GROUP SEASONAL BYTE

POLICY WORDINGS

This is Your Group Seasonal Byte Policy which has been issued by ***Us*** relying on the Information disclosed by You in Your Proposal for this Policy or its preceding Policy/Policies of which this is a Renewal. It contains details of what is covered, what is not covered, the conditions and the basis on which all claims will be settled. The proposal, Policy Schedule, Policy document and endorsements are part of the Policy. Your Policy is evidence of the contract of insurance.

1. GENERAL DEFINITIONS

In the document, following words are assigned specific meaning. Wherever the context permits, the singular will be deemed to include the plural, one gender shall be deemed to include the other genders and references to any statute shall be deemed to refer to any replacement or amendment of that statute. Where ***We*** explain what a word means that word will appear highlighted in bold print and have the same meaning wherever it is used in the Policy.

	Term	Definition
1.	**Age or Aged**	means completed Age in years as at the Commencement Date.
2.	**Any one Illness**	means continuous Period of Illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
3.	**Authority**	means the Insurance Regulatory and Development Authority of India established under the provisions of section 3 of the Insurance Regulatory and development Authority Act, 1999 (41 of 1999).
4.	**AYUSH**	means the forms of treatments other than “Allopathy” or “modern medicine” and includes Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy in the Indian context.
5.	**Bank Rate**	means Bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.
6.	**Cashless Facility**	means a facility extended by the Insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorization is approved.
7.	**Cancellation (of policy)**	means the terms on which the policy contract can be terminated either by the insurer or the insured by giving sufficient notice to other which is not lower than a period of

		fifteen days. The terms of cancellation may differ from insurer to insurer.
8.	**Certificate of Insurance**	means the certificate issued to the ***Insured Person*** confirming the Policy details & coverages opted under the Policy. The ***Certificate of Insurance*** forms part of the policy.
9.	**Complaint or Grievance**	means written expression (includes communication in the form of electronic mail or other electronic scripts), of dissatisfaction by a Complainant with insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities.
10.	**Complainant**	means a Policyholder or prospect or any beneficiary of an insurance Policy who has filed a Complaint or Grievance against an Insurer or a distribution channel.
11.	**Commencement Date**	means the start date of this Policy as specified in the Policy Schedule.
12.	**Comorbid condition**	means an illness or injury happening at the same time but not related to Specified Illness.
13.	**Condition precedent**	means a Policy term or condition upon which the insurer's liability under the Policy is conditional upon.
14.	**Congenital Anomaly**	means a condition which is present since birth, and which is abnormal with reference to form, structure or position. a. Internal Congenital Anomaly - congenital anomaly which is not in the visible and accessible parts of the body. b. External Congenital Anomaly - congenital anomaly which is in the visible and accessible parts of the body.
15.	**Day**	means a period of 24 consecutive hours during a period of confinement. The first Day of confinement shall commence at the time of admission to the ***Hospital*** and each subsequent Day shall commence 24 hours after the commencement of the previous Day. In the event of the time of discharge of the ***Insured Person*** from the ***Hospital*** being more than 12 hours, but less than 24 hours from the end of the previous Day, then the day of discharge shall also be regarded as a Day.
16.	**Daily Benefit Amount**	means the amount payable for each Day spent in the Hospital.

17.	**Deductible**	means a cost sharing requirement under a health insurance Policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of ***Hospital*** cash policies which will apply before any benefits are payable by the Insurer. A Deductible does not reduce the sum insured.
18.	**Dependents / Family**	means the persons named in the Policy Schedule who are the Insured Person's - i. Spouse – The Insured's legally married spouse as long as she continues to be married to the Primary Insured. ii. Children – The Insured's children as long as they are financially dependent on him/her with no source of independent income and have not established their own independent households. iii. Parents – The Insured's natural parents or parents that have legally adopted him iv. Parents in Law – The Insured's Parents in Law.
19.	**Diagnosis**	means conclusion drawn by a registered Medical Practitioner, supported by acceptable clinical, radiological, histological, histo-pathological, and laboratory evidence wherever applicable.
20.	**Date of Diagnosis**	means the day when the diagnosis of ***Specified Illness*** is established by a Specialist / ***Medical Practitioner*** through the use of the clinical and/or laboratory findings as supported by the Insured medical records.
21.	**Disclosure to information norm**	means the Policy shall be void and all premiums paid thereon shall be forfeited to the Company in the Event of misrepresentation, mis-description or non-disclosure of any material fact.
22.	**Emergency**	means severe ***Specified Illness*** resulting in symptoms which occur suddenly and unexpectedly and requires immediate care by a ***Medical Practitioner*** to prevent death or serious long-term impairment of the Insured Person's health.
23.	**Family Floater**	means a Policy described as such in the Policy Schedule where You and Your Family named in the Policy Schedule are covered under this Policy as at the Commencement Date. The Sum Insured for a Family Floater is the amount shown in the Policy Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Family during each Policy Year.

24.	**Franchise**	means an arrangement under a health insurance Policy that provides that the Insurer will not be liable upto the specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of ***Hospital*** cash policies but will pay for the entire amount of loss and days/hours when exceeds the agreed amount/days/hours.
25.	**Grace Period**	means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-existing diseases. Coverage is not available for the period for which no premium is received.
26.	**Hospital**	means any institution established for In-Patient Care and Day Care Treatment of Illness and/or injuries and which has been registered as a ***Hospital*** with the local authorities under Clinical Establishment (Registration and Regulation) Act,2010 or under enactments specified under the Schedule of Section 56 (1) of the said Act Or complies with all minimum criteria as under: i. has qualified nursing staff under its employment round the clock; ii. has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places; iii. has qualified ***Medical Practitioner*** (s) in charge round the clock; iv. has a fully equipped operation theatre of its own where surgical procedures are carried out; v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.
27.	**Hospitalisation or Hospitalised**	means admission in a ***Hospital*** for a minimum Period of 24 consecutive "In-patient Care" hours except for specified procedures / treatments, where such admission could be for a Period of less than 24 consecutive hours.

