apply under either section I or II (as mentioned above) where a cure has become available prior to the infection. "Cure" means any treatment that renders the HIV inactive or non-infectious.

## *Section 2 – Benefits*

### A: Critical Illness

### A1. Critical Illness

If the Insured Person is diagnosed to be suffering from a Critical Illness specified in the opted plan during the Policy Period, then, We shall pay the Sum Insured as a lump sum amount set out for that Critical Illness in the Policy Schedule provided that:

**Conditions**

1. The diagnosed critical illness is the first incidence
2. The Critical Illness is diagnosed after 90 days from the first risk commencement date.
3. The Insured Person survives the critical Illness, for a period as specified in the Policy Schedule.
4. Pre-existing diseases or its related



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conditions shall be covered after a waiting period of 48 months. The said conditions must be declared, if known, to the insured person at the time of application and must not have been explicitly excluded in the policy as permanent exclusion.

5. Multi-Pay Feature: Under multi-pay feature, if more than one claim of critical illness (es) is/are lodged during the lifetime of the Policy, We shall pay for second as well as third claim of critical illness as listed in Critical illness categories (Category A/B/C as mentioned below) provided that we shall not pay more than one claim under the same Critical illness category. In case of multiple claims under Multi-pay Feature, waiting period of 60 days from the date of diagnosis of earlier admissible Critical Illness Claim shall apply.

6. Based on the number of claim Payment made under (Multi- Pay Feature), the Coverage under this section will cease to exist upon payment of 3 claims, during the lifetime of the Policy for that particular insured person.

**Illustration for Multi-Pay Feature:**

For example, an Individual has opted for Smart Century Premier Plan under Section A: Critical Illness with Sum insured of Rs 10 Lacs and Policy Inception date is on 1st May 2021 with Policy tenure of 1 Year

| **Critical Illness Claim** | **Sum Insured available (Rs.)** | **Claim Amount (Rs.)** | **Conditions applicable** |
|---|---|---|---|
| 1st admissible Claims date on 1st September 2021 under Category A | • 10 Lacs for Category A<br>• 10 Lacs for Category B<br>• 10 Lacs for Category C | 10 Lacs under Category A | In future, no further claims will be payable under Category A in the Policy lifetime , however claims can be paid under Category B/C(one claim each) |



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| 2nd admissible Claims date on 5th December 2021 under Category B | • 10 Lacs for Category B<br>• 10 Lacs for Category C | 10 Lacs under Category B | In future, no further claims will be payable under Category A and Category B in the Policy lifetime, however claims can be paid under Category C (one claim ).<br>In case of multiple claims under Multi-pay Feature, waiting period of 60 days from the date of diagnosis of earlier admissible Critical Illness Claim shall apply. |
|---|---|---|---|
| 3rd admissible Claim on 10th March 2022 under Category C | • 10 Lacs for Category C | 10 Lacs under Category C | The Coverage under Critical Illness (Section A) will cease to exist upon payment of 3 claims, during the lifetime of the Policy.<br>In case of multiple claims under Multi-pay Feature, waiting period of 60 days from the date of diagnosis of earlier admissible Critical Illness Claim shall apply. |

7. Covered Critical Illness: A Covered Critical Illness shall mean any one of the following critical illnesses with specific meaning as defined in the policy.

**(i) <u>Smart Century Premier Plan</u>**

| Sr. No | Category A |
|---|---|
| 1 | Cancer of Specified Severity |
| 2 | Kidney Failure requiring regular dialysis |
| 3 | Major organ/Bone Marrow Transplant |
| 4 | Open Heart Replacement/Repair of Heart Valves |
| 5 | Open Chest Coronary Artery Bypass Graft |
| 6 | Myocardial Infarction (First Heart Attack of specific severity) |
| 7 | Refractory heart failure |
| 8 | Cardiomyopathy |
| 9 | Stroke resulting in permanent symptoms |
| 10 | Permanent Paralysis of Limbs |
| 11 | Parkinson's disease |
| 12 | Primary (Idiopathic) Pulmonary Hypertension |
| 13 | End Stage Lung Failure |
| 14 | Rabies |
| 15 | End Stage Liver Failure |
| 16 | Angioplasty |
| 17 | Chronic Aplastic Anemia |
| 18 | Cerebral Aneurysm with Specified Surgery |
| 19 | Hemiplegia |
| 20 | Chronic Relapsing Pancreatitis |
| 21 | Infective Endocarditis |
| 22 | Pericardectomy |
| 23 | Percutaneous Heart Valve Replacement |
| 24 | Pneumonectomy |
| 25 | Bariatric Surgery |
| 26 | Percutaneous Transluminal Angioplasty of Renal Artery |
| 27 | Severe Progressive Supranuclear Palsy |
| 28 | Surgical Removal of One Kidney |
| 29 | Total Glossectomy |
| 30 | Budd–Chiari syndrome |
| 31 | Carotid Angioplasty |
| 32 | Polycystic Kidney Disease |

| | |
|---|---|
| 33 | Primary Biliary Cirhosis |
| 34 | Cardiac Rupture |
| 35 | Total Laryngectomy |
| 36 | Cerebral Artery Bypass Surgery |
| 37 | Pulmonary Thromboembolism |
| 38 | Carotid endarterectomy Surgery |
| 39 | Spinal Surgery in case of Trauma |

| **Sr.No** | **Category B** |
|---|---|
| 40 | Multiple Sclerosis with Persisting Symptoms |
| 41 | Motor Neuron Disease with Permanent Symptoms |
| 42 | Alzheimer’s disease |
| 43 | Benign brain tumor |
| 44 | Major Head Trauma |
| 45 | Apallic syndrome |
| 46 | Deafness |
| 47 | Loss of speech |
| 48 | Loss of limbs |
| 49 | Loss of independent existence |
| 50 | Blindness |
| 51 | Third Degree Burns |
| 52 | Coma of specified severity |
| 53 | Chronic Rheumatoid Arthritis |
| 54 | Pheochromocytoma |
| 55 | Eisenmenger's Syndrome |
| 56 | Chronic Adrenal Insufficiency |
| 57 | Cardiac Pacemaker insertion |
| 58 | Surgical removal of an eyeball |
| 59 | Wilson's disease |
| 60 | Guillain Barre Syndrome (GBS) |
| 61 | Age Related Macular Degeneration |
| 62 | Surgery for removal of Acoustic Neuroma |
| 63 | Major Brain Surgery |

