Bajaj Allianz General Insurance Co. Ltd.
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Issuing Office

HERizon Care
Policy Wordings

SECTION A) PREAMBLE

Whereas the named Insured has made a proposal, and declarations to Bajaj Allianz General Insurance Company Limited (hereinafter referred to as the "Company") which is hereby agreed to be the basis of this Policy and in consideration of payment of Premium, as specified in the Schedule, by You and realized by Us, the Company agrees, subject to the following terms, exclusions, definitions, limitations, and conditions, to indemnify Insured Person(s)/make payment as is provided herein.

SECTION B) DEFINITIONS- STANDARD DEFINITIONS

1. **Accident, Accidental**
An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **AYUSH Hospital:**
An AYUSH Hospital is a healthcare facility where in medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a. Central or State Government AYUSH Hospital; or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy, or
   c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i. Having at least5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out
      iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3. **AYUSH Day Care Centre:**
AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health Centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s)on day care basis without in-patient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

4. **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 of pre-authorization is approved.

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

6. **Congenital Anomaly**
Congenital Anomaly means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
   a. Internal Congenital Anomaly- Congenital anomaly which is not in the visible and accessible parts of the body
   b. External Congenital Anomaly- Congenital anomaly which is in the visible and accessible parts of the body

7. **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/Insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

8. **Day Care Centre**
A day care centre means any institution established for day care treatment of Illness and / or injuries or a medical set-up with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner and must comply with all minimum criteria as under:-
   i. has qualified nursing staff under its employment,
   ii. has qualified medical practitioner(s) in charge,
   iii. has a 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.

9. **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 a hospitalization of more than 24 hours.

   Treatment normally taken on an outpatient basis is not included in the scope of this definition.

10. **Disclosure to information norm**
The Policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

11. Emergency Care
Emergency care means management of an Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured's health.

12. Grace Period:
Grace period means, is the extra time allowed after the due date for paying your insurance premium. During this grace period, you can pay the premium to keep your insurance policy active without any gaps or losing benefits like coverage for pre-existing conditions. However, the insurer does not have to provide coverage during the grace period if no premium payment is received.
Grace Period Durations: - If you pay your premium monthly, the grace period is 15 days. - For all other payment schedules (quarterly, half-yearly, annually), the grace period is 30 days.
Provided, Insurer shall provide coverage during the grace period if you make an instalment payment.

13. 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 the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1)
of the said Act OR complies with all minimum criteria as under
i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 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.

14. Hospitalization
Hospitalization means admission in a Hospital for a minimum period of 24 consecutive "Inpatient Care" hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

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

a. Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
b. Chronic condition – A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics
i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
ii. it needs ongoing or long-term control for 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.

16. Injury
Injury means accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

17. Inpatient Care
Inpatient care means treatment for which the Insured has to stay in a Hospital for more than 24 hours for a covered event.

18. 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 are considerably more sophisticated and intensive than in the ordinary and other wards.

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

20. Maternity expenses
Maternity expenses mean;
a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
b) expenses towards lawful medical termination of pregnancy during the Policy Period.

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

22. Medical expenses
Medical Expenses means those expenses that an Insured 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 had not been Insured and no more than other hospitals or Medical practitioners in the same locality would have charged for the same medical treatment.

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

24. Medically Necessary Treatment/ Medical Treatment

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

i. is required for the medical management of the illness or injury suffered by the Insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner,
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India

25. 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

26. 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.

27. Non- Network Provider

Non-Network provider means any Hospital, Day Care Centre or other provider that is not part of the network.

28. 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.

29. Pre-Existing Disease

Pre- existing disease means any condition, ailment or Injury or disease

a. That is/are diagnosed by a physician within 36 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 36 months prior to the effective date of the Policy issued by the Insurer or its reinstatement.

30. Portability

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

31. 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.

32. Reasonable and Customary charges

Reasonable and Customary charges mean 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.

33. 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.

34. 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.

35. Unproven/Experimental treatment

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

SECTION B) DEFINITIONS- SPECIFIC DEFINITIONS

The terms defined below and at other places in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

1. **Adoption** refers to the act where an adult formally becomes the guardian of a child and incurs the rights and obligations of a parent.

2. **Aggrieved person** refers to an Insured Person who has suffered bodily harm or subject to non-material harm as a result of a criminal offense

3. **AYUSH Treatment** refers to medical expenses incurred on Hospitalization under Ayurveda, Yoga and Naturopathy Unani, Siddha and Homeopathy systems

4. **Assisted Reproductive Technology** - means all medical procedures , techniques that attempt to obtain a pregnancy by handling the sperm or the oocyte outside the human body and transferring the gamete or the embryo into the reproductive system of a woman

5. **Assisted Reproductive Technology Clinic** - means any premises equipped with requisite facilities and medical practitioners registered with the National Medical Commission for carrying out the procedures related to the assisted reproductive technology

6. **Cryo-preservation** means the freezing and storing of oocytes

7. **Family-** Includes Self, Spouse(female), Live-in Partner, Sister, Mother, Mother-in-law, Daughter, Daughter in law, Granddaughter, Aunt, Sister in law, Grandmother, great granddaughter, Surrogate Mother, Oocyte Donor

   Note : Live-in Partner for the purpose of this Policy shall mean two unmarried adult persons of any gender, who have consensually chosen to reside jointly with the other adult person, in a long term relationship and in the same residence. For the purpose of clarity, it is, hereby, mentioned that this definition shall be construed to include persons belonging to the LGBTQIA+ community, wherein the scope of LGBTQIA+ shall be in accordance with the standing laws of India, as may be in force from time to time.

8. **Infertility** - means the inability to conceive after one year of unprotected coitus or other proven medical condition preventing conception

9. **Insured / Insured Member/ Insured Person** means the person(s), or Family members**,** named in the Schedule, and is between 90 days to 80 years of age at the commencement of the Policy Period.

10. **Insured event:** For the purpose of this Policy and the determination of the Company's liability under it, the Insured Event in relation to the Insured Person shall mean any illness, medical event or surgical procedure, as specifically defined below, whose signs or symptoms first commence during the Policy Period

11. **Intending Couple / Women** means a couple/women who have been medically certified to be infertile and who intend to become parent(s) through surrogacy

12. **Sum Insured or Limit of Indemnity** represents Our maximum liability to indemnify/ make payment for each and every claim per Insured Person and collectively for all Insured Persons mentioned in the Schedule during the Policy Period and in the aggregate for the Insured Person(s) named in the Schedule during the Policy Period, and means the amount stated in the Schedule against each Cover.

13. **Baby** means child born during the Policy Period and is aged up to 1 year.

14. **Nominee** means a person designated by You to receive the proceeds of this Policy upon Your death**.**

15. **Oocyte** means naturally ovulating oocyte in the female genetic tract

16. **Oocyte Donor** is a woman who donates her egg to another woman , who might not be able to conceive by herself naturally

17. **Oocyte Retrieval** is a procedure in order to remove oocytes from the ovary of a woman to enable fertilization

18. **Policy Period** means the period between the commencement date and the expiry date specified in the Schedule and includes both the commencement date as well as the expiry date**.**

19. **Policy Year**
    Policy Year means a period of 12 months. In case of a long-term Policy of more than one year, each year viz. 1st year, 2nd year, 3rd year,4th year, 5th year shall be treated as a separate Policy Year.

20. **Policy or Contract**
    Policy or Contract means the Proposal, these Policy Wordings along with the Policy Schedule, any annexures and any applicable endorsements or extensions attaching to or forming part thereof, either at the commencement of Policy Period or during the Policy Period, and shall be read together. The Policy contains details of the extent of cover available to the Insured Person, applicable exclusions and the terms & conditions applicable under the Policy.

21. **Policy Schedule or Schedule** means the policy schedule attached to and forming part of this Policy specifying the details of the Insured Persons, the Sum Insured, the Policy Period and the Sub-limits to which coverage/benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

22. **Proposal** means the proposal form and other information, declarations, and documentation supplied to Us in considering whether and on what terms to offer this insurance**.**

23. **Prospective Adoptive Parent** means person eligible to adopt a child as per the Juvenile Justice (Care and Protection of Children) 2015 (2 of 2016) Act, any amendments thereafter.

24. **Service Provider/s**
    Service Provider means the service provider/s engaged / named by the Company for providing the services as covered in this Policy.

25. **Survival period** refers to the period from the diagnosis and fulfilment of the critical Illness definition up to which the life assured or Insured Person must survive before the claim benefit will be paid

26. **Waiting Period** refers to the initial period from the inception of coverage under this Policy during which specified diseases/treatments are not covered. Upon completion of the Waiting Period, diseases/ treatments shall be covered, provided the Policy has been continuously renewed without any break.

27. **You, Your, Yourself/ Your Family** named in the schedule means the person or persons that We insure as set out in the Schedule

28. **We, Us, Our, Ours, Insurer, Company** means the Bajaj Allianz General Insurance Company Limited.

SECTION C) COVERAGE

Scope of Cover-
The Company hereby agrees to indemnify You for the expenses in respect of an admissible claim, for any or all of the following covers subject to the cover being opted and specified in the Policy Schedule. Our maximum liability for all claims shall be subject to the Sum Insured, limits, terms, conditions, definitions and exclusions mentioned in Your Policy against each of the listed cover/benefits.