28.	**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** 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** is defined as a disease, Illness, or Injury that has one or more of the following characteristics: - i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests; ii. it needs ongoing or long-term control or relief of symptoms; iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it; iv. it continues indefinitely; v. it recurs or is likely to recur.
29.	**Injury**	means accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a ***Medical Practitioner.***
30.	**Inpatient / Inpatient Care**	means treatment for which the ***Insured Person*** has to stay in a ***Hospital*** for more than 24 hours for a covered event.
31.	**Insured Person (Insured)**	means a person whose name specifically appears in the Policy Schedule and with respect to whom the premium has been received by Us.
32.	**Intensive Care Unit (ICU)**	means an identified section, ward or wing of a ***Hospital*** which is under the constant supervision of a dedicated ***Medical Practitioner*** (s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
33.	**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.

34.	**IRDAI**	means Insurance Regulatory and Development Authority of India.
35.	**Material Fact**	means a fact deemed so important that it would change the decision made by an Insurer if it were kept hidden.
36.	**Medical Advice**	means any consultation or advice from a ***Medical Practitioner*** including the issuance of any prescription or follow-up prescription.
37.	**Medical Expenses**	means those expenses that an ***Insured Person*** has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the ***Insured Person*** had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
38.	**Medical Practitioner**	means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. ***Medical Practitioner*** should not be the ***Insured Person*** or his/her immediate Family member or anyone who is living in the same household as the Insured Person.
39.	**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.
40.	**Network Provider**	means the ***Hospital*** enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.
41.	**Non-Network Provider**	means any hospital, day care centre or other provider that is not part of the network.

42.	**Nominee / Assignee**	means the person named in the Policy Schedule who is nominated by the Policyholder/Insured Person, to receive the benefits under this Policy in accordance with the terms of the Policy, if the Policyholder/Insured Person is deceased.
43.	**Notification of Claim**	means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
44.	**Outpatient (OPD) Treatment**	means the one in which the Insured visits a clinic/ ***Hospital*** or associated facility like a consultation room for Diagnosis and treatment based on the advice of a ***Medical Practitioner.*** The Insured is not admitted as a Day Care or In-Patient.
45.	**Policy**	means this Policy document read together with the attached Policy Schedule, Your Proposal Form including any attachment like endorsement, rider, condition, warranty, declaration etc.
46.	**Policyholder**	means the person named in the Policy Schedule as the Policyholder.
47.	**Policy Period**	means the period commencing from Policy start date and time as specified in the Policy Schedule and terminating at midnight on the Policy end date as specified in the Policy Schedule of this Policy.
48.	**Policy Schedule**	means schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the Policy Period and the limits and conditions, to which the benefits under the Policy are subject to, including any annexures and/or endorsements.
49.	**Policy Year**	means a period of 12 consecutive months commencing from the Policy Period Start Date and such 12 consecutive months thereafter but not beyond the Policy Period.
50.	**Portability**	means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions from one insurer to another or from one plan to another plan of the same insurer.
51.	**Pre-existing Disease**	means any condition, ailment or Injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which Medical Advice/ treatment was received within 48 months prior to the first Policy issued by the Insurer and renewed continuously thereafter.

52.	**Pre-Hospitalisation Medical Expenses**	means Medical Expenses incurred during pre-defined number of days preceding the Hospitalisation of the Insured Person, provided that: i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.
53.	**Post Hospitalisation Medical Expenses**	means Medical Expenses incurred during pre-defined number of days immediately after the ***Insured Person*** is discharged from the ***Hospital*** provided that: i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and ii. The Inpatient Hospitalisation claim for such Hospitalisation is admissible by the insurance company.
54.	**Primary Insured**	means the person who has been first enrolled by group Policy holder as a member under this Policy and who in turn has included his/her Family members.
55.	**Proposal Form**	means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the Insurer in respect of a risk, in order to enable the Insurer to take informed decision in the context of underwriting the risk, and in the Event of acceptance of the risk, to determine the rates, benefits, terms and conditions of the cover to be granted.
56.	**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.
57.	**Reasonable and Customary charges**	means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/Injury involved.
58.	**Relaxation Period**	means the specified period of time immediately following the premium instalment due date during which a payment can be made to continue a Policy in force without loss of continuity of waiting periods and coverage of Pre-existing diseases.

<table>
<tr><td>59.</td><td>Renewal</td><td>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.</td></tr>
<tr><td>60.</td><td>Road Ambulance</td><td>means a motor vehicle operated by a licenced/authorised service provider and equipped for taking sick or injured people requiring medical attention to and from Hospital in emergencies.</td></tr>
<tr><td>61.</td><td>Specialist</td><td>means a person who holds a master’s degree in the field of medicine or Surgery and valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.</td></tr>
<tr><td>62.</td><td>Specified Illness</td><td>means Diagnosis of below listed illness(es) confirmed by the Medical Practitioner on the basis of defined laboratory investigations or any other laboratory diagnosis as per the guidelines laid by Ministry of Health & Family Welfare, Govt of India.
<table>
<tr><th></th><th>Illness</th><th>Defined Laboratory Investigation</th></tr>
<tr><td>1</td><td>Dengue Fever</td><td>Non-Structural Protein-1 Antigen Positive/ IgM Antibody Capture ELISA (MAC- ELISA)</td></tr>
<tr><td>2</td><td>Zika Fever</td><td>Viral Nucleic Acid detection/Real Time-Polymerase Chain Reaction</td></tr>
<tr><td>3</td><td>Chikungunya</td><td>IgM Antibody Capture ELISA (MAC-ELISA)/Real Time-Polymerase Chain Reaction</td></tr>
<tr><td>4</td><td>Malaria</td><td>Microscopic laboratory testing or by a rapid diagnostic test</td></tr>
<tr><td>5</td><td>Leptospirosis</td><td>Microscopic agglutination test (MAT) or IgM-ELISA/ Polymerase Chain Reaction</td></tr>
<tr><td>6</td><td>Swine Flu</td><td>Real-time reverse transcriptase-polymerase chain reaction (rRT-PCR)</td></tr>
<tr><td>7</td><td>Vector Borne Encephalitis</td><td>Antibody Detection/Antigen Detection/Isolation/IgM-Enzyme Linked Immuno-Sorbent Assay/RT-PCR</td></tr>
</table></td></tr>
<tr><td>63.</td><td>Sum Insured</td><td>means the specified amount mentioned in the Policy Schedule which represents Our maximum liability for each Insured Person or Family in case of Family Floater for any and all benefits claimed for during the Policy Year.</td></tr>
</table>