| | |
|---|---|
| 64 | Complete Splenectomy |
| 65 | Whipple procedure |
| 66 | Loss of sight of one eye and loss of one limb |
| 67 | Embolization of Acquired AV fistula |
| 68 | Myoxomas |
| 69 | Diabetes Insipidus |
| 70 | Full dental reconstruction due to accident |
| 71 | Keyhole Craniotomy |
| 72 | Terminal Illness |

| **Sr.No** | **Category C** |
|---|---|
| 73 | Creutzfeldt-Jakob disease |
| 74 | Progressive Scleroderma |
| 75 | Medullary Cystic Disease |
| 76 | Muscular dystrophy |
| 77 | Poliomyelitis |
| 78 | Systemic lupus erythematosus with renal involvement |
| 79 | Myasthenia gravis |
| 80 | Good pastures syndrome with lung or renal involvement |
| 81 | Aorta Graft surgery |
| 82 | Bacterial Meningitis |
| 83 | Encephalitis |
| 84 | Fulminant Viral Hepatitis |
| 85 | Crohn's Disease |
| 86 | Ulcerative Colitis |
| 87 | Autoimmune Hepatitis |
| 88 | Total Pancreatectomy |
| 89 | Tuberculosis Meningitis |
| 90 | Dissecting Aortic aneurysm |
| 91 | Elephantiasis |
| 92 | Myelofibrosis |
| 93 | Cystic Fibrosis |
| 94 | Total proctocolectomy |


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| | |
|---|---|
| 95 | Toxic epidermal necrolysis (TEN) |
| 96 | Chronic PAN (Polyarteritis Nodosa) |
| 97 | Adult Polymyositis |
| 98 | Giant Cell Arteritis |
| 99 | Multiple System Atrophy |
| 100 | HIV due to blood transfusion and occupationally acquired HIV |

**(ii) Smart Half Century Plan**

| Sr. No | Category A |
|---|---|
| 1 | Cancer of Specified Severity |
| 2 | Kidney Failure requiring regular dialysis |
| 3 | Major organ/Bone Marrow Transplant |
| 4 | Open Heart Replacement/Repair of Heart Valves |
| 5 | Open Chest Coronary Artery Bypass Graft |
| 6 | Myocardial Infarction (First Heart Attack of specific severity) |
| 7 | Cardiomyopathy |
| 8 | Stroke resulting in permanent symptoms |
| 9 | Permanent Paralysis of Limbs |
| 10 | Parkinson's disease |
| 11 | Primary (Idiopathic) Pulmonary Hypertension |
| 12 | End Stage Lung Failure |
| 13 | Rabies |
| 14 | End Stage Liver Failure |
| 15 | Angioplasty |
| 16 | Chronic Relapsing Pancreatitis |
| 17 | Infective Endocarditis |
| 18 | Severe Progressive Supranuclear Palsy |

| Sr.No | Category B |
|---|---|
| 19 | Multiple Sclerosis with Persisting Symptoms |
| 20 | Motor Neuron Disease with Permanent Symptoms |
| 21 | Alzheimer's disease |


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| | |
|---|---|
| 22 | Benign brain tumor |
| 23 | Major Head Trauma |
| 24 | Apallic syndrome |
| 25 | Deafness |
| 26 | Loss of speech |
| 27 | Blindness |
| 28 | Third Degree Burns |
| 29 | Coma of specified severity |
| 30 | Chronic Rheumatoid Arthritis |
| 31 | Pheochromocytoma |
| 32 | Eisenmenger's Syndrome |
| 33 | Chronic Adrenal Insufficiency |
| 34 | Major Brain Surgery |
| 35 | Terminal Illness |

| Sr.No | Category C |
|---|---|
| 36 | Creutzfeldt-Jakob disease |
| 37 | Progressive Scleroderma |
| 38 | Medullary Cystic Disease |
| 39 | Systemic lupus erythematosus with renal involvement |
| 40 | Aorta Graft surgery |
| 41 | Bacterial Meningitis |
| 42 | Encephalitis |
| 43 | Fulminant Viral Hepatitis |
| 44 | Crohn’s Disease |
| 45 | Ulcerative Colitis |
| 46 | Dissecting Aortic aneurysm |
| 47 | Elephantiasis |
| 48 | Myelofibrosis |
| 49 | Multiple System Atrophy |
| 50 | HIV due to blood transfusion and occupationally acquired HIV |

**A2. Waiver of Premium (Applicable for Smart Century Premier Plan)**

We will waive 70% of payable renewal Premium for next 3 Policy Years of the Insured Person where the first Claim has been admitted by Us under Smart Century Premier Plan under Section A of this Policy

Premium will be waived for Renewal of that particular Insured Person to the extent applicable to coverages, terms and conditions of the expiring Policy.

**A3. Health Check up**

We will cover expenses for Preventive Health Check-up upto 1% of previous policy year Sum Insured maximum up to Rs 10,000 provided this coverage exists in the previous Policy year and no claim has been reported in the previous three consecutive Policy years with Us . This limit is maximum per insured person. This Benefit is payable over and above the Sum Insured.

For the purpose of this benefit, Preventive Health Check-up means medical test(s) undertaken for general assessment of health status and does not include any diagnostic or investigative medical tests for evaluation of illness or a disease.

**A4. Second Medical Opinion**

We will organize second Medical opinion upon specific request of Insured person from Network Provider or Medical Practitioner, if an Insured Person is diagnosed with covered Critical Illness during the Policy Period. The expert opinion would be directly sent to the Insured Person and would be subject to the following conditions.

a) This Benefit can be availed by the Insured Person only once in the Policy Period

b) The Second Medical Opinion shall be arranged only on the basis of information and documentation provided to Us.

c) Under this Benefit, We are only providing the Insured Person with access to a Second Medical Opinion and it shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.

d) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

e) Any Second Medical Opinion provided under this benefit shall not be valid for any medico-legal purposes.