Vita Shield			
Covers	**Sum Insured /Benefit offered**	**waiting period**	**Opt-in/Opt-out**
Critical illness Cover	Sum Insured options INR 3L/ 5L/ 7.5L/ 10L/ 15L/ 20L/ 25L/ 50L/ 1C and 2Cr. • Max Sum Insured offered shall be 10 times of annual income • Non- earning dependent members Sum Insured shall be restricted to INR10L OR Sum Insured opted for Primary Insured whichever is lower. • For renewals of age 61 years & above the maximum Sum Insured would be INR.10L or expiring Sum Insured whichever is lower • Benefit pay-out, 100% of opted Critical Illness Sum insured, subject to completion of Survival period	Waiting period - 90,120,180, 365 days Survival period - 0, 7, 15, 30 days	At inception
On the Mend	INR 5000/week for maximum 4 weeks per Policy Period, over and above Critical Illness Cover for Hospitalization more than 10 consecutive days	30 days at inception	
Holistic Wellness	Value Added services + Preventive Care (Health check up every 3 years)	Not applicable	
Extensions to Critical illness Cover	Extension 1 - Children Education Bonus, 10% of Critical Illness Sum Insured maximum up to INR 2L, over and above Critical Illness Cover	As per Critical illness Cover	At inception /renewal
	Extension 2 - Loss of Job 10% of Critical Illness Sum Insured maximum up to INR 5L, over and above Critical Illness Cover	As per Critical illness Cover	At inception /renewal
	Extension 3 - Incidental expenses 5% of the Critical Illness Sum Insured subject to a maximum limit of INR 25,000, over and above Critical Illness Cover	As per Critical illness Cover	At inception /renewal
Cradle Care (Surrogacy OR Oocyte Donor Cover)			
Covers		**waiting period**	**Opt-in/Opt-out**
Surrogacy Support	INR 50,000 / 1 L Indemnity based pay out	30 days at inception	At inception - Default cover for 3 years
Oocyte Donor Cover	INR 50,000/ 1 L Indemnity based pay out	30 days at inception	At inception Cover period 12 months only
Optional Covers (Applicable to “Vita Shield” cover)			
Covers		**waiting period**	**Opt-in/Opt-out**
Nurture Nest	Sum Insured – INR 1L / 2L / 3L Indemnity base pay out A. Expenses towards Surgical management for Infertility - up to Sum insured B. Adoption Expense - up to INR 50,000 C. Egg Freezing (Cryo-Preservation) procedure Expense - 30% of Nurture nest Sum Insured	24 months from the time the cover is opted	At inception /renewal*
MotherHood	Sum Insured – INR 1L / 2L / 3L Indemnity base pay out A. Assisted Reproductive Technology Expenses B. Maternity Expense	24 months from the time the cover is opted	At inception /renewal*
Fetal Flourish	INR 1L / 2L / 3L / 4L / 5L Indemnity based pay out A. Pre-natal Health B. Congenital Disability Benefit	24 months from the time the cover is opted	At inception /renewal*
	Extension 4. Hospital Daily allowance Sum Insured – INR 1000 / 1500 / 2000 per day Mother / Child is hospitalised (until child turns 1 year old), max up to 10 days over and above Fetal Flourish Sum insured	As per Fetal Flourish Cover	At inception /renewal*
Prophylactic Surgeries	Sum Insured – INR 1L / 2L / 3L Indemnity based pay out	24 months from the time the cover is opted	At inception /renewal*
Legal Expense Support	Sum Insured – INR 50,000 per policy year Benefit pay-out	30 days at inception	At inception /renewal*

Note:
i. It is mandatory to opt for either Vita Shield or Cradle Care cover/benefit under the Policy,
ii. Optional Covers can be opted only with Vita Shield cover/benefit.
iii. All respective extensions cover once opted cannot be opted out at renewal, subject to the respective cover being continuously renewed in the Policy

iv. In the event of Us paying a claim under Critical Illness cover of Vita Shield cover/benefit, then the coverage under HERizon Care Policy for the respective Insured Member for the rest sections other than Critical illness shall continue for the remaining Policy Period , however at Renewal the Policy will cease to existing with reference to that Insured Member .
v. *If opted out at renewal and want to opt back in, waiting periods will apply afresh

Policy Type: Individual Sum Insured basis only

Policy Tenure: 1 Year, 2 Year, 3 Year , 4 year, 5 year

What we will pay for

1. Vita Shield

The Vita Shield cover/benefit has 3 inbuilt covers and 3 optional extensions as specified below:

A. Critical Illness Cover

If the Insured Member is diagnosed as suffering from any of the below listed "Critical Illnesses Cover", which first occurs or manifests itself during the Policy Period, then we will pay 100% of Sum Insured specified against this cover subject to below.

i. A Survival period of minimum number of days from the date of diagnosis as specified in Policy Schedule shall be applicable for all claims .
ii. In the event of claim being admissible under more than one Critical Illness listed below, our maximum liability is restricted to 100% of Sum Insured against this cover.
iii. List of Critical Illness and procedures covered

Sr. No.	Critical Illness
1.	Breast Cancer
2.	Fallopian Tube Cancer
3.	Uterine/Cervical Cancer
4.	Ovarian Cancer
5.	Vaginal Cancer
6.	Thyroid Cancer
7.	Multi trauma
8.	Third degree Burns
9.	Osteoporotic Fracture
10.	Cancer of Specified Severity (All cancers other than those under 1-6 above)
11.	Myocardial Infarction (First Heart Attack – of Specific Severity)
12.	Open Chest CABG
13.	Open Heart Replacement or Repair of Heart Valves
14.	Major Surgery of Aorta
15.	Heart Transplant
16.	Cardiomyopathy
17.	Kidney Failure Requiring Regular Dialysis
18.	Systematic lupus Erythematosus. with Renal Involvement
19.	Kidney Transplant
20.	Stroke Resulting in Permanent Symptoms
21.	Coma of Specified Severity
22.	Permanent Paralysis of one limb
23.	Motor Neurone Disease with Permanent Symptoms
24.	Multiple Sclerosis with Persisting Symptoms
25.	Benign Brain Tumour
26.	Brain Surgery
27.	Major Head Trauma
28.	Blindness in both the eyes
29.	Deafness in both ears
30.	Loss of Speech
31.	End stage lung failure
32.	End Stage liver failure
33.	Major organ /Bone Marrow Transplant
34.	Primary (Idiopathic)Pulmonary Hypertension

Note: the conditions listed in table above are as defined in Annexure I of this Policy Wordings

Extensions (applicable to Critical Illness cover)

You can opt for any of the below extensions on payment of additional premium along with Vita Shield Section. The payout for the extensions shall be over and above the Critical Illness Sum Insured.

Extension 1. Children Education Bonus

In the event of a Claim being admissible under Section C. 1. A .Critical Illness cover under the Policy, We will pay Children's Education Bonus for future education of Your children. The amount payable under this Extension would be restricted to 10% of Critical Illness Sum Insured maximum up to INR 2 Lakhs as a lump sum for one or more child put together, subject to dependent child(ren) are less than 25 years of age.

Extension 2. Loss of Job

In the event of the Insured Member loses their job within a period of 3 months following the date of diagnosis of any of the listed covered conditions under Section C.1.A. "Critical Illness Cover" under the Policy, We will pay a lump sum payment amounting to 10% of Critical Illness Sum Insured, up to a maximum of INR 5 Lakhs, as a compensation for loss of employment. Claim under this Extension of Loss of Job shall be paid only if We have accepted a claim under Section C. 1. A. Critical Illness cover under the Policy.

Specific Exclusions

The Company shall not be liable to make any payment under this extension with respect to:

i. Loss of Job due to voluntary resignation from service ,
ii. Loss of Job for reasons not associated with diagnosis of the listed critical illness
iii. Self-employed persons;
iv. Any claim relating to unemployment from a job which is casual, temporary, seasonal or contractual in nature or any claim relating to an employee not on the direct rolls of the employer
v. Any unemployment from a job under which no salary or any remuneration is provided to the Insured Member

Extension 3. Incidental Expense

The benefits under this extension is intended to aid faster recovery of the Insured Member post a critical illness being diagnosed and claim being paid by Us under Section C. 1. A. (Critical Illness Cover) of the Policy. The Company will make an additional lump sum payment of 5% of the Critical Illness Sum Insured, upto a maximum limit of INR 25,000, as specified in the Policy Schedule towards expenses incurred for Medically necessary reconstructive surgery, Physiotherapy/Home Nursing expense, Post-Surgical Implants or Rehabilitation counselling of the Insured.

B. On the Mend (Getting back on Feet)

In the event of the Insured Member is diagnosed of any of the listed covered conditions under Section C.1.A. (Critical Illness cover) of the Policy and the Claim being admissible under Section C. 1. A. (Critical Illness cover), We will pay You a weekly expense of INR 5000 / week for maximum 4 weeks per Policy Year, as post Hospitalization rehabilitation expense, subject to following

i. Hospitalization is for at least 10 consecutive days,
ii. We have received a medical certificate from treating Medical practitioner confirming that Insured Member is not able to perform 3 out of 6 daily living activities.
iii. The Activities of Daily Living are:
    a. 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;
    b. Dressing: the ability to put on, take off, secure, and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
    c. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa.
    d. Mobility: the ability to move indoors from room to room on level surfaces;
    e. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
    f. Feeding: the ability to feed oneself once food has been prepared and made available.

C. Holistic Wellness

Wellness is crucial because it promotes overall health, enhances quality of life, and prevents chronic diseases. It encompasses physical, mental, and emotional well-being, leading to increased productivity, better stress management, and a more balanced life. Under this benefit the Insured Member is eligible for a Holistic Wellness experience which shall include Value Added Services and Preventive Care.

a) Value Added Services

We will facilitate services for below listed coverages during the Policy Period up to the number of sessions/ vouchers as specified under this cover. These services would be offered on the App / Website of Insurer or the concerned Service Provider. Services offered under this benefit include

a. Knowledge and Content
b. Community, courses and webinar support
c. Tele Consultation Cover (Insta Consultation)
d. Diet and Nutrition Consultations Cover
e. Emotional Wellness Cover
f. Physical Fitness Cover

Note: Max 4 Teleconsultations will be available per Policy Year for c.d. and e. put together

a. Knowledge and Content

Hereunder, the Insured Member has an access to wellness content, which provides valuable information and help individuals make informed choices and adopt healthy habits.

b. Community, courses and webinar support

The Insured will have access to an online community where they can post questions and receive answers from experts and other individuals. The Insured member will also have access to specific courses based on their journey on the digital platform of Insurer or concerned Service Provider. The

Insured can use the same platform to access webinars on specific topics from time to time.

c. Teleconsultation Cover
If the Insured Member requires support / consultations for any of the conditions listed below, they can consult with a Medical Practitioner/ Physician/ Specialist listed on the digital platform of Insurer or concerned Service Provider's App via video, audio, or chat channel, as applicable in the instances mentioned below. The Insured Member will be able to select the specialty of Doctor and will be able to consult the Doctor available at the time of call. This cover shall be in compliance with the Telemedicine Practice Guidelines dated 25th of March 2020 and any amendments thereafter. This is a cashless service.