64.	**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.***
65.	**TPA**	means any person who is registered under the IRDAI (Third Party Administrators - Health Services) Regulations, 2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.
66.	**Unproven/Experimental treatment**	means the treatment, including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
67.	**Waiting Period**	means the period during which ***We*** shall not be liable to make payment for any claim within specified number of days from the commencement date of the policy.
68.	**We/Our/Us/Insurer**	means DHFL General Insurance Limited
69.	**You/Your**	means the Policyholder or Primary Insured named in the Policy Schedule.

2. SCOPE OF COVER

Your opted plan/ coverage(s) are mentioned in the Policy Schedule / Certificate of Insurance. ***We*** will provide the coverage as detailed below for an event that occurs during the Policy Year. Each coverage is subject to the terms, conditions and exclusions of this Policy. ***We*** will pay as specified under each of the coverage in the Policy Schedule / Certificate of Insurance, provided that –

a. The ***Insured Person*** is diagnosed with the "Dengue Fever" as defined in the ***Specified Illness*** of this Policy; and

b. Such ***Specified Illness*** is diagnosed after 15 days from the date of commencement of first Policy and being renewed thereafter within the Grace Period.

A. INDEMNITY PLAN

INPATIENT TREATMENT - We will cover Reasonable and Customary charges for Medically Necessary Treatment taken by the ***Insured Person*** during the Policy Year for the Specified Illness(es) as mentioned in the Policy Schedule / Certificate of Insurance.

I. INPATIENT HOSPITALISATION

We will cover the following Medical Expenses incurred as In-Patient in a ***Hospital*** for more than 24 consecutive hours:

Expenses shall include -

a. Room Rent and Nursing charges;
b. Intensive Care Unit (ICU) charges;
c. Operation Theatre charges;
d. Fees of Medical Practitioner/Specialists;
e. Investigation & Diagnostic procedures;
f. Medicines, Drugs and Consumables;
g. Anaesthesia, Blood, Oxygen

II. PRE - HOSPITALISATION

We will cover the Pre-hospitalisation Medical Expenses incurred upto 15 days before the date of admission to the Hospital.

Note –

The date of admission to the ***Hospital*** for this coverage shall be the date of the Insured Person's first admission to the ***Hospital*** in relation to Any One Illness.

III. POST- HOSPITALISATION

We will cover the Post-Hospitalisation Medical Expenses incurred upto 15 days after the Insured Person's date of discharge from the Hospital.

However, In case of Any one illness where ***Insured Person*** undergoes more than one Hospitalisation within 45 days, the cover for post hospitalisation expenses cumulatively shall not exceed 15 days.

IV. AYUSH

We will cover the Medical Expenses incurred on In-patient Hospitalisation up to the Sum Insured for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy treatment undergone in:

a. A government ***Hospital*** or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health.

b. Teaching Hospitals of AYUSH colleges recognised by Central Council of Indian Medicine (CCIM) and Central Council of Homoeopathy (CCH).

c. AYUSH Hospitals having a registration with a Government authority under the appropriate Act in the State/UT and complies with the following as minimum criteria:

i. Has at least 15 in-patient beds;
ii. Has minimum five qualified and registered AYUSH doctors;
iii. Has qualified paramedical staff under its employment round the clock;
iv. Has dedicated AYUSH therapy sections;
v. Maintains daily records of patients and makes these accessible to the insurance company's authorised personnel.

V. EMERGENCY ROAD AMBULANCE / REPATRIATION OF MORTAL REMAINS (RMR) / FUNERAL EXPENSES

We will cover the expenses up to the sub-limit stated in the Policy Schedule incurred towards transportation of an ***Insured Person*** by a registered healthcare or ambulance service provider in case of an Emergency provided that ***We*** have accepted the claim under In-patient Hospitalisation – 2) A) I)

Expenses shall include:

a. Transportation Costs towards transferring the ***Insured Person*** to ***Hospital*** or from one ***Hospital*** to another ***Hospital*** or to a Diagnostic Centre for advanced diagnostic treatment where such facility is not available at the existing ***Hospital*** and advised by the treating ***Medical Practitioner.***

b. When the ***Insured Person*** requires to be moved to a better ***Hospital*** facility due to lack of super speciality treatment in the existing Hospital.
When the ***Insured Person*** requires to be moved to home after discharge from the Hospital. The medical condition of ***Insured Person*** is such that it requires services of Ambulance and is certified by treating ***Medical Practitioner.***

c. We will also cover the following expenses if the ***Insured Person*** dies in the ***Hospital*** during the course of Hospitalisation.

i. Transportation of Mortal remains from ***Hospital*** to home and/or to cremation ground for funeral purpose;
ii. Cremation Expenses;
iii. Coffin Charges.

B. BENEFIT PLAN

FIXED CASH BENEFIT - If the ***Insured Person*** is admitted in a ***Hospital*** during the policy year for the treatment of ***Specified Illness*** and such hospitalisation is medically necessary & recommended by the ***Medical Practitioner***, then ***We*** will pay lumpsum amount as stated in the Policy Schedule / Certificate of Insurance.