**A5. Smart Cancer Care**

If the Insured Person is diagnosed to be suffering from Cancer of the nature as specified below during the Policy Period and survives the duration as specified on the Policy Schedule, then, We shall pay the below specified percentage of Sum Insured mentioned in the Policy Schedule against this benefit provided that the Critical Illness is diagnosed during the Policy Period as a first incidence subject to:

**Conditions**

a) Maximum liability during the

lifetime of the Insured Person: 100% of the Sum Insured applicable to this benefit

b) Cover Termination: Once a claim for Advanced stage of Cancer becomes admissible, coverage for this benefit shall terminate.

c) Maximum number of claims: One under Early Stage Cancer and/or Major and/or Advanced Stage.

d) For any of the specified Early Stage Cancer Condition or Carcinoma-in-situ (CIS) 20% of the Sum Insured as specified in the Policy Schedule shall be payable only once and only for the first event of early stage/CIS cancer.

e) For specified Major Stage Cancer, 30% of the Sum Insured as specified in the Policy Schedule shall be payable.

f) For specified Advanced Stage Cancer, 50% of the Sum Insured as specified in the Policy Schedule shall be payable.

g) If more than one stage is diagnosed within a period of 7 days, only one claim, with the highest Benefit pay-out shall be admissible.

h) Cancer is diagnosed after 90 days from the first risk commencement date.

i) The Insured Person survives the diagnosed Cancer for a period as specified in the Policy Schedule.

j) Pre-existing diseases or its related conditions shall be covered after a waiting period of 48 months. The said conditions must be declared, if known, to the insured person at the time of application and must not have been explicitly excluded in the policy as permanent exclusion.

k) This benefit has a separate sum insured and is over and above the Critical Illness Benefit Sum Insured.

**Various Stages of Cancer as defined under Smart Cancer Care:**

**a. Early Stage:**

This shall include the following:

1. Carcinoma in situ of the following sites: breast, uterus, ovary, fallopian tube, vulva, vagina, cervix uteri, colon, rectum, penis, testis, lung, liver, stomach, nasopharynx or bladder. Carcinoma in situ means the focal autonomous new growth of carcinomatous cells confined to the cells in which it originated and has not yet resulted in the invasion and/or destruction of surrounding tissues.

   'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The diagnosis of the Carcinoma in situ must always be supported by a histopathological report. Furthermore, the diagnosis of Carcinoma in situ must always be positively diagnosed upon the basis of a microscopic examination of the fixed tissue, supported by a biopsy result.

   Clinical diagnosis that does not meet this standard or Cervical Intraepithelial Neoplasia (CIN)

classification which reports CIN I, CIN II, and CIN III (severe dysplasia without carcinoma in situ) not meeting the required definition are specifically excluded.

1. Prostate Cancer that is histologically described using the TNM Classification as T1N0M0 or Prostate cancers described using another equivalent classification. Thyroid Cancer that is histologically described using the TNM Classification as T1N0M0. Tumours of the Urinary Bladder histologically classified as T1N0M0 (TNM Classification). Chronic Lymphocytic Leukaemia (CLL) RAI Stage 1 or 2. CLL RAI 0 or lower is excluded.

**b. Major Stage (Cancer of Specified Severity):**

I. A malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues.

This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukaemia, lymphoma and sarcoma.

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 & CIN-3.

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

**c. Advanced Stage (Metastatic Cancer):**

All Stage IV malignant tumor with the presence of distant metastasis. A spread to lymph nodes only is not covered under this definition. The diagnosis of malignancy must be confirmed by histological evidence. Metastatic cancer


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is a cancer that has spread from the part of the body where it started (the primary site) to other parts of the body. When cancer cells break away from a tumour, they can travel to other areas of the body through the bloodstream, the lymph system (which contains a collection of vessels that carry fluid and immune system cells) or through the peritoneum

Following is excluded:

i. Locally advanced cancers (these will be considered as Early Stage/ Major for the purpose of this policy)

ii. Any leukaemia and lymphoma (these will be considered as Major for the purpose of this policy)

**Survival Period:**

The payment of a Benefit under this Section shall be subject to survival of the Insured Person for the number of days as specified in the Policy Schedule following the first diagnosis of the Cancer irrespective of stage

**B: Cancer 360 Degree-Indemnity Cover**

The following benefits are payable for Treatment of Cancer (including In-situ Cancer or any pre-cancerous lesions) subject to applicable waiting period, otherTerms and Conditions of the policy:

**B1. In-Patient Treatment**

We will cover Medical Expenses up to the Sum Insured as specified in the Policy Schedule for Treatment of Cancer during the policy period which requires an Insured Person's admission in a hospital as an In -Patient .

Reasonable and Customary Charges for Medically Necessary treatment directly related to the hospitalization would be payable prescribed in writing, by a treating Medical Practitioner.

**B2. Pre- Hospitalization expenses**

We will cover Reasonable and Customary Pre-Hospitalization Medical expenses up to the Sum Insured and which is incurred up to 60 days before the date of admission to the hospital.

The benefit is payable if We have admitted a claim under In-Patient Treatment (SectionB1) or Day Care Treatment (Section B4) or Home Care (Section B6) of this policy.

**B3. Post-Hospitalization expenses**

We will cover Reasonable and Customary Post-Hospitalization Medical expenses up to the Sum Insured and which is incurred upto 90 days after the date of discharge from the hospital.

The benefit is payable if We have admitted a claim under In-Patient Treatment (Section B1) or Day Care Treatment (Section B4) or Home Care (Section B6) of this policy.

**B4. Day Care Treatment**

We will cover Reasonable and customary Medical expenses for Day Care Treatments up to the Sum Insured which an Insured Person undergoes due to Cancer (including In-situ Cancer or any pre-cancerous lesions) during the policy period.

Treatment normally taken on out-patient basis is not included in the scope of this cover.

### B5. Organ Donor Expenses

We will cover Reasonable and Customary Medical and surgical Expenses of the organ donor for harvesting the organ up to the Sum Insured where an Insured Person is the recipient provided that:

i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organs (Amendment) Bill, 1994 and its subsequent amendments and the organ donated is for the use of the Insured Person, and

ii. The Insured Person has been medically advised to undergo an organ transplant necessitated as a part of cancer treatment and We have accepted an inpatient Hospitalization claim for the Insured Person under In Patient Treatment for Cancer (under B1).

### B6. Home Care (Cancer)

We will cover Reasonable and customary Medical expenses for Home Care Treatment for cancer up to the Sum insured for the Insured Person's Medically necessary Treatment at his/her home provided that:

I. Duration of the each Home Care Treatment does not exceed 15 days

II. OPD Treatment is not covered under this section

III. The same treatment is eligible for coverage under In Patient Treatment (under B1)

IV. The amount, frequency and time period of the home treatment services should be reasonable and advised by the treating Medical Practitioner

V. Treatment under this Benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the home treatment plan, in accordance with the condition of the Insured Person.

VI. Home Treatment services are provided through Network Service Provider / Empanelled Service Provider in select cities for select treatment procedures only. Please contact Us or visit our website (www.tataaig.com) for updated list of treatment procedures and cities where Home Treatment service is provided.