	Condition covered	Description of services offered
Fertility	PCOS/ PCOD/Irregular Periods	Support to improve insulin sensitivity, regulate menstrual cycles, manage hormonal imbalances and weight
	Infertility	For couples trying to conceive, positive lifestyle habit changes for healthy conception. Aim is to induce pregnancy by understanding and course correcting medical complications
Pregnancy	Pregnancy Support	Guidance on holistic health and knowledge for a healthy delivery including prenatal bonding, Lactation counselling etc.
Baby Care	Baby Care Support (0-1 year of age)	Support for new parents especially with lactation and all other details for baby care to maintain a healthy baby and healthy mother. Complementary food and going back to work
Parenting	Parenting Support (1-18 years of age)	Support based around specific needs of the parent or child: 1) Parent- parenting technique, managing family/ workplace/ stress, physical and emotional health 2) Child- Nutritional Support
General Health	• Anaemia • PMS, Menopause • STI/ UTI • Cervical Cancer • Breast Cancer • Contraception • Osteoporosis • Any other Conditions pertaining to female wellbeing	Medical Guidance and counselling to ensure physical and emotional health

Exclusions for Teleconsultation Cover
1. Teleconsultation outside the digital platform of Insurer or concerned Service Provider's application/website
2. In-clinic/physical consultation .
3. Teleconsultation benefit is not transferrable to any other person.
4. If the Teleconsultation is not availed in the Policy Year, the benefit cannot be carried forward to the subsequent Policy Year.
5. Reimbursement of expenses incurred for Teleconsultation benefit is excluded.
6. Expenses for consultations with Cosmetologist or Cosmetic and Plastic Surgeon are excluded

d. Diet and Nutrition Consultation Cover
If the Insured Member wants to maintain a balance between good nutrition and diet, she can consult a Dietician or Nutritionist listed on the digital platform of the Insurer/ Service Provider's App via video, audio, or chat channel. This is a cashless service and can be availed through the prescribed network of Service Provider.

Exclusions for Diet and Nutrition Consultation Cover
1. Teleconsultation outside the digital platform of the Insurer or concerned Service Provider's App / website
2. Consultation with the dietician is strictly limited to in-app/website video/audio/chat consultation, no in-clinic/physical consultation is allowed.
3. Dietician and Nutritionist consultation benefit is not transferrable.
4. If the benefit is not availed in the policy year, it cannot be carried forward to the subsequent policy year.
5. Reimbursement of dietician and nutritionist consultation expenses is excluded.

e. Emotional Wellness Cover
If the Insured Member/s wants to avail emotional wellness services, they can consult an emotional wellness coach/psychologist listed on the Digital platform of the Insurer/ Service Provider's App via video or audio. This is a cashless service and can be availed through the prescribed network of Service Provider.

Exclusions for Emotional Wellness Cover
1. Consultation with the emotional wellness coach/psychologist is strictly limited to in-app/website video/audio consultation, no in-clinic/ physical consultation is allowed.
2. Emotional wellness benefit is not transferrable.
3. If the benefit is not availed in the Policy Year, it cannot be carried forward to the subsequent Policy Year.
4. Reimbursement of emotional wellness coach/psychologist consultation expenses is excluded.

f. Physical Fitness Cover
The Insured Member/s can avail online Physical Fitness sessions with listed Fitness trainers on the digital platform of the Insurer or concerned Service Provider's App via live online sessions. All the sessions will be under the supervision of a Physical Fitness expert and will be a group session.

Exclusions for Physical Fitness Cover
1. This benefit cannot be availed by children below 18 years.
2. If the benefit is not availed/partially availed in the policy year, it cannot be carried forward to the subsequent policy year.

b) Preventive care
At the end of every continuous period of three years during which the Insured Member(s) have held Our HERizon Care Policy, they become eligible for a free preventive health check-up covering below tests. This health check-up can be availed by all Insured Members aged 18 years and above.

CBC	Vitamin D (25-Hydroxy)
Serum Calcium	HbA1c (Haemoglobin A1c)
Total Iron Binding Capacity	T3,T4, TSH
Iron, Serum	Vitamin B12

2. Cradle Care (Surrogacy and Oocyte Donor Cover)
This cover/benefit is specially designed for
a) Surrogate mothers to provide a guarantee of compensation for medical expenses of surrogate mother and such other prescribed expenses incurred on such surrogate mother during the process of surrogacy
b) Oocyte Donor to cover medical expenses related to complications arising due to oocyte retrieval .

A. Surrogate Care
We will indemnify Insured Member against Surrogate mother's reasonable and customary medical expenses incurred towards Inpatient Hospitalization expenses covering complications arising during Surrogacy pregnancy and post-partum, subject to the following conditions
i. For the purpose of this cover one member of the Intending couple / Intending woman will be the proposer and the Surrogate Mother will be the Insured .
ii. The Proposal for insurance has to be made 30 days before the embryo transfer for the surrogate mother
iii. The cover will commence from the date of initiation of the treatment/procedure or Policy inception dated whichever later.
iv. The Policy tenure for this coverage is fixed at 36 months from the date of initiation of the treatment/procedure. After completion of 36 months period, Surrogate Care cover will cease for the insured surrogate mother
v. Our maximum liability under this cover for all claims shall be as per the limit specified against this cover/benefit in the Policy Schedule
vi. This cover/benefit shall only be available to Insured Person who is the Surrogate mother and is between the age of 25 to 35 years
vii. The surrogacy is carried out according to the Surrogacy Act 2021, and any amendments thereafter.

Specific Exclusions:
i. Procedures undertaken at an unauthorized fertility center
ii. Pre and Post hospitalization treatment expenses
iii. Payment for services rendered to a surrogate
iv. Expenses for Delivery / Medical termination of pregnancy
v. Any Illness or Injury other than complications of Surrogacy pregnancy and post-partum.

B. Oocyte Donor cover
We will indemnify Insured Person against Oocyte Donor's reasonable and customary medical expenses incurred towards Inpatient Hospitalization expenses covering complications arising during the process of oocyte retrieval, subject to following conditions
i. For the purpose of this cover one member of the Intending couple / Intending woman will be the proposer and the Oocyte Donor will be the Insured
ii. The Proposal for insurance has to be made 30 days before the ovarian stimulation for oocyte donor
iii. The cover will commence from the date of initiation of the treatment/procedure or Policy inception dated whichever later.
iv. The cover will be available for up to 12 months from the date of initiation of the treatment/procedure. After completion of 12 months period, Oocyte Donor cover will cease for the Oocyte Donor
v. Our maximum liability under this cover for all claims shall be as per the limit specified against this cover/benefit in the Policy Schedule
vi. This cover/benefit shall only be available to Insured Person who is the Oocyte Donor

vii. The Treatment is carried out in accordance to THE ASSISTED REPRODUCTIVE TECHNOLOGY (REGULATION) ACT, 2021, and any amendments thereafter

Specific Exclusions:
i. Procedures undertaken at an un authorized fertility center
ii. Pre and Post hospitalization treatment expenses
iii. Payment for services rendered to an Oocyte Donor
iv. Any illness or injury other than complications arising due to the process of oocyte retrieval.

3. Optional Covers
In consideration of payment of additional premium by the Insured to the Company and realization thereof by the Company, it is hereby agreed that the Insurer will pay benefit amount under cover or indemnify Insured Member against the Reasonable and Customary expenses, as the case may be, in respect of an admissible claim under any or all of the following Optional covers as opted subject to the Sum Insured, limits, terms, conditions and definitions, exclusions contained or otherwise expressed in this Policy.

A. Nurture Nest (Baby bearing Support)
Our maximum liability for all claims under the below listed covers shall not exceed the Sum Insured limit specified against Nurture Nest section in the Policy Schedule
The Sum insured for Nurture Nest Section shall not exceed that of Section 1. Vita Shield sum insured
If opted , Exclusions - Sterility and Infertility (Excl17) stands waived up to the limit covered under this cover/benefit

a. Expenses towards Surgical management for Infertility
We will indemnify You against reasonable and customary medical expenses incurred towards surgical management for treatment of Infertility subject to following conditions
1. The treatment is availed as Inpatient hospitalization during Policy Year.
2. Waiting Period of 24 months from the risk inception date of Nurture Nest cover under the HERizon Care policy with Us.
3. This cover shall only be available for Insured Person aged between 21years to 45 years of age.

Specific Exclusions:
i. Sub-fertility services that are deemed to be unproven, experimental or investigational
ii. Pre and Post hospitalization treatment expenses

iii. Reversal of voluntary sterilization
iv. Surgery / procedures that enhances fertility but not associated with female genital organs, such as Bariatric Surgery, Diagnostic Laparoscopy and such other similar surgery / procedures
v. Costs associated with cryopreservation and storage of sperm, eggs and embryos
vi. Services done at unrecognized center

b. Adoption Expense
We will indemnify You against reasonable and customary expenses incurred towards any legal and medical expenses incurred towards one time child adoption, subject to
1. The adoption is in accordance and in compliance with The CARA Adoption regulations 2022, and any amendments thereafter.
2. Our maximum liability for all claims under this cover shall be up to INR 50,000.
3. Waiting period of 24 months would apply to the Insured Member who is the Prospective Adoptive parent, from the date of issuance Nurture Nest cover under the Policy with Us

c. Egg Freezing (Cryo-Preservation) procedure Expense
We will indemnify You against Medical Expenses incurred towards one time process of harvesting and storage of the Oocyte for cryo-preservation and any complication thereof, subject to following conditions
i. Our maximum liability for all claims under this cover shall be limited up to 30 % of Sum Insured limit specified against Nurture Nest cover
ii. Waiting period of 24 months would apply to the Insured Member who is the Prospective Adoptive parent, from the date of issuance Nurture Nest cover under the HERizon Care policy with Us
iii. This cover shall only be available for Insured Person aged between 21years to 45 years of age.