Conditions -

1. The Lumpsum benefit shall become payable only when ***Insured*** Person is Inpatient in a hospital for more than 24 consecutive hours.
2. Once the lumpsum amount is paid, coverage shall be considered as exhausted for the remaining policy year.
3. In case, ***Insured Person*** is diagnosed with ***Specified Illness*** but is not required to undergo hospitalization, then ***We*** will pay a lumpsum amount equal to the sum insured or Rs 10,000/- whichever is lower only once during the Policy Year.
    a. If the Sum insured is exhausted by such payment, cover shall be considered as exhausted for the remaining policy year.
    b. If the sum insured is available after such payment, cover shall continue during the Policy Year till the exhaustion of balanced Sum Insured.
4. Refer the illustration in Annexure – III.

C. DAILY BENEFIT PLAN

HOSPICASH BENEFIT - If an ***Insured Person*** is admitted in a ***Hospital*** during the policy year for the treatment of ***Specified Illness*** and such hospitalisation is medically necessary & recommended by the Medical Practitioner, then ***We*** will pay Daily Benefit amount for each day in Hospital, during the Policy Year for treatment of such specified illness.

Conditions –

1. A Deductible / Franchise as specified in the ***Policy Schedule / Certificate of Insurance*** shall apply.
2. The benefits shall become payable only after Hospitalisation of ***Insured Person*** exceeds the specified number of hours/days.
3. This Benefit shall be payable for a maximum limit of days as specified in the ***Policy Schedule/*** Certificate of Insurance.

3. WAITING PERIODS

All waiting Periods shall apply individually for each ***Insured Person*** and claims shall be assessed accordingly.

3.1. **Initial waiting Period for 15 days** - ***We*** will not be liable for any claim for ***Specified Illness*** within 15 days from the commencement date of the Policy.

3.2. **Waiting Period for Pre-Existing *Specified Illness*** – The initial waiting period of 15 days will be increased to 90 days, if the ***Insured Person*** is suffering from any of the listed ***Specified Illness*** as shown in the ***Policy Schedule/Certificate of Insurance*** at the time of taking the policy. We will not be liable for any claim during the Policy Period for any Specified Illness which has been diagnosed prior to Policy inception. We will cover any new event post 90 days of waiting period.

4. GENERAL EXCLUSIONS

We will not make payment for a claim resulting directly or indirectly from or attributable to any of the following:

EXCLUSIONS SPECIFIC TO THE POLICY WHICH CANNOT BE WAIVED

1. **Covered Illnesses:**
   a. Any Illness(es) which is not specified under ***Specified Illness*** and not mentioned in the ***Policy Schedule / Certificate of Insurance.***
   b. Any ***Specified Illness*** that is not diagnosed by the ***Medical Practitioner.***

2. **Comorbid Conditions**
   Any medical expenses or non-medical expenses related to Comorbid Conditions.

3. **Geography**
   Any diagnosis and treatment related to Specified Illness outside India.

4. **Ancillary Charges**
   Any charges related to admission, discharge, administration, registration, documentation & filing, service charge, surcharges and Luxury tax levied by the ***Hospital*** or by home healthcare service provider.

5. **Dietary supplements**
   Any substances that can be purchased without prescription, vitamins, minerals, nutritional / electrolyte supplements and tonics unless certified to be required by the attending ***Medical Practitioner*** as a direct consequence of an otherwise covered claim.

6. **Incidental Services & Supplies**
   Items of personal comfort and convenience – charges for television, telephone calls, internet, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products, toiletry items, barber or beauty service and guest service.

7. **Medically Necessary Expenses**
   Any treatment or part of a treatment that is not reasonable and medically necessary and drugs or treatments which are not supported by a prescription.

8. **Preventive Vaccinations**
   Expenses towards any treatment related to preventive care, vaccination, inoculation and immunizations (except in case of post-bite vaccination treatment) unless certified and recommended by the attending ***Medical Practitioner*** as part of in-patient treatment as a direct consequence of an otherwise covered claim.

9. **Unrelated diagnostic procedures**
   Diagnostic, X-ray or laboratory examinations or other diagnostic studies which are not consistent with or incidental to the Diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital.

10. **Sexually Transmitted Disease**
    Any sexually transmitted disease, Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.

11. **Congenital anomalies**
    Screening, counselling and treatment related to External congenital anomalies.

12. **Unrecognized Physician**
    Certification/diagnosis/treatment from persons not registered as Medical Practitioners, or from a ***Medical Practitioner*** who is practicing outside the discipline that he/she is licensed for.

13. **Maternity and Pregnancy**
    Pregnancy, voluntary termination, miscarriage (unless due to an Accident), childbirth, maternity (including Caesarean section), abortion or complications of any of these.

14. **Experimental or Unrecognized Treatment**
    Treatments which are experimental, investigational or unproven, which are not consistent with or incidental to the Diagnosis and treatment of the positive existence, pharmacological regimens, stem cell implantation/ therapy or Surgery.

5. GENERAL TERMS & CONDITIONS

5.1 CONDITION PRECEDENT TO THE CONTRACT

1. AGE

A person shall be eligible to become an ***Insured Person*** under this policy from birth (as a dependent child). However, there is no maximum age limit.

2. CONDITION PRECEDENT

This Policy requires fulfilment of the terms and conditions of this Policy at all times by You or any of the Insured Persons, payment of premium (including payment of instalment premium by the due dates as mentioned in the Policy Schedule) and Disclosure to Information Norm. This is a precondition to any liability under the Policy.

3. DISCLOSURE TO INFORMATION NORM

The Policy shall be void and all premium paid shall be forfeited to Us, in the event of misrepresentation, mis-description or non-disclosure of any Material Fact.

In the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a Claim being fraudulent or any fraudulent means or device being used by the Policyholder/ ***Insured Person*** or any one acting on his/ their behalf to obtain a benefit under this Policy, ***We*** may cancel this Policy at Our sole discretion. In such a case, the premium paid shall be forfeited and any benefit paid under the Policy shall also be forfeited and (if appropriate) shall be recoverable.