VII. We do not assume any liability towards, and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner and/or Network Service Provider / Empanelled Service Provider or in any service under this Benefit or for any consequences of actions taken or not taken in reliance thereon.

### B7. Chemotherapy and Radiotherapy Cover

We will cover Reasonable and Customary Medical Expenses up to the Sum Insured as specified in the Policy Schedule for availing Chemotherapy (including Oral Chemotherapy) and Radiotherapy treatment, provided that the Medical Expenses are related to Cancer.

### B8. OPD Cover (Outpatient)

We will cover Reasonable and Customary Medical expenses related to consultations, diagnostics and pharmacy up to 1% of Sum Insured subject to maximum of Rs. 10,000/- per policy year .

**B9. Advanced Treatments for Cancer**

We will cover Reasonable and Customary Medical Expenses incurred for availing Advanced Treatments for Cancer up to the Sum Insured as mentioned in the Policy Schedule as listed below

- Proton Treatment
- Immunotherapy including immunology agents
- Personalized and Targeted Therapy
- Hormonal Therapy or Endocrine manipulation
- Vaporisation of the prostate
- Stem cell transplantation
- Robotic/ Stereotactic radio Surgeries
- Any other Advanced and established Medical Practice(that has significant Medical documentation to support their effectiveness)

**B10. Hotel accommodation**

We will pay 1% of Sum Insured subject to maximum Rs 5000 per day up to 5 days per policy year for hotel accommodation for the Insured Person/accompanying person/attendant if the Insured Person is travelling a distance > 200 kms from his place of residence for treatment of Cancer.

For a Claim to be payable we must have accepted a Claim under In-Patient Treatment(Section B1) or Day Care Procedures (Section B2) or OPD Cover(Section B8).

**B11. Transportation Expenses**

We will arrange for your travel to Hospital/ Day Care Centre and also travel back to your residence/starting point of the said trip within the city in which you normally reside to avail Cancer Treatment through our empanelled service provider. Where ever this facility cannot be provided ,We will Pay a fixed amount of Rs 500 Per day.

Conditions:

- The Insured Person can avail this Benefit maximum up to 10 days in a Policy Year.
- The maximum number of trips in a day is limited to 2 trips a day whenever this facility is availed through our empanelled service provider.
- Services that are provided through our empanelled service provider, We would not be liable for any consequential loss, additional costs or the services incurred which are beyond the scope of this policy.
- The decision to utilize this service is solely at Your discretion.
- We do not assume any liability towards quality of service rendered, any loss or damage arising out of or in relation to these services rendered by the empanelled service provider.
- This facility may be availed through Our Website or Our mobile application or through calling Our call centre on the toll free number

specified in the Policy Schedule

**B12. Ambulance Cover**

We will cover expenses incurred on transportation of Insured Person in a registered ambulance to a Hospital for admission in case of an Emergency or from one hospital to another hospital for better medical facilities and treatment, subject to Rs. 5000 per Hospitalization.

For this claim to be paid, the claim must be admissible under In-Patient Treatment (Section B1) or Day Care Treatment (Section B4) of this policy.

The Insured Person can Claim either of Transportation Expenses (Section B11) or Ambulance Cover (Section B 12).

**B13. High End Diagnostics**

We will cover Reasonable and Customary charges incurred for the following diagnostic tests only on OPD basis if required as part of a medically necessary treatment subject to maximum Rs. 25,000 per policy year:

i. Computed Tomography (CT) guided Biopsy

ii. Liver Biopsy

iii. Magnetic Resonance Cholangiography Scan

iv. Positron Emission Tomography–Computed Tomography (PET-CT)

v. Positron emission tomography–Magnetic Resonance Imaging (PET-MRI)

**B14. Palliative Care for Cancer**

We will cover Palliative or Supportive Care up to 10% of sum insured ; maximum upto Rs.5 Lacs in a policy year for taking care of the overall side effects of treatment on the Insured Person after diagnosis of Cancer subject to

I. Palliative Care is medically prescribed by the Medical Practitioner for improving the quality of life of the Insured Person.

II. The benefit is payable if We have admitted a claim under In-Patient Treatment (Section B1) or Day Care Treatment (Section B4) or Home Care(Section B6) .

Please note : Medical Exclusion (Code-Excl05) is superseded to the extent covered under this Benefit

**B15. Psychiatric Counseling**

We will cover expenses incurred for a consultation with a psychologist up to an amount of Rs 2000 per session if the same is availed by the insured Person for dealing with emotional/mental trauma after being diagnosed with Cancer.

The maximum number of session that can be availed under this Benefit is up to 8 sessions per Policy year .

**B16. Health Check up**

We will cover expenses for Preventive Health Check-up upto 1% of previous Policy sum insured maximum up to Rs 10,000 provided this coverage exists in the previous Policy and no claim has been reported in the previous three consecutive Policy years with Us . This limit is maximum per insured person. This Benefit is payable over and above the Sum Insured.

For the purpose of this benefit, Preventive

Health Check-up means medical test(s) undertaken for general assessment of health status and does not include any diagnostic or investigative medical tests for evaluation of illness or a disease.

**B17. Second Medical Opinion**

We will organise second medical opinion upon specific request of Insured person from Network Provider or Medical Practitioner, if an Insured Person is diagnosed with Cancer during the Policy Period. The expert opinion would be directly sent to the Insured Person and would be subject to the following conditions.

a) This Benefit can be availed by the Insured Person only once in the Policy Period

b) The Second Medical Opinion shall be arranged only on the basis of information and documentation provided to Us.

c) Under this Benefit, We are only providing the Insured Person with access to a Second Medical Opinion and it shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.

d) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

e) Any Second Medical Opinion provided under this benefit shall not be valid for any medico-legal purposes.

**B18. Global Cover**

We will cover Reasonable and Customary Medical Expenses of the Insured Person incurred outside India, up to the sum insured, for Medically necessary Treatment of Cancer provided that the diagnosis was made in India and the insured person travels abroad for treatment.

The Medical Expenses payable shall be limited to Inpatient and daycare Hospitalization only on reimbursement basis

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 for the following day published by RBI shall be considered for conversion.