B. MotherHood
Our maximum liability for all claims under the below listed covers shall not exceed the Sum Insured limit specified against MotherHood section in the Policy Schedule
The Sum Insured for MotherHood Section shall not exceed that of Section 1. Vita Shield Sum Insured
If opted , Exclusions - Sterility and Infertility (Excl17) and Maternity (Excl18) stands waived up to the limit covered under this cover/benefit.

a. Assisted Reproductive Technology Expenses
We will indemnify You against reasonable and customary Medical Expenses incurred for the Insured Person for the below listed procedures subject to following conditions
1. The Insured Member can avail this cover only in a single Policy Period during the lifetime of the Policy renewal with Us.
2. The Treatment is carried out in accordance to The Assisted Reproductive Technology (Regulation) Act, 2021, and any amendments thereafter.
3. This cover shall only be available for Insured Person aged between 21years to 45 years of age
4. Waiting period of 24 months from the risk inception date of Motherhood Care cover under the HERizon Care policy with Us
5. Cover will be available for following Listed procedures
    a. Intra Uterine Insemination (IUI)
    b. In vitro fertilization and embryo transfer (IVF-ET) and similar techniques.
    c. Intracytoplasmic sperm injection (ICSI)
    d. Gamete Intrafallopian Tube Transfer (GIFT)
    e. Zygote Intra-Fallopian Transfer (ZIFT)

    Specific Exclusions:
    i. Sub-fertility services that are deemed to be unproven, experimental or investigational
    ii. Pre and Post treatment expenses
    iii. Reversal of voluntary sterilization
    iv. Payment for services rendered to a surrogate
    v. Costs associated with cryopreservation and storage of sperm, eggs and embryos
    vi. Services done at unrecognized center

b. Maternity Expense
We will indemnify You against the Medical Expenses for the delivery of a baby (Self / Surrogate Mother) and / or expenses related to medically recommended and lawful termination of pregnancy, limited to maximum 2 deliveries or termination(s) or either during the lifetime of the Insured Member, subject to following conditions
i. Our maximum liability per delivery or termination shall be as per the Maternity Package limit specified in the Policy Schedule.
ii. We will pay the In-patient Medical Expenses of pre-natal (complete pre-natal period) and post-natal hospitalization (up to 90 days post-delivery) per delivery or termination up to the Sum Insured specified against this cover/benefit in the Policy Schedule
iii. The cover will be subject to a waiting period of 24 months from the date of risk inception date of the HERizon Care policy with Us.

C. Fetal Flourish (Health support for your baby)
Our maximum liability for all claims under the below listed covers shall not exceed the Sum Insured limit specified against Fetal Flourish section in the Policy Schedule
The Sum insured for Fetal Flourish Section shall not exceed that of Section 1. Vita Shield Sum Insured

a. Pre-natal Health
We will indemnify You against reasonable and customary medical expenses incurred towards invasive investigations and/or treatment for complications of Your Unborn baby, subject to following conditions
i. The treatment is carried out as inpatient /Daycare hospitalization.
ii. The cover will be subject to a waiting period of 24 months from the risk inception date of Fetal Flourish cover under HERizon Care policy with Us
iii. If Fetal Flourish section is opted by You, then Standard Exclusion Investigation and Evaluation (Code-Excl04) stands waived up to the limit covered under this benefit

List of procedures covered :

1. Prenatal Invasive techniques
- Amniocentesis
- Chorionic Villus Sampling (CVS)
- Percutaneous Umbilical Blood Sampling (PUBS) or Cordocentesis
- Fetal Tissue Biopsy
- Amnioinfusion
- Fetoscopy

2. In Utero-surgeries
- Fetoscopic Laser Surgery for Twin-to-Twin Transfusion Syndrome (TTTS)
- Open Fetal Surgery for Myelomeningocele (Spina Bifida)
- Fetoscopic Endotracheal Occlusion (FETO) for Congenital Diaphragmatic Hernia (CDH)
- Amniotic Band Syndrome (ABS) Surgery
- Fetal Aortic Valvuloplasty for Severe Aortic Stenosis
- Thoracoamniotic Shunt for Fetal Pleural Effusion

Note: the description of procedures listed above are given in Annexure II of Policy Wordings

Specific Exclusions for Pre-natal Health
1. Voluntary/unlawful termination of pregnancy/investigations done for identification of fetal sex
2. Expenses related to Delivery/termination of pregnancy
3. Pre and Post hospitalization treatment expenses
4. Treatment that are deemed to be unproven, experimental or investigational
5. Treatment done at unrecognized center

b. Congenital Disability Benefit
We will indemnify You against reasonable and customary in-patient medical expenses for treatment of Your Baby born during the Policy Period with any one or more of the Congenital Disabilities listed below, subject to following conditions

i. This benefit will be available for first two children only and will not be available if the birth of the Baby occurs after the mother, who is the Insured Member, attains the age of 40 years.
ii. The cover will be subject to a Waiting Period of 24 months from the risk inception date of Fetal Flourish cover under HERizon Care policy with Us
iii. This cover shall be applicable till the Baby attains the age of 1 year.
iv. List of conditions covered as below

a) **Down's syndrome**
Diagnosis confirmed by chromosomal analysis showing trisomy 21 pattern (an extra chromosome), translocation (a breaking off of one chromosome and attaching to another), or mosaicism (some cells have 46 chromosomes and some have 47); resulting in genetic, physical, mental defects.

b) **Congenital cyanotic heart disease**
Congenital heart diseases characterized by presence of cyanosis at birth due to any one or more of the following cardiac lesions.
i. Tetrology of Fallot
ii. Transposition of great vessels
iii. Total Anomalous pulmonary venous drainage
iv. Truncus Arteriosus,
v. Tricuspid Atresia,
vi. Hypoplastic Left Heart Syndrome

c) **Tracheo-esophageal fistula**
Fistula detected at birth due to developmental defect of either trachea and or esophagus, excluding any other cause for such a fistula

d) **Cleft Palate with or without cleft lip**
The cleft in the soft or hard palate, partial or complete, unilateral or bilateral, which is due to developmental defect present at birth either as a single defect or with additional defect of cleft lip.
Specific Exclusions
Cleft lip alone is specifically excluded.

e) **Spina bifida**
Presence of developmental vertebral column defect resulting in incomplete closure of spinal column with meningocele / myelomeningocole.

Specific Exclusions
i. Spina bifida occulta is specifically excluded.
ii. Pre and Post hospitalization expenses

Extension 4 Hospital Daily allowance (Applicable to Fetal Flourish section)

You can opt for this extension on payment of additional premium along with Fetal Flourish section. The payout for the extension shall be over and above the Fetal Flourish section Sum Insured .
We shall pay a Daily Allowance as specified in Policy Schedule for each continuous and completed period of 24 hours of Hospitalization of the Mother who is the Insured Member or her Baby (up to 1year of age) for whom we have accepted claim under either Pre-natal Health or Congenital Disability Benefits listed above.
Our limit of liability is restricted to a maximum period of 10 days per Policy Year.

D. Prophylactic Surgeries

We will indemnify You against reasonable and customary in-patient medical expenses for undergoing the below listed prophylactic surgeries subject to below conditions.

i. The Sum Insured for Prophylactic Surgery Section shall not exceed that of Section 1. Vita Shield Sum Insured
ii. The cover under this section will be subject to a Waiting Period of 24 months from the date of issuance of Prophylactic Surgeries cover under HERizon Care Policy with Us,
iii. List of Surgeries covered , subject to terms and condition as specified below

1. Prophylactic Mastectomy : Medically necessary removal of one or both breasts to reduce the risk of breast cancer and meeting all the below mentioned Criteria

- Prescribed by the treating Medical Practitioner
- **Genetic mutations:** Women with BRCA1 or BRCA2 gene mutations.
- **Family history:** Strong family history of breast cancer, particularly in close relatives (mother, sister, daughter).

2. Prophylactic Oophorectomy : Medically necessary removal of the ovaries to reduce the risk of ovarian cancer and also reduce breast cancer risk in women with BRCA mutations and meeting all the below mentioned criteria

- Prescribed by the treating Medical Practitioner
- **Genetic mutations:** Lynch syndrome or BRCA1 or BRCA2 gene mutations or similar positive gene mutations .
- **Family history:** Strong family history of ovarian cancer, particularly in close relatives (mother, sister, daughter).
- **Age and menopause status:** Typically recommended after childbearing is complete, often before or during early menopause.

3. Hysterectomy : Medically necessary removal of the uterus to prevent uterine cancer and meeting all the below mentioned criteria

- Prescribed by the treating Medical Practitioner as an Adjunctive Surgery to Prophylactic Mastectomy
- **Genetic conditions:** Lynch syndrome or BRCA1 or BRCA2 gene mutations or similar positive gene mutations
- **Family history:** Strong family history of cancer, particularly in close relatives (mother, sister, daughter)along with family history
- **Recurrent abnormal bleeding or pre-cancerous cells:** Persistent issues that increase the risk of cancer.

4. Salpingectomy : Medically necessary removal of the fallopian tubes to prevent ovarian cancer and meeting all the below mentioned criteria.

- Prescribed by the treating Medical Practitioner
- **Genetic mutations:** BRCA1 or BRCA2 gene mutations.
- **During other surgeries:** Sometimes recommended during other pelvic surgeries, such as hysterectomy, especially if there is a family history of ovarian cancer.
- Salpingectomy for any type of contraception, sterilization is excluded

5. Bariatric Surgery : Medically necessary preventative surgery for obesity-related cancers, such as breast, endometrial, and ovarian cancers. If You are hospitalized on the advice of a Medical Practitioner because of Conditions mentioned below which required You to undergo Bariatric Surgery during the Policy Period, then We will pay You, Reasonable and Customary Expenses related to Bariatric Surgery subject to all the below mentioned criteria being met

For adults aged 18 years or older, presence of severe documented in contemporaneous clinical records, defined as any of the following:

Body Mass Index (BMI);

a. greater than or equal to 40 or

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

i.Obesity-related cardiomyopathy
ii.Coronary heart disease
iii.Severe Sleep Apnea
iv.Uncontrolled Type 2 Diabetes

E. Legal Expense Support

In the event of any of the following incidents involving an Insured Member as the Aggrieved person, We will pay You a lumpsum amount of INR 50,000 as cost of legal expense, provided a First Information Report (FIR) has been registered for the incident. The Insured Member can avail this cover once per Policy Year with us.

a) Sexual Assault
b) Kidnapping
c) Acid attack

SECTION D) WAITING PERIOD and EXCLUSIONS UNDER THE POLICY

I. Waiting Period

1. Any claim under Section C 1. Vita Shield benefit reported within the Waiting Period as specified in Policy Schedule from the date of commencement of the Policy is excluded. This exclusion shall not apply to an Insured for whom coverage has been renewed, without a break, for subsequent years. This exclusion is not applicable to claim under Section C 1.A Critical illness cover for (7) Multi trauma ,(8) Third Burns (27) Major Head Trauma and Section C 1. C. Daily Health cover.