4. ELECTRONIC TRANSACTIONS

The Policy holder / ***Insured Person*** agrees to adhere to and comply with all terms and conditions as may be imposed for electronic transactions from time to time. The Policyholder hereby agrees and confirms that all transactions effected by or through facilities including the Internet, , call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of automated machines network or through other means of telecommunication, established by or on behalf of Us, for and in respect of the Policy or its terms, shall constitute legally binding and valid when done in adherence to and in compliance with the terms and conditions for such facilities and as may be prescribed from time to time and shall be within the terms and conditions of this contract. However, these terms and condition shall not override provisions of any law(s) or statutory regulations as amended from time to time.

5. NO CONSTRUCTIVE NOTICE

Any knowledge or information of any circumstance or condition in relation to the Policyholder/ ***Insured Person*** which is in Our possession and not specifically informed by the Policyholder/ ***Insured Person*** shall not be held to bind or prejudicially affect ***Us*** notwithstanding subsequent acceptance of any premium.

5.2 CONDITIONS APPLICABLE DURING CONTRACT

1. ALTERATIONS TO THE POLICY

The Proposal Form, declaration, Certificate, and Policy constitutes the complete contract of insurance. For any change(s) / alteration/ modification in contract You are requested to give ***Us*** in writing. Any change that ***We*** make will be communicated to You by a written endorsement signed and stamped by Us. This Policy cannot be changed by any one (including an insurance agent or broker) except Us.

2. CANCELLATION OF POLICY

a. Cancellation by *Us* - *We* may cancel this Policy/ ***Certificate of Insurance*** on grounds of misrepresentation, fraud, non-disclosure of Material Facts, non-cooperation by You or anyone acting on Your behalf. When such cancellation of the Policy/ ***Certificate of Insurance*** will be on the grounds of misrepresentation, fraud, non-disclosure of Material Facts, it will be from inception date or the Renewal date (as the case may be) upon fifteen (15) days' written notice delivered to or mailed to Your last address as shown in our records followed by an endorsement without refund of any premium.

In case of cancellation of the Policy/ ***Certificate of Insurance*** by ***Us*** on account of non-cooperation, You shall be entitled to refund of pro-rata premium for the unexpired portion of the Policy on the date of cancellation except for those Insured Person(s) for whom a claim has been paid or is payable under the Policy.

b. Cancellation by You - You may cancel this Policy / ***Certificate of Insurance*** at any time by sending fifteen (15) days' notice in writing to Us, stating when cancellation is to take effect. In the event of such cancellation, ***We*** shall refund premium for the period this policy/ ***Certificate of Insurance*** has been in force in accordance with the short period rate table given below.

However, there will be no refund of premium in respect of the ***Insured Person*** for whom a claim has been paid or is payable under the Policy.

Months	1 year	2 years	3 years	4 years	5 years
1	59%	77%	83%	86%	88%
2	40%	67%	76%	81%	84%
3	21%	57%	70%	76%	80%
4	2%	47%	63%	71%	76%
5	0%	37%	56%	66%	72%
6	0%	27%	50%	61%	68%
7	0%	18%	43%	56%	64%
8	0%	8%	36%	51%	60%
9	0%	0%	30%	46%	56%

10	0%	0%	23%	41%	52%
11	0%	0%	16%	36%	48%
12	0%	0%	10%	31%	44%
13		0%	3%	26%	39%
14		0%	0%	21%	35%
15		0%	0%	16%	31%
16		0%	0%	11%	27%
17		0%	0%	6%	23%
18		0%	0%	1%	19%
19		0%	0%	0%	15%
20		0%	0%	0%	11%
21		0%	0%	0%	7%
22		0%	0%	0%	3%
23		0%	0%	0%	0%
24		0%	0%	0%	0%
25			0%	0%	0%
26			0%	0%	0%
27			0%	0%	0%
28			0%	0%	0%
29			0%	0%	0%
30			0%	0%	0%
31			0%	0%	0%
32			0%	0%	0%
33			0%	0%	0%
34			0%	0%	0%
35			0%	0%	0%
36			0%	0%	0%
37				0%	0%
38				0%	0%
39				0%	0%
40				0%	0%
41				0%	0%
42				0%	0%
43				0%	0%
44				0%	0%
45				0%	0%
46				0%	0%

47				0%	0%
48				0%	0%
49					0%
50					0%
51					0%
52					0%
53					0%
54					0%
55					0%
56					0%
57					0%
58					0%
59					0%
60					0%

3. COMMUNICATIONS & NOTICES

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

- To any Insured Person, then it shall be sent to You at Your last updated address as shown in Our records and You shall act for all Insured Persons for these purposes.

- To Us, it shall be delivered to Our address specified in the Schedule.

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

c. Notice and instructions will be deemed served ten (10) days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

d. You must immediately bring to Our notice any change in the address or contact details. If You fail to inform Us, ***We*** shall send notice to the last known address and it would be considered that the notice has been sent to You.

e. You must include Your Policy number for any communication with Us.

4. GEOGRAPHY

This Policy applies to events or occurrences taking place only in Republic of India. All payments under this Policy will only be made in Indian Rupees.

5. GROUP ADMINISTRATOR

The Group Administrator i.e. Policyholder shall take all reasonable steps to cover their members or employees of the company and ensure timely payment of premium in respect of the persons covered. The Group administrator will collect premium from members wherever applicable as mentioned in the Group/Master policy issued to the Group administrator. The Group administrator will neither charge more premium nor alter the scope of coverage offered under the Group/Master policy.

Group/Master policy will be issued to the group administrator and all members wherever required will be provided with the ***Certificate of Insurance*** by Us. Wherever mutually agreed group administrator will issue the ***Certificate of Insurance*** to its member as per agreed terms and conditions and in the format prescribed by ***Us*** and shall keep the record of such issuance. ***We*** reserve the right to inspect the record at any time to ensure that terms and conditions of group policy and provisions of IRDAI group guidelines contained in circular ref: 015/IRDA/Life/Circular/GI Guidelines/2005 dated 14th July 2005 and any amendments thereto are being adhered. ***We*** may also require submission of certificate of compliance from Your Group Administrator auditors.