We shall require the following additional documents supporting the claim under this benefit:

- Proof of diagnosis in India
- Insured's Passport and Visa

**B19. Consumable Benefit**

We will pay for expenses incurred, for specified consumables which are listed in 'Annexure – 1 List 1 as Optional Items' under 'Guidelines on Standardization in Health Insurance, 2016' and its amendments, which are consumed during the period of hospitalization

directly related to the insured's medical or surgical treatment of Cancer. Details of Annexure I-List I-Optional items are available on our website (www.tataaig.com)

However, the following items shall be excluded from scope of this coverage:

- Items of personal comfort, toiletries, cosmetics and convenience shall be excluded from scope of this coverage.
- External durable devices like Bilevel Positive Airway Pressure (BIPAP) machine, Continuous Positive Airway Pressure (CPAP) machine, Peritoneal Dialysis (PD) equipment and supplies, Nimbus/water/air bed, dialyzer and other medical equipments.
- Any item which is neither medical consumable nor medically necessary nor prescribed by doctor

For this claim to be paid, the main claim must be admissible under section B1 or B4 or B6 of this policy.

**C: Hospital Cash**

The following benefits shall be payable subject to applicable waiting period and other terms/conditions of the policy:

**C1. In –Patient Hospital Cash**

We will pay a Fixed Daily Cash Benefit as specified in the Policy Schedule for each continuous and completed 24 Hours of Hospitalization for Medically necessary treatment of the Insured Person due to an illness during the Policy Year, provided that:

i. All Benefits will be available up to the maximum number of coverage days specified in the policy schedule.

ii. On the day of discharge, when insured person is discharged before completion of consecutive 24 hours of hospitalization, we shall pay 50% of daily cash benefit.

**C2. Prolonged Hospital Cash Benefit**

We will pay a fixed amount of Rs 10,000 in the event of insured person hospitalisation for an illness/injury exceeds continuous period 10 days.

This Benefit is over and above the In – Patient Hospital Cash (Section C1) and can be availed only once per Policy year provided that the In-patient Hospital Cash claim is admissible under benefit C1 of this policy.

**C3. ICU Cash Benefit**

In case Insured Person's Hospitalization is in Intensive Care Unit (ICU), We will pay twice the In –Patient Hospital Cash Benefit(Section C1) for the duration of stay in Intensive Care Unit(ICU) for each continuous and completed 24 Hours of Hospitalization for Medically necessary treatment of the Insured Person due to an illness during the Policy Year.

Note: During the hospitalization period if the insured person is transferred from hospital ward/room to ICU or vice versa the benefit would be payable only under one heading as specified above, as per the hospital bill for the respective day.

**C4. Accidental Hospitalization Cash Benefit**


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In case Insured Person's Hospitalization is due to an accidental injury, We will pay twice the In-Patient Hospital Cash Benefit (Section C1). for each continuous and completed 24 Hours of Hospitalization for Medically necessary treatment of the Insured Person due to an injury during the Policy Year.

In the event, claim is admissible under this benefit, We will not pay for inpatient hospital cash benefit (Section C1) for that particular claim.

**C5. Accidental Hospitalization ICU Cash Benefit**

In case Insured Person's Hospitalization is in Intensive Care Unit (ICU) due to an accidental injury, We will pay twice the ICU Cash Benefit (Section C3) for each continuous and completed 24 Hours of Hospitalization for Medically necessary treatment of the Insured Person due to an injury during the Policy Year.

In the event, claim is admissible under this benefit, We will not pay for ICU cash benefit (Section C3) for that particular claim.

**D: Optional Benefits**

The following Optional Benefit shall apply only if the premium in respect of the Optional Benefit has been received and the same is mentioned in the Policy Schedule. Benefits under this Section are subject to the applicable waiting period, terms, conditions and exclusions of this Policy.

**D1. Wellsurance Benefit:**

**(a) Minor Surgical Benefit:**

We will pay lump sum as specified in the Policy schedule irrespective of the actual Medical expenses for hospitalization, subject to the waiting period of 90 days in the event of an Insured Person undergoing any Medically necessary Covered Minor Surgery which is not due to any Pre-existing Condition.

Covered Minor Surgeries

i. Appendectomy/Cholecystectomy: Surgical removal of the appendix due to acute appendicitis, rupture of appendix. Surgical removal of gall bladder due to acute or chronic Cholecystitis or Symptomatic gall stones.

ii. Removal of Gall stones/ kidney stones: Laser/ surgical removal of gall stones and kidney stones.

iii. Hernia repair: Hernia repair surgery is done by using mesh to repair the weakness on the abdominal wall from where the bulging appeared.

iv. Hemorrhoids: Piles/ Hemorrhoids removal in case of Symptomatic bleeding anal varices.

v. Removal of Skin lesion: Removal of Skin lesion like Symptomatic cyst, melanoma ganglion.


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vi. Biopsy of Growth: Surgical removal of a portion of growth for histopathological study.

**(b) Major Surgical Benefit**

We will pay lump sum as specified in the Policy schedule irrespective of the actual Medical expenses for hospitalization, subject to the waiting period of 90 days in the event of an Insured Person undergoing any Medically necessary Covered Major Surgery which is not due to any Pre-existing Condition.

Covered Major Surgeries

i. Post traumatic surgery: Surgery due to trauma induced surgeries of skull fracture, pelvis fracture, and compound / comminuted fractures requiring ORIF (Open Reduction and Internal Fixation) in other parts of body.

ii. Knee replacement: This procedure is performed by using artificial prosthesis in case of traumatic arthritis, severe knee injuries.

iii. Knee ligament surgery: Surgery conducted to repair ligaments of knee joint damaged due to trauma

iv. Hip replacement: Procedure is performed by using artificial prosthesis in case of severe injuries, trauma.

v. Cosmetic Reconstructive Surgery

Surgery conducted as a reconstructive procedure on structures of the body for the purpose of restoring / improving bodily function or correcting significant deformity resulting from accidental injury as covered under the Hazard, subject to the maximum shown in the Policy Schedule.

**(c) Post Operative Expenses (Physiotherapy)**

We will pay lump sum amount for Physiotherapy for any covered Major or Minor Surgery as defined above post discharge from Hospital. The Benefit shall be paid lump sum as specified in the Policy schedule irrespective of the actual expenses incurred. We will pay once during the lifetime of the Insured person.

**(d) Ambulance Service**

We will pay lump sum amount towards road Ambulance while admitting and/or while discharging from the Hospital as specified in the policy.

***E : Personal Accident (only applicable for Section A: Critical Illness)***

If no claim is reported under benefit section A1 or A5 in the expiring policy year in a Long term policy or Policy period in an Annual policy, We will pay Rs. 3 Lac of Sum Insured, if the Insured person suffers an injury due to an accident during the current Policy year/Policy period which is the sole and direct cause of death of Insured Person within twelve (12) months from the date of Accident.