2. Waiting period of 24 month would apply from the date of risk inception of Section C 3. A. Nurture Nest cover under the HERizon Care policy with Us. If Insured had opted out of this cover at renewal and want to opt back in, Waiting Periods will apply afresh

3. Waiting Period of 24 month would apply from the date of risk inception Section C 3. B. Motherhood cover under the HERizon Care policy with Us. If Insured had opted out of this cover at renewal and want to opt back in, Waiting Periods will apply afresh

4. Waiting Period of 24 month would apply to the mother who is the Insured Person from the date of risk inception of Section C 3. C. Fetal Flourish cover under the HERizon Care policy with Us. If Insured had opted out of this cover at renewal and want to opt back in, Waiting Periods will

apply afresh

5. Waiting Period of 24 month would apply from the date of risk inception of Section C 3. D. Prophylactic Surgeries cover under the HERizon Care policy with Us. If Insured had opted out of this cover at renewal and want to opt back in, Waiting Periods will apply afresh

6. 30-daywaiting period (Excl03)
a. Expenses related to the treatment of any Illness within 30 days from the first HERizon Care Policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b. This exclusion shall not, however apply if the Insured Person has Continuous Coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently

II. Standard Exclusions applicable to all benefits

1. Investigation and Evaluation (Code-Excl04)
a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded even if the same requires confinement at a Hospital.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

2. Rest Cure, rehabilitation and respite care (Code-Excl05)
a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address medical, physical, social, emotional and spiritual needs

3. Obesity/Weight Control (Excl06)
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
    1. Surgery to be conducted is upon the advice of the Doctor
    2. The surgery/Procedure conducted should be supported by clinical protocols
    3. The member has to be 18 years of age or older and
    4. Body Mass Index (BMI);
    a. greater than or equal to 40 or
    b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
        i. Obesity-related cardiomyopathy
        ii. Coronary heart disease
        iii. Severe Sleep Apnea
        iv. Uncontrolled Type2 Diabetes

4. Change-of-gender treatments (Excl07)
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

5. Cosmetic or plastic Surgery (Excl08)
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

6. Hazardous or Adventure Sports (Excl09)
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para- jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7. Breach of law (Excl10)
Expenses for treatment directly arising from or consequent upon any Insure Person committing or attempting to commit a breach of law with criminal intent.

8. Excluded Providers (Excl11)
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website
/ notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

10. 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. (Excl13)

11. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless pre- scribed by a medical practitioner as part of hospitalization claim or daycare procedure. (Excl14)

12. Refractive Error (Excl15)
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 diopters

13. Unproven Treatments (Excl16)
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or sup- plies that lack significant medical documentation to support their effectiveness.

14. Sterility and Infertility (Excl17)

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

15. Maternity (Excl 18)

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.

III. General Exclusions applicable to all coverages/benefits

The Company shall not be liable for and no indemnity is available hereunder in respect of

1. Any illness or conditions covered for which care, treatment, or advice was recommended by or received from a Physician, or which first manifested itself, was diagnosed before the inception of HERizon Care Policy, or for which a claim has or could have been made under any earlier insurance policy.
2. Occupational diseases.
3. War, whether war be declared or not, invasion, act of foreign enemy, hostilities, civil war, insurrection, terrorism or terrorist acts or activities, rebellion, revolution, mutiny, military or usurped power, riot, strike, lockout, military or popular uprising, civil commotion, martial law or loot, sack or pillage in connection therewith, confiscation or destruction by any government or public authority or any act or condition incidental to any of the above.
4. Naval or military operations of the armed forces or air force and participation in operations requiring the use of arms or which are ordered by military authorities for combating terrorists, rebels and the like.
5. Any natural peril (including but not limited to storm, tempest, avalanche, earthquake, volcanic eruptions, hurricane, or any other kind of natural hazard).
6. Radioactive contamination.
7. Consequential losses of any kind, be they by way of loss of profit, loss of opportunity, loss of gain, business interruption, market loss or otherwise, or any claims arising out of loss of a pure financial nature such as loss of goodwill or any legal liability of any kind whatsoever.
8. Intentional self-injury and/or the use or misuse of intoxicating drugs and/or alcohol.
9. Any treatment received outside India is not covered under this Policy
10. Treatment for any other system other than modern medicine (allopathy) and AYUSH therapies
11. All non-medical Items as per Annexure III

SECTION E) GENERAL TERMS AND CONDITIONS (APPLICABLE TO ALL COVERS/BENEFITS UNDER THE POLICY)

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 Insured.

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. Premium Payment in Instalments (Wherever applicable)

If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Annual (for long term polices only), Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. The Grace Period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium.
ii. If the Policy is renewed during Grace Period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the Policy shall be protected.
iii. If the premium is paid in instalments during the Policy Period, coverage will be available for the Grace Period also.
iv. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period.
v. No interest will be charged If the instalment premium is not paid on due date.
vi. In case of instalment premium due not received within the Grace Period, the Policy will automatically get cancelled.
vii. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
viii. The Company has the right to recover and deduct all the pending installments from the claim amount due under the Policy.

4. Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any cover/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

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

6. Claim Settlement. (provision for Penal interest)

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of 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 Insured Person 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 15 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 15 days, the Company shall be liable to pay interest to the Insured Person 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).
Note : In case of claim related to Section C. 2 Cradle Care , the claim payout shall be to the Surrogate mother or the Oocyte Donor as per the cover opted

7. Renewal of Policy

The Policy shall ordinarily be renewable except on misrepresentation by the Insured Person. 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 15 days/30 days (applicable as per the option of premium payment in monthly installment or otherwise) to maintain continuity of benefits without break in policy. Coverage is not available during the Grace Period.

v. No loading shall apply on renewals based on individual claims experience.

8. 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.

9. 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.

10. 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 the link https://irdai.gov.in/document-detail?documentId=393128
(Please note referred link is of the IRDAI website and subject to change from time to time.)

11. Moratorium Period

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

12. Cancellation

(A) Cancellation by the Insured

The Insured can cancel this Policy by providing a written notice of 7 days. In such a case, the Company will refund the premium for the unexpired Policy Period as detailed below:

1. Cancellation of Policy where full premium received at Policy inception -
   - Annual Policy: The premium refund for the unexpired risk Policy Period will be on a pro-rata basis, provided no claim has been made during the Policy Year.
   - Multi-year Policy:
     - For any Policy year where the risk date has not yet started, the premium will be refunded without any deduction.
     - For any Policy Year where the risk has started, the premium will be refunded for the unexpired risk period on a pro-rata basis for that Policy Year, provided no claim has been made during the Policy Year and in full for future Policy Years.

2. Cancellation of Policy where Premium Received on Instalment Basis
   The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the Policy Year.

(B) Additional Deductions

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

(C) Cancellation by the Company
The Company may cancel the Policy at any time on the grounds of misrepresentation, non-disclosure of material facts, or fraud by the Insured/Insured Person, by providing 15 days' written notice. There will be no refund of premium for cancellations on these grounds.

13. Fraud

i. 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.

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

iii. 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 or to pay the claim under 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 actor 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.

14. Free Look Period

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

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

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

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

15. Nomination

The Insured 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 Insured. 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 Insured, the Company will pay the nominee {as named in the Policy Schedule /Endorsement (if any) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Insured whose discharge shall be treated as full and final discharge of its liability under the Policy.

16. 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 the link https://irdai.gov.in/document-detail?documentId=393128
(Please note referred link is of the IRDAI website and subject to change from time to time.)

17. Deductions in case of return of Policy.

Notwithstanding anything contained in any other clauses/conditions in this Policy, where (i) the risk under the Policy has already commenced, or (ii) only a part of the insurance coverage has commenced, and the option of Policy return is exercised by the Insured Person under clause 14 above, then in addition to deductions under clause 14 above, expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charge will also be deducted before refund of premium to Insured.

18. Grievance Redressal Procedure

The Company has always been known as a forward-looking customer centric organization. It takes immense pride in its approach of "Caringly Yours". To provide you with top-notch service on all fronts, the company has provided with multiple platforms via which you can always reach out to us at below mentioned touch points

1. Our toll-free number 1-800-209- 5858 or 020-30305858, say Say "Hi" on WhatsApp on +91 7507245858
2. Branches for resolution of your grievances / complaints, the Branch details can be found on our website www.bajajallianz.com/branch-locator.html
3. Register your grievances / complaints on our website www.bajajallianz.com/about-us/customer-service.html
4. E-mail

a) Level 1: Write to bagichelp@bajajallianz.co.in and for senior citizens to seniorcitizen@bajajallianz.co.in
b) Level 2: In case you are not satisfied with the response given to you at Level 1 you may write to our Grievance Redressal Officer at ggro@bajajallianz.co.in
c) Level 3: If in case, your grievance is still not resolved, and you wish to talk to our care specialist, please give a missed call on +91 80809 45060 OR SMS To 575758 and our care specialist will call you back

5. If you are still not satisfied with the decision of the Insurance Company, you may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. Detailed process along with list of Ombudsman offices are available at www.cioins.co.in/ombudsman

The contact details of the Ombudsman offices are mentioned in Annexure IV.

SECTION E) SPECIFIC TERMS AND CONDITIONS (APPLICABLE TO ALL COVERS/BENEFITS UNDER THE POLICY)

19. Due Observance

The due observance of and compliance with the terms, provisions, warranties and conditions of this Policy in so far as they relate to anything to be done or complied with by the Insured Personshall be a condition precedent to the Company's liability under this Policy.