The Group administrator will provide all possible help to its member and facilitate any service required under the Policy including claims. Notwithstanding this a member of the group covered under the Policy shall be free to contact ***Us*** directly for filing the claim or any assistance required under the Policy.

6. INSTALMENT PREMIUM

In case premium is payable in instalments as specified in the Policy Schedule / certificate of insurance, instalments shall be payable on or before the due date for continuity of coverage under the Policy. You will have relaxation period of fifteen (15) days from the due date for payment of instalment. ***We*** will not charge interest on the instalment premium paid during the relaxation period and there will be no impact on coverage of Pre-Existing Disease and continuity of waiting periods. In case ***We*** do not receive the premium within the relaxation period, the Policy will be terminated and all claims that fall beyond the instalment due date will not be covered under the Policy. In the event of a claim before instalment due date, all the subsequent premium instalments shall immediately become due and payable. ***We*** shall have the right to recover and deduct any or all the pending instalments from the claim amount due under the Policy.

IMPORTANT POINTS TO BE NOTED WHILE OPTING FOR INSTALMENT PREMIUM PAYMENT VIA ELECTRONIC CLEARING SERVICE (ECS)

1. Completely filled & signed Electronic Clearing Service Mandate Form is mandatory.
2. Ensure that the Premium amount which would be auto debited & frequency of instalment is duly filled in the ECS Mandate form.
3. New ECS Mandate Form is required to be filled in case of any change in the Premium due to change of Daily Benefit Amount / Sum Insured / coverages/revision in premium.
4. You need to inform ***Us*** atleast 15 days prior to the due date of instalment premium if you wish to discontinue with the ECS facility.
5. Non-payment of premium on due date as opted by You in the mandate form subject to an additional 15 days of relaxation period will lead to termination of the policy.

7. POLICY DISPUTES

Any and all disputes or differences concerning the interpretation of the coverage, terms, conditions, limitations and/ or exclusions under this Policy shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

8. PROTECTION OF POLICY HOLDERS INTEREST

This Policy is subject to IRDAI (Protection of Policyholders' Interest) Regulation, 2017 or any amendment thereof from time to time.

9. RECORDS TO BE MAINTAINED

You or the Insured Person, as the case may be shall keep an accurate record containing all medical records pertaining to the treatment taken for any liability under the Policy and shall allow ***Us*** or Our representative(s) to inspect such records. You or the ***Insured Person*** as the case may be, shall furnish such information as may be required by ***Us*** under this Policy at any time during the Policy Period and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy.

10. REVISION & MODIFICATION OF PRODUCT

Any revision or modification will be done with the approval of the Authority. ***We*** shall notify You about revision / modification in the product including premium. Such information shall be given to You at least ninety (90) days prior to the effective date of modification or revision coming into effect.

11. TERMINATION OF POLICY

This Policy terminates on earliest of the following events-

a. Cancellation of Policy as per the cancellation provision.
b. On the Policy expiry date.
c. On death of the Insured Person.

12. WITHDRAWAL OF THE PRODUCT

The product will be withdrawn only after due approval from the Authority. ***We*** will inform the Group Organiser /Administrator in the event ***We*** may decide to withdraw the product.

In such cases, where Policy is falling due for Renewal within 15 days from the date of withdrawal, ***We*** will provide the Group Organiser/Administrator one-time option to renew the existing Policy with ***Us*** or migrate to modified or new suitable health insurance policy with Us. Any Policy falling due for Renewal after 15 days from the date of withdrawal will have to migrate to modified or new suitable health insurance policy with Us.

The Group Organiser/Administrator will inform individual members about such withdrawal of product by Us.

Individual members will also have an option to opt for suitable health insurance Policy with ***Us*** subject to applicable Portability norms in vogue.

However, even if the Group Organiser/Administrator does not respond to Our intimation in case of such withdrawal, the Policy will stand withdrawn on the Renewal date.

5.3 CONDITIONS FOR RENEWAL OF CONTRACT

1. CONTINUITY

Insured Person would have an option to migrate to Our individual health insurance plans if the group Policy is discontinued or if ***Insured Person*** is leaving the group on account of resignation, retirement, termination of employment or otherwise, subject to Our underwriting guidelines. Dependent children likewise when exiting on account of reaching upper age limit will have an option to migrate to Our individual health insurance plans subject to Our underwriting guidelines. ***Insured Person*** will be entitled for accrued continuity benefits as per prevailing portability guidelines issued by the Authority.

2. PORTABILITY

Insured Persons covered under this Group Health Insurance Policy shall have the right to migrate from such group policy to a suitable individual health insurance policy offered by ***Us*** provided that member shall apply to port the entire Policy along with all the members of the family, if any, at least 45 days before the premium Renewal date of his/ her existing health insurance policy. Insured Persons will be entitled for accrued continuity benefits as per prevailing portability guidelines issued by the Authority.

3. RENEWAL TERMS

This Policy may be renewed by mutual consent every year and in such event, the Renewal premium shall be paid to ***Us*** on or before the date of expiry of the Policy. However, ***We*** shall not be bound to give notice that such Renewal premium is due. Also, ***We*** may exercise option of not renewing the Policy on grounds of fraud, misrepresentation, or suppression of any Material Fact either at the time of taking the Policy or any time during the currency of the Policy.

A Grace Period of thirty (30) days is allowed for Renewal of the policy. This will be counted from the next day following the expiry date, during which a payment can be made to renew the Group Health Policy without loss of continuity benefits such as waiting periods. Coverage is not available for the period for which no premium is received, and Insurer has no liability for the claims arising during this period.