This cover shall be available only to those insured persons who are covered under the policy in the expiring policy year. This cover shall not be applicable to dependent children covered in the policy.

## *Section 3 – Exclusions*

**1. Standard Exclusions**

**A. General Exclusions**

We will neither be liable nor make any payment for any claim in respect of any Insured Person which is caused by, arising from or in any way attributable to any of the following exclusions, unless expressly stated to the contrary in this Policy.

**1) Medical Exclusions**

i. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof .(Code-Excl12)

ii. Obesity and weight control: (Code-Excl06)

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

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

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

d. Body Mass Index (BMI);

i. greater than or equal to 40 or

ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

1. Obesity-related cardiomyopathy

2. Coronary heart disease

3. Severe Sleep Apnea

4. Uncontrolled Type2 Diabetes

iii. Investigation and 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.

iv. 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

v. Change of Gender Treatment (Code- Excl07): Expenses related to any treatment, including surgical management, to change



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characteristics of the body to those of the opposite sex.

vi. 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.

vii. 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,

viii. 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.

ix. Maternity (Code- Excl18):

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

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

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

**2) Non-Medical Exclusions**

i. 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

ii. 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.

iii. 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. Specific Exclusions (Exclusions other than as mentioned under Section 3 (1) above)**

**A. Waiting Periods**

We shall not be liable to make any payment under the policy in connection with or in respect of following **expenses** till the expiry of waiting period mentioned below:

**i. Initial Waiting Period**

a. Expenses related to the treatment of any illness within 90 days (applicable for Section 2 A: Critical Illness and Section 2 B: Cancer 360 Degree Indemnity Cover) and 30 days(applicable for Section 2 C:Hospital Cash) from the first policy commencement date depending on plan chosen by the Insured Person and as specified in the Policy Schedule 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.

**ii. Pre-existing Diseases Waiting Period**

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, for continuous coverage after the date of inception of the first policy with us.

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

c. Coverage under the policy after the expiry of specified months as per the Policy Schedule for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

**iii. Specified Disease/Procedure Waiting Period (Applicable only**


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**for Hospital Cash section):**

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

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

d. 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.

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

List of Specific Diseases/procedures:

I. Tumors, Cysts, polyps including breast lumps (benign)

II. Polycystic ovarian disease

III. Fibromyoma

IV. Adenomyosis

V. Endometriosis

VI. Prolapsed Uterus

VII. Non-infective arthritis

VIII. Gout and Rheumatism

IX. Osteoporosis

X. Ligament, Tendon or Meniscal tear

XI. Prolapsed Inter Vertebral Disc

XII. Cholelithiasis

XIII. Pancreatitis

XIV. Fissure/fistula in anus, haemorrhoids, pilonidal sinus

XV. Ulcer & erosion of stomach & duodenum

XVI. Gastro Esophageal Reflux Disorder (GERD)

XVII. Liver Cirrhosis

XVIII. Perineal Abscesses

XIX. Perianal / Anal Abscesses

XX. Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone.

XXI. Benign Hyperplasia of prostate

XXII. Varicocele

XXIII. Cataract

XXIV. Retinal detachment

XXV. Glaucoma

XXVI. Congenital Internal Diseases

XXVII. Adenoidectomy

XXVIII. Mastoidectomy

XXIX. Tonsillectomy

XXX. Tympanoplasty

XXXI. Surgery for nasal septum deviation



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XXXII. Nasal concha resection

XXXIII. Surgery for Turbinate hypertrophy

XXXIV. Hysterectomy

XXXV. Joint replacement surgeries Eg: Knee replacement, Hip replacement

XXXVI. Cholecystectomy

XXXVII. Hernioplasty or Herniorraphy

XXXVIII. Surgery/procedure for Benign prostate enlargement

XXXIX. Surgery for Hydrocele/ Rectocele

XL. Surgery of varicose veins and varicose ulcers

**B. General Exclusions**

We will neither be liable nor make any payment for any claim in respect of any Insured Person which is caused by, arising from or in any way attributable to any of the following exclusions, unless expressly stated to the contrary in this Policy.

**1) Medical Exclusions**

**Specific to Section 2 A: Critical Illness:**

i. Any Critical Illness other than as defined under Section A1

**Specific to Section 2 B: Cancer 360 Degree -Indemnity Cover**

ii. Any Illness or Injury other than Cancer

**Other Exclusions:**

| **Exclusion** | **Applicable Section(s)** |
|---|---|
| iii. Alcoholic pancreatitis | Applicable to Hospital cash (Section C) |
| iv. Congenital External Diseases, defects or anomalies; | Applicable to Hospital Cash(Section C) and Wellsurance Benefit (Section D) |
| v. Growth hormone therapy; | Applicable to Hospital Cash(Section C) |
| vi. Sleep-apnoea | Applicable to Hospital Cash(Section C) |
| vii. Admission primarily for administration of Intra-articular or intra-lesional injections or Intravenous immunoglobulin infusion or supplementary medications like Zolendronic Acid | Applicable to Hospital Cash (Section C) |
| viii. Venereal disease, sexually transmitted disease or illness; | Applicable to Hospital Cash (Section C) and Wellsurance Benefit (Section D) |


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| | |
|---|---|
| ix. Dental treatment or surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization | Applicable to Hospital Cash (Section C) and Wellsurance Benefit (Section D) |
| x. Any existing disease specifically mentioned as Permanent exclusion in the Policy Schedule | Applicable to all Sections |

**2) Non-Medical Exclusions**

i. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, ionising radiation.

ii. Any Insured Person's participation or involvement in naval, military or air force operation,

iii. Intentional self-injury or attempted suicide while sane or insane.

iv. Treatment rendered by a Medical Practitioner which is outside his discipline

v. Doctor's fees charged by the Medical Practitioner sharing the same residence as an Insured Person or who is an immediate relative of an Insured Person's family.

vi. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.

vii. Crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively and explicitly stated and covered in the policy).

viii. Any illness diagnosed or injury sustained or where there is change in health status of the member after date of proposal and before commencement of policy and the same is not communicated and accepted by us

## *Section 4 – General Terms & Clauses*

**i. 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. 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).The Clause shall be suitably modified by the insurer based on the amendment(s), if any to the relevant provisions of Protection of Policyholder's Interests Regulations, 2017)

**4. Complete Discharge**

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

**5. Multiple Policies (Applicable to Cancer 360 Degree )**

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. Policy Holder 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.