20. Discounts

i. Long Term Policy Discount - applicable in case of single payment for Policy Period of more than one year
   a. 4 % discount is applicable if Policy is opted for 2 years
   b. 8 % discount is applicable if Policy is opted for 3 years
   c. 10% discount is applicable if Policy is opted for 4 years
   d. 11 % discount is applicable if Policy is opted for 5 years

   This is not applicable if premium is paid in instalments.

ii. Preventive Health Discount - 5% discount on insured first year HERizon Care policy premium only, if Insured is HPV vaccinated

iii. Family discount - 10% family discount shall be offered if 2 eligible Family Members are covered under a single Policy and 15 % if more than 2 of any of the eligible Family Members are covered under a single Policy. Moreover, this family discount will be offered for both new policies as well as for renewal policies

iv. Early entry discount - 5% discount shall be offered if, Insured is opting the HERizon Care Policy prior to 35 years of age. In policies where Proposer is also an Insured member, and her age is 35 years or below, this discount shall be extended to all other Insured Members also who are aged 35 years and below in the same Policy. This discount shall be applicable at inception of Policy as well as at each subsequent renewal, irrespective of claims, until the Insured Person/s completes 45 years of age.
Note: This discount will apply only if long term Policy is opted. This will not apply to policies where premium is paid in instalments.

v. Loyalty Discount – Discount of 5% shall be offered if the Insured Person is having any of the listed active Bajaj Allianz General Insurance Co. Ltd.'s retail policy of Motor, Health, Home, Cyber and Pet Insurance with a minimum premium of INR 2500.

vi. Employee Discount – 20% discount on published premium rates will be applicable for the Company's employees and employees of group companies, employees of Corporate customers of Bajaj Allianz General Insurance Co. Ltd. provided the Policy is booked in direct code. This discount shall also be applicable to Intermediaries of Bajaj Allianz General Insurance Co. Ltd. for their own policies booked under Direct code, provided that the Intermediaries themselves are covered under the Policy and any other partner Viz. Bank, Financial Institution

vii. Online/Direct Business Discount - Discount of 10% will be offered in this product for Policies underwritten through direct/online channel.
Note: this discount is not applicable for Policies where employee discount is given.

21. Pre policy Medical Test

Medical tests may be needed based on Insured Person age, section opted, Sum Insured, and health declaration (if any).

- These tests will be done at our empanelled diagnostic centres, and the results will be valid for 30 days.
- If the proposal is accepted and Policy issued, 100% of the standard Pre-policy medical test costs will be reimbursed

Sum Insured in INR	18 yrs to 30 Yrs	31 yrs. – 45 year	Age above 45 years
1 to 10 Lacs	No Medical Test**	No Medical Test**	VHC *
Above 10 Lac to below 35 Lacs	No Medical Test**	VHC *	VHC *+ USG(Abd. and Pelvis) + mammography, PAP smear
35 lacs to 1 Crore	VHC *	VHC* + USG(Abd. and Pelvis) + mammography, PAP smear	VHC* + USG(Abd. and Pelvis) + mammography, PAP smear + Hepatitis B Antigen
Above 1 crore to 2 crores	VHC* + USG(Abd. and Pelvis) + mammography, PAP smear + Hepatitis B Antigen	VHC* + USG(Abd. and Pelvis) + mammography, PAP smear + Hepatitis B Antigen	VHC* + USG(Abd. and Pelvis) + mammography, PAP smear + Hepatitis B Antigen

*VHC - Full Medical Report, ECG with reporting, FBG, CBC WITH ESR , Cholesterol, HDL Cholesterol, Triglycerides, Creatinine, GGTP, SGOT, SGPT, HbA1c, Urinalysis, Total Protein, Sr. Albumin, Sr. Globulin, A:G Ratio
** Subject to no adverse health conditions

22. Medical Underwriting

The Company may add a risk loading to the premium applicable for the person to be insured, based on the information provided in the proposal form and the health status of those Insured Person.

i. The maximum risk loading for any individual for all conditions put together will not exceed 200% per Insured Person.
ii. Such loading will be intimated to the customer and consent shall be taken before Policy is issued
iii. This loading will take effect from the Policy's Commencement Date and will apply to any subsequent renewals with the company.

23. Territorial Limits and Governing Law

The Company's liability to make any payment shall be within India and in Indian Rupees only.

24. Arbitration and Reconciliation

Arbitration Clause shall not be applicable.

25. Sum Insured Enhancement

The Insured Person can apply for enhancement of Sum Insured at the time of renewal, by submitting a fresh proposal form to the Company, subject to underwriting by the Company. For any increase in Sum Insured, the Waiting Period shall start afresh only for the enhance portion of the Sum Insured.

26. Insured

No person other than a person named as an Insured shall be covered under this Policy unless and until his name has been notified in writing to the Company. Cover under this Policy shall be withdrawn from any person named as an Insured Person immediately upon the Insured Person delivering written notice of the same to the Company requesting for withdrawal of cover. The Named Insured agrees to and shall hold the Company harmless

against any and all claims, costs and expenses that may result because of the incorrect or unintentional cancellation of this insurance in relation to any Insured Person.

27. Material Changes

The Insured Person shall notify the Company in writing of any material change in the risk in relation to the declaration made in the Proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

28. Notice and Communication

i. Any notice, direction, instruction, or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address and/or to Your email address that You have registered with Us/provided to Us or through any other electronic mode mentioned in the Schedule.

29. Governing Laws/Jurisdiction

This Policy and the construction, interpretation and meaning of the provisions of this Policy shall be determined exclusively in accordance with Indian laws. All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian laws.

30. Entire Contract

The Proposal Form, these Policy wordings, and Policy Schedule constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by Us, which approval shall be evidenced by an endorsement on the Schedule.

SECTION E) OTHERS TERMS AND CONDITIONS

31. Claim Procedure

a. You or someone claiming on Your behalf must inform Us in writing immediately within 48 hours of diagnosis of any of the listed Critical Illnesses / 48 hours of Hospitalisation in case of emergency Hospitalisation and 48 hours prior to Hospitalisation in case of planned Hospitalisation
b. You must immediately consult a Medical practitioner nd follow the advice and treatment that he recommends.
c. You must have Yourself examined by Our medical advisors if We ask for this, and as often as We consider this to be necessary at Our cost.
d. You or someone claiming on Your behalf must promptly and in any event within 30 days of diagnosis of any of the listed Critical Illnesses/ within 30 days of discharge from a Hospital(if admitted) give Us the documentation as listed out in greater detail below and other information We ask for to investigate the claim or Our obligation to make payment for it.

Note : Waiver of conditions (a) and (d) may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the Insured was placed it was not possible from him or any other person to give notice or file claim within the prescribed time limit.

32. Cashless treatment - **Applicable for Nurture Nest , MotherHood , Fetal Flourish , Prophylactic Surgeries and Cradle Care covers**

Cashless treatment is only available at Network Hospitals. 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, the Insured must call Us and request preauthorization by way of the written form which the Company will provide.
b) After considering the Insured’s request and after obtaining any further information or documentation We have sought, the Company may if satisfied send to the Insured or the Network Hospital, an authorization letter. The authorization letter, the ID card issued to the Insured along with this Policy and any other information or documentation that the Company have specified must be produced to the Network Hospital identified in the pre-authorization letter at the time of Insured’s admission to the same.
c) If the procedure above is followed, the Insured will not be required to directly pay for the Medical Expenses raised out of Accidental Bodily Injury, in the Network Hospital that the Company is liable to indemnify under Accidental Hospitalization Expenses Section and the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital. Pre-authorization does not guarantee that all costs and expenses will be covered.
d) 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. You shall, in any event, be required to settle all other expenses directly.

33. Claim documents to be submitted for claim

A. General (applicable to all claims)

- Claim Form duly signed by the insured along with NEFT Form signed by the Claimant
- Aadhar card and PAN card Copies (Not mandatory if the same is linked with the policy while issuance or in previous claim)
- Any additional documents required for confirming the admissibility of claim

B. Documentation for claim under Vita Shield

1. Claim for Critical illness Cover
   i. Certificate from the attending Medical Practitioner of the Insured confirming, inter alia,
      a. Name of the Insured;
      b. Name, date of occurrence and medical details of the Insured Event;
      c. Confirmation that the Insured Event does not relate to any Pre-Existing Condition; and
      d. Confirmation that the Insured Event does not relate to any Illness or Injury which existed within the waiting period applicable from the risk inception date of the Policy .
   ii. Investigation reports and films supporting the diagnosis
   iii. Attested copy of disability certificate from Civil Surgeon of Government Hospital stating percentage of disability (if applicable)

2. Claim for Children Education Bonus
   i. Document supporting the age of dependent child for claim under
   ii. Bonafide Certificate duly signed by the educational institution where Insured’s dependent children are studying;

3. Claim for Loss of Job
   - Copy of Your Letter of Appointment by Your employer

- A letter from Your employer stating the reasons for termination of the contract of Your employment
- Previous three month's pay slips
- Other documents as may be required by Us to process the claim

4. Claim for On the Mend cover
   Discharge Summary / Discharge Certificate.
   Medical certification from Medical Practitioner confirming insured is not able to perform 3 out of 6 daily living activities

5. Claim for Surrogate Care cover
   - Photo Identification card
   - Photocopy of certificate of registration of Intending couple and Surrogate mother to the surrogacy clinic
   - Original Discharge Summary / Discharge Certificate.
   - Original Final Hospital Bill
   - First consultation letter for Illness
   - Medical certificate for the duration of illness
   - All required Original Investigation Reports

6. Claim for Oocyte Donor cover
   - Photo Identification card
   - Photocopy of certificate of registration of Oocyte donor at IVF clinic
   - Original Discharge Summary / Discharge Certificate.
   - Original Final Hospital Bill
   - Document supporting the details of treatment
   - Medical certificate for the duration of illness
   - All required Original Investigation Reports

7. Claim for Nurture Nest and MotherHood Covers
   - Original Discharge Summary / Discharge Certificate.
   - Document supporting the details of treatment
   - Original Final Hospital Bill
   - First consultation letter for Illness
   - Medical certificate for the duration of illness
   - All required Original Investigation Reports as per the Illness
   - Photocopy of Certificate and Original bills for expenses related to adoption procedure
   - Original bills for expenses related to Egg Freezing (Cryo-Preservation) procedure

Annexure I – Critical illness Cover – Definitions

a. **Breast Cancer**
The diagnosis by a Consultant oncologist of the presence of malignant tumor of breast characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue microscopically confirmed by Consultant pathologist, supported by histological evidence of malignancy.