5.4 CONDITIONS WHEN A CLAIM ARISES

1. ARBITRATION

If ***We*** admit liability for any claim but any difference or dispute arises as to the amount payable for any claim the same shall be decided by reference to Arbitration. The Arbitrator shall be appointed in accordance with the provisions of the Arbitration and Conciliation Act, 1996 or any amendment thereto. No reference to Arbitration shall be made unless ***We*** have admitted Our liability for a claim in writing.

2. COMPLETE DISCHARGE

Payment made by ***Us*** to You /Assignee/Nominee/legal representative, as the case may be, in respect of any coverage under the Policy shall in all cases be complete and construe as an effectual discharge in favour of Us.

3. DISCLAIMER OF CLAIM

If ***We*** shall disclaim liability to the Insured for any claim and if the Insured shall not, within twelve (12) calendar months from the date or receipt of the notice of such disclaimer notify ***Us*** in writing that he does not accept such disclaimer and intends to recover his claim from Us, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under the Policy.

4. PHYSICAL EXAMINATION

Any ***Medical Practitioner*** authorized by ***Us*** shall be allowed to examine the ***Insured Person*** in case of any alleged Specified Illness. Non-co-operation by the ***Insured Person*** will result into rejection of his/her claim. ***We*** will bear the cost towards performing such medical examination (at the specified location) of the Insured Person.

5. CLAIM PROCESS & MANAGEMENT

In the event of any claim under the Policy, completed claim form and required documents

must be furnished to ***Us*** within the stipulated time. Failure to furnish this documentation within the stipulated time shall not invalidate nor reduce any claim if You can satisfy ***Us*** that it was not reasonably possible for You to submit / give proof within such time.

a. POLICYHOLDER'S / INSURED PERSON'S DUTIES AT THE TIME OF CLAIM

On occurrence of an event which will eventually lead to a Claim under this Policy, the Policyholder / ***Insured Person*** shall:

a. Forthwith intimate the Claim in accordance with claim intimation section # 5.4)5)II) of this Policy.

b. Claim processing is through Our service partner TPA, details of the same will be available on the ***Policy Schedule / Certificate of Insurance*** / Health Card issued by ***Us*** .

c. You can log on to Our /TPA website for Network Providers list. TPA will facilitate cashless claims processing (inpatient only) in case of Indemnity Plan.

d. If so requested by Us, the ***Insured Person*** will have to submit himself / herself for a medical examination including any Pathological / Radiological examination by Independent ***Medical Practitioner*** as often as it is considered reasonable and necessary. The cost of such examination will be borne by Us.

e. Allow the ***Medical Practitioner*** or any of Our representatives to inspect the medical and Hospitalization records, investigate the facts.

f. Assist and not hinder or prevent Our representatives in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.

b. CLAIM INTIMATION

If You suffer from any of the ***Specified Illness*** that may result in a claim, then as a Condition Precedent to Our liability, You must comply with the following claims procedures:

You must notify Your claim to ***Us*** / Our TPA in writing or at call centre.

Plan	Type of Event	Notify *Us* or Our TPA
▪ Indemnity Plan	Planned Hospitalisation for Specified Illness	Immediately and in any event at least 48 hours prior to **Your** admission.
▪ Daily Benefit Plan	Emergency Hospitalisation for Specified Illness	Within 24 hours of **Your** admission to ***Hospital*** or before discharge whichever is earlier
▪ Benefit Plan	Diagnosis of Specified Illness	Immediately and in any event at least 48 hours from the date of diagnosis.

The following details are to be provided to ***Us*** at the time of intimation of Claim:

a. Policy Number
b. Name of the Policyholder
c. Health card id number
d. Name of the ***Insured Person*** in whose relation the Claim is being lodged
e. Name of Specified Illness
f. Name and Address of the attending ***Medical Practitioner*** and ***Hospital*** (if admission has taken place)
g. Date of Diagnosis of Specified Illness
h. Date of Admission
i. Any other information, documentation as requested by Us

c. CASHLESS FACILITY (APPLICABLE ONLY FOR INDEMNITY PLAN)

Cashless Facility is available for Hospitalisation only at Our Network Provider. The ***Insured Person*** can avail Cashless Facility at Network Provider, by presenting the health card as provided by ***Us*** with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / Aadhar Card, any other identity proof as approved by Us.

A. For Planned Hospitalization

i. The ***Insured Person*** should at least 48 hrs prior to admission to the ***Hospital*** approach the Network Provider for Hospitalisation for medical treatment.
ii. The Network Provider will issue the request for authorization letter for Hospitalisation in the pre-authorization form prescribed by the Authority.
iii. The Network Provider shall electronically send the pre-authorization form along with all the relevant details to the 24 (twenty-four) hour authorization/cashless department of the TPA along with contact details of the treating ***Medical Practitioner*** and the Insured Person.
iv. Upon receiving the pre-authorization form and all related medical information from the Network Provider, the eligibility of cover under the Policy will be verified.
v. Wherever the information provided in the request is sufficient to ascertain the authorisation, the authorisation letter will be issued to the Network Provider. Wherever additional information or documents are required, the same will be called for from the Network Provider and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a period of 3 hours from the receipt of last complete documents.
vi. The Authorisation letter will include details of sanctioned amount and any non- payable items if applicable.
vii. The authorisation letter shall be valid only for a period of 15 days from the date of issuance of authorization.

In the event that the cost of Hospitalisation exceeds the authorized limit as mentioned in the authorization letter:

a. The Network Provider shall request for an enhancement of authorisation limit. Eligibility will be verified, and the enhancement will be evaluated on the availability of further limits.
b. We shall accept or decline such additional expenses within 3 hours of receiving the request for enhancement.

At the time of discharge:

a. The Network Provider may forward a final request for authorization for any residual amount along with the discharge summary and the billing format in accordance with the process.
b. Upon receipt of the final authorisation letter, Insured may be discharged by the Network Provider.
c. Network provider to ensure that the final authorization letter is signed by Insured.
d. Insured must ensure to take photocopies of relevant medical records for future reference.