**6. 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.

**7. Cancellation**

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

| Length of time Policy in force | Tenure (Years) | | |
|---|---|---|---|
| | 1 | 2 | 3 |
| Upto 1 Month | 75.00% | 87.50% | 91.5% |
| >1 month & Upto 3 Months | 50.00% | 75.00% | 88.5% |
| >3 months & Upto 6 Months | 25.00% | 62.50% | 75% |


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| >6 months & Upto 12 Months | Nil | 50.00% | 66.5% |
|---|---|---|---|
| >12 months & Upto 15 Months | Not Applicable | 25% | 50% |
| >15 months & Upto 18 Months | Not Applicable | 12.5% | 41.5% |
| >18 months & Upto 24 months | Not Applicable | Nil | 33% |
| >24 months & Upto 30 months | Not Applicable | Not Applicable | 8% |
| Exceeding 30 months | Not Applicable | Not Applicable | Nil |

Not with standing 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. Policy will be cancelled since inception without any refund of premium on cancellation of policy on grounds of misrepresentation, non-disclosure of material facts or fraud and no claim will be entertained on such policy.

**8. `Migration**

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

For Detailed Guidelines on Migration, kindly refer Guidelines issued by IRDAI (Insurance Regulatory and Development Authority of India) on Migration and Portability of Health Insurance policies – Ref: IRDAI/HLT/REG/CIR/194/07/2020) dated 22nd July 2020 and subsequent amendments thereof.

**9. Portability**

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

will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer Guidelines issued IRDAI (Insurance Regulatory and Development Authority of India) on Migration and Portability of Health Insurance policies – Ref: IRDAI/HLT/REG/CIR/194/07/2020) dated 22nd July 2020 and subsequent amendments thereof.

**10. Renewal of Policy**

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

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

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits. 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. 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.

**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. Free look period**

The Free Look Period shall be applicable


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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

## 15. Redressal of Grievance

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

Website: www.tataaig.com

Toll Free: 1800 266 7780 or 1800 22 9966 (only for Senior Citizen policyholders)

Email: customersupport@tataaig.com

Courier: Customer Support, Tata AIG General Insurance Company Limited

A-501 Building No. 4 IT Infinity Park, Dindoshi, 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 manager. customersupport@tataaig.com.

For updated details of grievance officer, kindly refer the link (https://www.tataaig.com/grievance-redressal-policy)

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 (details as mentioned in the Annexure A of this policy) for redressal of grievance as per Insurance Ombudsman Rules 2017.

Grievance may also be lodged at IRDAI Integrated Grievance Management System (https://igms.irda.gov.in/)

## 16. 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.

**ii. Specific terms and clauses (terms and clauses other than those mentioned under Section 5 (i) above)**

**17. Premium Payment**

Policyholder is required to pay Premium before Policy Commencement date as opted in the proposal form.

**18. Insured Person**

i. Only those persons named as an Insured Person in the Schedule shall be covered under this Policy.

ii. Any person may be added during the Policy Period after his application has been accepted by Us, additional premium has been paid and We have issued an endorsement confirming the addition of such person as an Insured Person subject to our Underwriting guidelines.

**19. Loadings**

i. We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance).

ii. The maximum risk loading applicable for an individual shall not exceed 100% of premium per diagnosis / medical condition and an overall risk loading of over 150% of premium per person . Here the word premium refers to corresponding individual premium as per the rate chart.

iii. The loading shall only be applied basis an outcome of Our medical underwriting.

iv. These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us .These loadings shall also be applied on the enhanced Sum Insured at the time of renewal.

a. We will inform You about the applicable risk loading through a counter offer letter.

b. You need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter.

c. In case, you neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 10 days subject to deduction of the Pre-Policy Check up charges, if applicable.

v. Please note that We will issue Policy only after getting Your consent.

**20. Entire Contract**

i. This Policy, its Schedule, endorsement(s), proposal constitutes the entire contract of insurance. No change in this policy shall be valid unless approved by Us and such approval be endorsed hereon.

ii. This Policy and the Schedule shall be

read together as one contract and any word or expression to which a specific meaning has been attached in any part of this Policy or of the Schedule shall bear such meaning wherever it may appear.

**21. Change of Policyholder**

i. The change of Policyholder is permitted only at the time of renewal.

ii. If the Insured Person is no longer eligible on grounds of age or dependency, the insured member will be eligible to apply for a new policy and enjoy continuity benefits upto Sum Insured.

**22. Notices**

i. Any notice, direction or instruction under this Policy shall be in writing and if it is to:

a. Any Insured Person, then it shall be sent to You at Your address specified in the Schedule to this Policy and You shall act for all Insured Persons for these purposes.

b. Us, it shall be delivered to Our address specified in the Schedule to this Policy.

c. No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on Our behalf unless We have expressly stated to the contrary in writing.

## *Section 5 – Claims Procedure and Claims Payment*

This section explains about the procedures involved in filing a claim by the insured member and processes related to managing the claim by Us. All the procedures and processes such as notification of claim, availing cashless service, supporting claim documents and related claim terms of payment are explained in this section.

**1. Notification of Claim**

| | **Treatment, Consultation or Procedure:** | **We must be informed:** |
|---|---|---|
| 1 | If any treatment for which a claim may be made and that treatment requires planned Hospitalisation: | At least 48 hours prior to the Insured Person's admission. |
| 2 | If any treatment for which a claim may be made and that treatment requires emergency Hospitalisation | Within 24 hours of the Insured Person's admission to Hospital. |

**2. Cashless Service (Applicable for Cancer 360 Degree)**



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| | Treatment, Consultation or Procedure: | Treatment, Consultation or Procedure Taken at: | Cashless Service is Available: | We must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars: |
|---|---|---|---|---|
| | If any planned treatment, consultation or procedure for which a claim may be made: | Network Hospital | We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital. | At least 48 hours before the planned treatment or Hospitalisation |
| | If any treatment, consultation or procedure for which a claim may be made, requiring emergency hospitalisation | Network Hospital | We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital. | Within 24 hours after the treatment or Hospitalisation |

**3. Procedure for Cashless Service**

i. Cashless Service is only available at Network Hospitals. Please refer our website (www.tataaig.com) for list of network hospitals.

ii. In order to avail of cashless treatment, the following procedure must be followed by You:

a. Prior to taking treatment and/ or incurring Medical Expenses at a Network Hospital, You must call Us and request pre-authorization.

b. For any emergency Hospitalisation, We must be informed no later than 24 hours of the start of Your hospitalization/ treatment.

c. For any planned hospitalization, We must be informed atleast 48 hours prior to the start of your hospitalization/treatment.

d. We will check your coverage as per the eligibility and send an authorization letter to the provider. You have to provide the ID card issued to You along with any other information or documentation that is requested by Us to the Network Hospital.

e. In case of deficiency in the documents sent to Us for cashless authorization, the same shall be communicated to the hospital by Us within 6 hours of receipt of the documents.