Specific Exclusions
i. Tumor's, which are histologically described as pre malignant.
ii. Benign Breast Lumps e.g. fibro adenoma, fibrocystic diseases of breast etc.
iii. All hyperkeratosis or basal cells carcinomas, melanomas, squamous cell carcinoma, Kaposi's sarcoma and other tumors associated with HIV infections or AIDS.

b. **Fallopian Tube Cancer**
The clinical diagnosis by a Consultant oncologist of the presence of malignant tumor or lesion of the Fallopian Tubes characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue microscopically confirmed by the Consultant pathologist, supported by histological evidence of malignancy.

Specific Exclusions
Dysplasia, inflammatory masses, Hydatidiform mole, trophoblastic tumors.

c. **Uterine/Cervical Cancer**
The clinical diagnosis by a Consultant oncologist of the presence of malignant tumor or lesion of the uterine cervix/ uterine endometrium characterized by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue at the respective site microscopically confirmed by the Consultant pathologist, supported by histological evidence of malignancy.

Specific Exclusions
i. Tumor's, which are histologically described as pre malignant
ii. Squamous Intraepithelial Lesion (SIL)
iii. Fibroid, endometriosis, cystic lesions, Hyperplasia of any type presenting as tumors
iv. Hydatidiform mole, trophoblastic tumor's

d. **Ovarian Cancer**
The clinical diagnosis by a Consultant oncologist of the presence of malignant tumor or lesion of the ovary, characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue microscopically confirmed by the Consultant pathologist, supported by histological evidence of malignancy.

Specific Exclusions
i. Non-cancerous (benign) ovarian masses including abscesses or infections, fibroids, cysts, polycystic ovaries, endometriosis-related masses,
ii. Hydatidiform mole, trophoblastic tumors

e. **Vaginal Cancer**
The clinical diagnosis by a Consultant oncologist of the presence of malignant tumor or lesion of the vagina characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue microscopically confirmed by the Consultant pathologist, supported by histological evidence of malignancy.

Specific Exclusions
Vulval cancers/tumors Vaginal / Vulval granulomatous diseases.

f. **Thyroid Cancer**
The diagnosis by a Consultant oncologist of the presence of malignant tumor of Thyroid stage T3 b , chracterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue microscopically confirmed by Consultant pathologist, supported by histological evidence of malignancy.

Specific Exclusions
i. Thyroid tumors histologically described as pre malignant and up to stage T3a as per TNM staging for thyroid cancer.
ii. Benign lumps, tumors or non-malignant tumors of the thyroid gland

g. **Multi trauma**
The diagnosis and certification by a Consultant surgeon of a severe injury due to an accident resulting in multiple fractures (excluding hairline fractures) involving long bones of upper or lower limbs, vertebral column, head and/or injury to internal organs endangering insured's life due to traumatic/ hemorrhagic shock (involving two or more sites on the body)
Specific exclusions
Fracture at single site on the body, Injuries involving fractures of small bones of hand, feet, ribs even if multiple are excluded. These exclusions are applicable to any type of fracture such as open or closed, displaced or un-displaced, simple or compound types.

h. **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.

Specific exclusions
Radiation induced burns are specifically excluded.

i. **Osteoporotic Fracture**
Osteoporotic fracture of bone or multiple bones due to injury, illness or stress that surpass the bone's load-bearing capacity leading to a permanent inability to perform min 3 out of 6 Activities of Daily Living (ADL)disability of insured
A specialist medical practitioner must be of the opinion that the disability will be permanent with no hope of recovery and must be present for more than 3 months.

Activities of Daily Living (ADL) means the following: -
i. Transfer- Getting in and out of a chair without requiring physical assistance.
ii. Mobility- The ability to move from room to room without requiring any physical assistance.
iii. Continence- The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.
iv. Dressing- Putting on and taking off all necessary items of clothing without requiring assistance of another person.
v. Bathing / Washing- The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash b any other means.
vi. Eating- All tasks of getting food into the body once it has been prepared.

j. **Cancer of Specified Severity**
I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy.
The term cancer includes leukemia, lymphoma and sarcoma.
II. The following are excluded –
i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
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;

k. **Myocardial Infarction First Heart Attack of specific severity**
The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

Specific exclusions:
a. Other acute Coronary Syndromes
b. Any type of angina pectoris
c. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

l. **Open Chest CABG**
The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass

grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

Specific exclusion - Angioplasty and/or any other intra-arterial procedures.

m. **Open Heart Replacement Or 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-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.

n. **Major Surgery Of Aorta**
The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

o. **Heart Transplant**
The actual undergoing of a transplant of human heart that resulted from irreversible end stage heart failure. The undergoing of a heart transplant has to be confirmed by a specialist medical practitioner.

p. **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 IV, or its equivalent, for at least six (6) months based on the following classification criteria:

a. Class IV - 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 and
b. Echocardiography findings confirming presence of cardiomyopathy and Left Ventricular Ejection Fraction (LVEF %) of 40% or less
Cardiomyopathy directly related to alcohol or drug abuse is excluded.

q. **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 (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

r. **Systemic Lupus Erythematosis with renal involvement**
A multisystem, multifactorial, autoimmune disorder characterized by the development of auto-antibodies directed against various self-antigens. In respect of this contract, systematic lupus erythematosus will be restricted to those forms of systematic lupus erythematosus which involve the kidneys (Class III to Class V Lupus nephritis, established by renal biopsy, and in accordance with the WHO classification as noted below). Other forms, discoid lupus and those forms with haematological and joint involvement are specifically excluded. The final diagnosis must be supported by a consultant physician specializing in Rheumatology and Immunology.
WHO Lupus nephritis classification

WHO Class I (minimal)	Negative, normal urine
WHO Class II (mesangial)	Moderate proteinuria, occasionally active sediment
WHO Class III (focal segmental)	Proteinuria, active sediment
WHO Class IV (diffuse)	Acute nephritis with active sediment and/ or nephrotic syndrome
WHO Class V (membranous)	Nephrotic syndrome or severe proteinuria

s. **Kidney Transplant**
The actual undergoing of a transplant of human kidney that resulted from irreversible end stage kidney failure. The undergoing of a kidney transplant has to be confirmed by a specialist medical practitioner.

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

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.

u. **Coma of Specified Severity**
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.
The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

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

w. **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.

x. **Multiple Sclerosis with Persisting Symptoms**
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.
(iii) Neurological damage due to SLE is excluded.

y. **Benign Brain Tumor**
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.
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.

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

z. **Brain Surgery**
The actual undergoing of surgery to the brain, under general anesthesia, during which a Craniotomy is performed. Burr hole procedures, transsphenoidal procedures, other minimally invasive procedures and brain surgery as a result of an accident is excluded. The procedure must be considered necessary by a qualified specialist and the benefit shall only be payable once corrective surgery has been carried out.

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

Specific Exclusion - Spinal cord injury;

bb. **Blindness in both the eyes**
Total, permanent and irreversible loss of total vision in both eyes as a result of illness or accident. The Blindness is evidenced by:
1. corrected visual acuity being 3/60 or less in both eyes or ;
2. the field of vision being less than 10 degrees in both eyes.

The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure

cc. **Deafness in both ears**
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 90 decibels across all frequencies of hearing” in both ears.

dd. **Loss of Speech**
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.

ee. **Lung Transplant due to End stage lung failure**
The actual undergoing of a transplant of human lung that resulted from irreversible end stage lung disease. The undergoing of a lung transplant has to be confirmed by a specialist medical practitioner.
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 liter 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 pressure of 55mmHg or less ($PaO_2 < 55$mmHg); and
iv. Dyspnea at rest.

ff. **Liver Transplant due to End Stage liver failure**
The actual undergoing of a transplant of human liver that resulted from irreversible end stage liver failure. The undergoing of a liver transplant has to be confirmed by a specialist medical practitioner.
End stage liver failure is evidenced by 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

Specific Exclusion - Liver failure secondary to drug or alcohol abuse is excluded.

gg. **Pancreas Transplant**
The actual undergoing of a transplant of pancreas, that resulted from irreversible end-stage failure of the pancreas. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
Specific Exclusion - Where only islets of Langerhans are transplanted

hh. **Bone Marrow Transplant**
The actual undergoing of a transplant of:

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

Specific Exclusion - Other stem-cell transplants.

Annexure II - Description of procedures listed under Section C 3. II. Fetal Flourish

Amniocentesis:
Procedure: A needle is inserted through the mother's abdomen into the amniotic sac to collect amniotic fluid.
Timing: Usually performed between 15 and 20 weeks of gestation.
Uses: To detect chromosomal abnormalities (e.g., Down syndrome), genetic disorders, neural tube defects, and infections.

Chorionic Villus Sampling (CVS):
Procedure: A sample of chorionic villi (tiny projections from the placenta) is taken either through the cervix (transcervical) or the abdomen (transabdominal).
Timing: Usually performed between 10 and 13 weeks of gestation.
Uses: To diagnose chromosomal abnormalities and genetic disorders earlier in pregnancy compared to amniocentesis.

Percutaneous Umbilical Blood Sampling (PUBS) or Cordocentesis:
Procedure: A needle is inserted through the mother's abdomen into the umbilical cord to obtain fetal blood.
Timing: Usually performed after 18 weeks of gestation.
Uses: To diagnose and treat fetal blood conditions, infections, and certain genetic disorders; also used for fetal blood transfusions.

Fetal Tissue Biopsy:
Procedure: A sample of fetal tissue is obtained using a needle inserted through the mother's abdomen.
Timing: Varies depending on the condition being investigated.
Uses: To diagnose specific genetic disorders or structural abnormalities.

Amnioinfusion:
Procedure: Saline or another fluid is infused into the amniotic sac via a needle through the abdomen.
Timing: Performed during pregnancy when there is a need to increase amniotic fluid volume.
Uses: To treat conditions like oligohydramnios (low amniotic fluid) and to improve ultrasound imaging of the fetus.