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f. In case the ailment /treatment is not covered under the policy or cashless is rejected due to insufficient documents submitted, a rejection letter would be sent to the hospital within 6 hours.

g. Rejection of cashless in no way indicates rejection of the claim. You are required to submit the claim along with required documents for us to decide on the admissibility of the claim.

h. If the cashless is approved, the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.

i. Pre-authorization does not guarantee that all costs and expenses will be covered. We reserve the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy.

**4. Supporting Documentation & Examination**

i. You or someone claiming on Your behalf shall provide Us with documentation, medical records and information We may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days or earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment.

ii. Failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if you can satisfy us that it was not reasonably possible for you to give proof within such time.

iii. We may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person.

iv. **Such documentation will include the following:**

a) Our claim form, duly completed and signed for on behalf of the Insured Person.We, upon receipt of a notice of claim, will furnish Your representative with such forms as We may require for filing proofs of loss or you may download the claim form from our Web site www.tataaig.com

b) **For Section 2 A: Critical Illness / Section C:Hospital Cash / Optional Benefit Section D: Wellsurance Benefit**

1. Medical Certificate and investigation report confirming the diagnosis of Critical Illness/Surgery

2. Copy of complete medical records such as Hospital Discharge card/ Summary, Indoor case papers along with the diagnostic Laboratory & radiological investigation reports including CT Scan, MRI & USG report with plates, wherever applicable and done



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3. A precise diagnosis of the treatment for which a claim is made
4. Previous and subsequent consultation letter(including first consultation letter), medical records and prescriptions related to illness/ surgery
5. Copy of MLC (Medico legal case) records, if carried out and FIR (First information report) if registered, in case of claims arising out of an accident and available with the claimant.
6. Death certificate/Death summary, if applicable
7. Post Mortem report (wherever applicable & conducted)
8. Legal heir/succession certificate, if applicable & available
9. Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements

In the event insured person suffers from one of the following critical illness and where death occurs within 3 months of such diagnosis, but after confirmed diagnosis of the illness, then the modified condition as mentioned below shall be applicable to the respective Critical Illness. However, this is subject to fulfilment of other conditions as laid down under definitions of respective critical illness and for the period for which the Insured survived the diagnosis of Critical Illness

| Critical Illness (Section 2 A1) | Name of Critical Illness | Modified Condition applicable |
|---|---|---|
| 9 | Stroke resulting in permanent symptoms | Evidence of permanent neurological deficit lasting for the period for which the Insured person survived |
| 10 | Permanent Paralysis of Limbs | Evidence of existence of paralysis for the period for which the Insured person survived |
| 11 | Parkinson's disease | Medical documentation of conditions (i-vi) of activities of daily living for the period the Insured Person survived |
| 13 | End Stage Lung Failure | Condition (I) wherein FEV1 test results for the period the Insured Person survived |

**c) For Section 2 B: Cancer 360 Degree**

a. Original Bills (pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.

b. All medical reports, case histories, investigation reports, indoor case papers/ treatment papers (in reimbursement cases, if available),


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discharge summaries.

c. A precise diagnosis of the treatment for which a claim is made.

d. A detailed list of the individual medical services and treatments provided and a unit price for each in case not available in the submitted hospital bill.

e. Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. In case of pre/post hospitalization claim Prescriptions must be submitted with the corresponding Doctor/ hospital invoice.

f. All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made, if and where applicable.

g. Treating doctor's certificate regarding missing information in case histories

h. Copy of settlement letter from other insurance company

i. Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements

j. Legal heir/succession certificate , if required

k. PM report (wherever applicable)

l. Transportation and Hotel accommodation bills (wherever applicable)

v. Note: In case You are claiming for the same event under an indemnity based policy of another insurer and are required to submit the original documents related to Your treatment with that particular insurer, then You may provide Us with the attested copies of such documents along with a declaration from the particular insurer specifying the availability of the original copies of the specified treatment documents with it.

vi. We at our own expense, shall have the right and opportunity to examine insured persons through Our Authorised Medical Practitioner whose details will be notified to insured person when and as often as We may reasonably require during the pendency of a claim hereunder.

**5. Claims Payment**

i. We shall be under no obligation to make any payment under this Policy unless We have received all premium payments(including applicable loadings) in full in time and We have been provided with the documentation and information We have requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.

## *Section 6 - Dispute Resolution*

**1. Dispute Resolution Clause**

Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law.



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**2. Arbitration**

If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.

3. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

**Annexure A**

**NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES**

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

| SN | Centre | Address & Contact |
|---|---|---|
| 1 | Ahmedabad | Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001.<br>Tel.: 079 - 25501201/02/05/06<br>Email: bimalokpal.ahmedabad@cioins.co.in |
| 2 | Bengaluru | Office of the Insurance Ombudsman, Jeevan Soudha Building,<br>PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road,<br>JP Nagar, Ist Phase, Bengaluru – 560 078.<br>Tel.: 080 - 26652048 / 26652049<br>Email: bimalokpal.bengaluru@cioins.co.in |
| 3 | Bhopal | Office of the Insurance Ombudsman, Janak Vihar Complex,<br>2nd Floor, 6, Malviya Nagar, Opp. Airtel Office,<br>Near New Market, Bhopal – 462 003.<br>Tel.: 0755 - 2769201 / 2769202<br>Email: bimalokpal.bhopal@cioins.co.in |


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| SN | Centre | Address & Contact |
|---|---|---|
| 4 | Bhubaneswar | Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in |
| 5 | 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 |
| 6 | 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 |
| 7 | New 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 |
| 8 | 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 |
| 9 | 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 |
| 10 | 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 |
| 11 | 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 |


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| SN | Centre | Address & Contact |
|---|---|---|
| 12 | Kolkata | Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in |
| 13 | 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 |
| 14 | 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 |
| 15 | 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 |
| 16 | Patna | Office of the Insurance Ombudsman, 2nd Floor, North wing, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in |
| 17 | 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 |

For updated list and details of Insurance Ombudsman Offices, please visit website http://ecoi.co.in/ombudsman.html

**Prohibition of Rebates** - Section 41 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.



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