Fetoscopy:
Procedure: A small camera (fetoscope) is inserted into the uterus through a small incision in the abdomen.
Timing: Typically performed after 18 weeks of gestation.
Uses: To directly visualize the fetus and obtain tissue samples or perform fetal surgery.

3. Utero-surgeries - procedures performed on the fetus while it is still in the womb to correct congenital anomalies or conditions that can lead to severe morbidity or mortality.

a. Fetoscopic Laser Surgery for Twin-to-Twin Transfusion Syndrome (TTTS):
Condition: TTTS is a condition that affects identical twins sharing a placenta where blood flow between the twins is imbalanced.
Procedure: Using a fetoscope, a laser is used to coagulate the abnormal blood vessels connecting the twins' circulations.
Timing: Typically performed between 16 and 26 weeks of gestation.
Benefits: Improves outcomes by balancing blood flow and reducing the risk of heart failure and other complications.

b. Open Fetal Surgery for Myelomeningocele (Spina Bifida):
Condition: Myelomeningocele is a type of spina bifida where the spinal cord and membranes protrude through a gap in the spine.
Procedure: The uterus is opened, and the fetal spine is repaired to close the defect and protect the spinal cord.
Timing: Usually performed between 19 and 26 weeks of gestation.
Benefits: Reduces the risk of neurological deficits, improves motor outcomes, and decreases the need for postnatal surgery.

c. Fetoscopic Endotracheal Occlusion (FETO) for Congenital Diaphragmatic Hernia (CDH):
Condition: CDH is a defect where abdominal organs herniate into the chest cavity, affecting lung development.
Procedure: A balloon is placed in the fetal trachea to promote lung growth by blocking fluid from escaping the lungs.
Timing: Typically performed between 26 and 30 weeks of gestation.
Benefits: Enhances lung development, improving survival rates and respiratory outcomes after birth.

d. Amniotic Band Syndrome (ABS) Surgery:
Condition: ABS occurs when fibrous bands in the amniotic sac constrict fetal parts, leading to deformities or amputations.
Procedure: Using a fetoscope, the constricting bands are cut to release the affected fetal parts.
Timing: Varies depending on the severity and location of the bands.

Benefits: Prevents further damage and preserves the function and development of the affected parts.

e. Fetal Aortic Valvuloplasty for Severe Aortic Stenosis:
Condition: Severe aortic stenosis can lead to underdevelopment of the left ventricle (hypoplastic left heart syndrome).
Procedure: A balloon is inserted into the fetal heart to open the narrowed aortic valve.
Timing: Usually performed between 20 and 30 weeks of gestation.
Benefits: Improves blood flow through the heart, promoting normal development of the left ventricle.

f. Thoracoamniotic Shunt for Fetal Pleural Effusion
Condition: Accumulation of fluid in the fetal chest cavity (pleural effusion) can compress the lungs and heart.
Procedure: A shunt is placed to drain the fluid from the chest cavity into the amniotic sac.
Timing: Varies depending on the severity and progression of the effusion.
Benefits: Relieves pressure on the lungs and heart, improving fetal development and survival.

Annexure III.

List I: List of Non-Medical Items

SL No	Item	
1	Baby Food	Not Payable
2	Baby Utilities Charges	Not Payable
3	Beauty Services	Not Payable
4	Belts/ Braces	Not Payable
5	Buds	Not Payable
6	Cold Pack/Hot Pack	Not Payable
7	Carry Bags	Not Payable
8	Email / Internet Charges	Not Payable
9	Food Charges (Other Than Patient's Diet Provided By Hospital)	Not Payable
10	Leggings	Essential in bariatric and varicose vein surgery and should be Considered For These Conditions Where Surgery Itself Is Payable.
11	Laundry Charges	Not Payable
12	Mineral Water	Not Payable
13	Sanitary Pad	Not Payable
14	Telephone Charges	Not Payable
15	Guest Services	Not Payable
16	Crepe Bandage	Not Payable
17	Diaper Of Any Type	Not Payable
18	Eyelet Collar	Not Payable
19	Slings	Not Payable
20	Blood Grouping And Cross Matching Of Donors Samples	Not Payable
21	Service Charges Where Nursing Charges Also Charged	Not Payable
22	Television Charges	Not Payable
23	Surcharges	Not Payable
24	Attendant Charges	Not Payable
25	Extra Diet Of Patient (Other Than That Which Forms Part Of Bed Charge)	Not Payable
26	Birth Certificate	Not Payable
27	Certificate Charges	Not Payable
28	Courier Charges	Not Payable
29	Conveyance Charges	Not Payable
30	Medical Certificate	Not Payable
31	Medical Records	Not Payable
32	Photocopies Charges	Not Payable
33	Mortuary Charges	Not Payable
34	Walking Aids Charges	Not Payable
35	Oxygen Cylinder (For Usage Outside The Hospital)	Not Payable

36	Spacer	Not Payable
37	Spirometer	Not Payable
38	Nebulizer Kit	Not Payable
39	Steam Inhaler	Not Payable
40	Arm sling	Not Payable
41	Thermometer	Not Payable
42	Cervical Collar	Not Payable
43	Splint	Not Payable
44	Diabetic Foot Wear	Not Payable
45	Knee Braces (Long/ Short/ Hinged)	Not Payable
46	Knee Immobilizer/ Shoulder Immobilizer	Not Payable
47	Lumbosacral Belt	Not Payable
48	Nimbus Bed Or Water Or Air Bed Charges	Not Payable
49	Ambulance Collar	Not Payable
50	Ambulance Equipment	Not Payable
51	Abdominal Binder	Not Payable
52	Private Nurses Charges - Special Nursing	Not Payable
53	Sugar Free Tablets	Not Payable
54	Creams Powders Lotions (Toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)	Not Payable
55	ECG Electrodes	Not Payable
56	Gloves	Not Payable
57	Nebulisation Kit	Not Payable
58	Any Kit With No Details Mentioned [Delivery Kit,	Not Payable
59	Kidney Tray	Not Payable
60	Mask	Not Payable
61	Ounce Glass	Not Payable
62	Oxygen Mask	Not Payable
63	Pelvic Traction Belt	Not Payable
64	Pan Can	Not Payable
65	Trolley Cover	Not Payable
66	Urometer , Urine Jug	Not Payable
68	Vasofix Safety	Not Payable

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

S. No.	Item
1	Baby Charges (Unless Specified /Indicated)
2	Hand Wash
3	Shoe Cover
4	Caps
5	Cardle Charges
6	Comb
7	Eau-De-Cologne/Room Freshners
8	Foot Cover
9	Gown
10	Slippers
11	Tissue Papper
12	Tooth Paste
13	Tooth Brush

14	Bed Pan
15	Face Mask
16	Flexi Mask
17	Hand Holder
18	Sputum Cup
19	Disinfectant Lotions
20	Luxury Tax
21	Hvac
22	House Keeping Charges
23	Air Conditioner Charges
24	IM / IV Injection Charges
25	Clean Sheet
26	Blanket/Warmer Blanket
27	Admission Kit
28	Diabetic Chart Charges
29	Documentation Charges/Administrative Expenses
30	Discharge Procedure Charges
31	Daily Chart Charges
32	Entrance Pass / Visitors Pass Charges
33	Expenses Related To Prescription On Discharge
34	File Opening Charges
35	Incidental Expenses / Misc. Charges (Not Explained)
36	Patient Identification Band / Name Tag
37	Pulse-oxymeter Charges

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

S. No.	Item
1	Hair Removal Cream
2	DISPOSABLES RAZORS CHARGES(For Site Preparations)
3	Eye Pad
4	Eye Shield
5	Camera Cover
6	DVD ,Cd Charges
7	Gauze Soft
8	GAUZE
9	Ward And Theatre Booking Charges
10	Arthroscope And Endoscopy Instruments
11	Microscope Cover
12	Surgical Blades, Harmonic-scalpel, Shaver
13	Surgical Drill

14	Eye Kit
15	Eye Drape
16	X-Ray Film
17	Boyles Apparatus Charges
18	Cotton
19	Cotton Bandage
20	Surgical Tape
21	Apron
22	Tourniquet
23	Orthobundle, Gynaec Bundle

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

S. No.	Item
1	Admission/Registration Charges
2	Hospitalization For Evaluation/Diagnostic Purpose
3	Urine Container
4	Blood Reservation Charges And Ante Natal Booking Charges
5	BIPAP Machine
6	CPAP/CAPD Equipment
7	Infusion Pump-Cost
8	Hydrogen Peroxide \Spirit\Disinfection Etc.
9	Nutrition Planning Charges - Dietician Charges - Diet Charges
10	HIV Kit
11	Antiseptic Mouthwash
12	Lozenges
13	Mouth Paint
14	Vaccination Charges
15	Alcohol Swabs
16	Scrub Solution / Sterillium
17	Glucometer & Strips
18	Urine Bag

V.1

Annexure IV.
Contact details of the Ombudsman offices

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 – 25501201 /02 /05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra and Nagar Haveli, Daman and Diu
BENGALURU - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL - Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR – Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 – 2596461 / 2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH - Insurance Ombudsman Office of the Insurance Ombudsman, S.C.O. No. 101, 102 and 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 – 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu and Kashmir, Ladakh and Chandigarh.
CHENNAI - Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)
DELHI – Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi and following Districts of Haryana - Gurugram, Faridabad, Sonepat and Bahadurgarh.
GUWAHATI - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

Office Details	Jurisdiction of Office Union Territory, District)
Email: bimalokpal.guwahati@cioins.co.in	
HYDERABAD - Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 –2740363 / 2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
Kochi – Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA – Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman and Nicobar Islands.
LUCKNOW – Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar..
MUMBAI - Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/ 27/ 29/ 31/ 32/ 33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai and Thane).
NOIDA - Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA – Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068	Bihar, Jharkhand.

Office Details	Jurisdiction of Office Union Territory, District)
Email: bimalokpal.patna@cioins.co.in	
PUNE - Insurance Ombudsman 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- 24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

Note: Address and contact number of Governing Body of Insurance Council:
Council for Insurance Ombudsmen,
3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.
E-mail: inscoun@cioins.co.in, **Tel**: 022 -69038800/69038812, **Website**: https://www.cioins.co.in