B. In case of Emergency Hospitalization

i. The ***Insured Person*** may approach the Network Provider for Hospitalisation.
ii. Insured Person will need to provide health Card / Health insurance Policy details at ***Hospital*** admission counter.
iii. The Network Provider shall forward the request for authorization within 24 hours of admission to the ***Hospital*** or before discharge whichever is earlier.
iv. In the interim, the Network Provider may either consider treating the ***Insured Person*** by taking a token deposit or treating as per their norms.
v. The Network Provider shall refund the deposit amount to you barring a token amount to take care of non-covered expenses once the authorization is issued.
vi. The Network Provider will send the claim documents to TPA within 15 days from the date of discharge from Hospital
vii. Any additional documents may be called as required based on the circumstances of the claim.
viii. There can be instances where Cashless Facility may be denied for Hospitalisation due to insufficient Sum Insured or insufficient information to determine admissibility in which case You/Insured Person may be required to pay for the treatment and submit the claim for reimbursement to TPA which will be considered subject to the Policy Terms &Conditions.
ix. We in Our sole discretion, reserves the right to modify, add or restrict any Network Provider for Cashless services under the Policy. Before availing the Cashless service, the Policyholder / ***Insured Person*** is required to check the applicable/latest list of Network Provider on TPA's website or by calling call centre

d. CLAIM REIMBURSEMENT PROCESS

Wherever You have opted for a reimbursement of expenses, You may submit the documents for reimbursement of the claim to Our / TPA office not later than 15 days from the date of discharge from the Hospital. You can obtain a Claim Form from any of Our / TPA Offices or download a copy from Our website at www.dhflinsurance.com.

e. CLAIM DOCUMENTS

In case of any Claim for the covered Benefit, the list of necessary documents as mentioned below shall be provided by the Policyholder/Insured Person, immediately but not later than 15 days from the date of completion of treatment / discharge from the Hospital, to avail the Claim.

Completed claim forms and required documents must be furnished to ***Us*** within the stipulated timelines for all claims. ***We*** may consider the delay in extreme cases of hardship where it is proved to Our satisfaction that under the circumstances in which the ***Insured Person*** was placed, it was not possible for him or any other person to give notice or file claim within the prescribed time limit. However, no proof will be accepted if furnished later than one (1) year from the time the loss occurred. Requirement of all or any of the following documents will depend on the nature of claim.

a. Claim Form Duly Filled and Signed
b. Original signed pre-authorisation request, if applicable
c. Copy of authorisation approval letter (s)
d. Copy of Photo ID of Patient Verified by the Hospital
e. Original Discharge/Death Summary
f. Operation Theatre Notes (if any)
g. Original ***Hospital*** Main Bill along with break up Bill and original receipts
h. Original Investigation Reports, X Ray, MRI, CT Films, HPE
i. Doctors Reference Slips for Investigations/Pharmacy
j. Original Pharmacy Bills
k. Post Mortem Report (if applicable and conducted).
l. KYC documents (Photo ID proof, Pan Card, Aadhar Card)
n. Cancelled cheque for NEFT payment

f. SCRUTINY OF CLAIM DOCUMENTS

We shall scrutinize the Claim and accompanying documents. Any deficiency of documents shall be intimated to You and the Network Provider, as the case may be and subsequent reminders will follow.

a. During claim processing if the claims are found deficient in documents, TPA shall intimate the same to the Policyholder / ***Insured Person*** within five (5) working days of receiving claim documents.
b. First reminder for deficient documents will be sent within seven (7) days of first deficiency letter and Second reminder – within ten (10) days of first

reminder deficiency letter. Final reminder letter will be sent from ten (10) days from second reminder.

c. We will send a maximum of three (3) reminders following which, ***We*** will send a rejection letter after fifteen (15) days from the final reminder if the deficient documents are not received.

g. CLAIM INVESTIGATION

We may investigate Claims at Our own discretion to determine the validity of Claim. Such investigation may be concluded within thirty (30) days from the date of receipt of last necessary document of the Claim. Verification carried out, if any, will be done by individuals or entities authorized by ***Us*** to carry out such verification/investigation(s) and the costs for such verification/ investigation shall be borne by Us.

h. PRE-& POST HOSPITALISATION CLAIMS (APPLICABLE ONLY FOR INDEMNITY PLAN)

Claim documents for Pre-& Post hospitalisation should be sent to TPA within 15 days of completion of treatment.

i. SETTLEMENT AND REPUDIATION OF A CLAIM

We shall be under no obligation to make any payment under this **Policy** unless **We** have been provided with the documentation and information to establish the validity of the claim.

i. We shall ordinarily settle a Claim including rejection within 30 days of the receipt of the last "necessary" documents as listed in the section 5) e) - Claim Documents.

ii. Where the circumstances of a claim warrant an investigation 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.

iii. Once the entire Sum Insured has been paid under Benefit Plan, the sum insured of benefit plan shall be considered as exhausted for the respective policy Year for the respective insured person and the policy shall be allowed for renewal. If the payment of Rs 10,000 was already made in lieu of non-hospitalisation case earlier, then we will pay the balanced sum insured for the hospitalisation of second specified illness during the policy year, provided this second illness happens after 6 months of first claim.

iv. <u>Multiple Policies</u>

a. In case of Multiple Similar Policies

<u>Indemnity Plan -</u> If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the *Policyholder* shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

Daily Benefit Plan / Benefit Plan - In case of multiple policies which provide fixed benefits, on the occurrence of the insured event, each *Insurer* shall make the claim payment independent of payments received under other similar polices in accordance with the terms and conditions of their respective policies.

i. In all such cases, the *Insurer* who has issued the chosen *Policy* 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. Claims under other *Policy/ies* may be made after exhaustion of *Sum Insured* in the earlier chosen *Policy / Policies*. The *Policyholder* shall also have the right to prefer claims from other *Policy /Policies* for the amounts disallowed under the earlier chosen *Policy /Polices*, even if the *Sum Insured* is not exhausted.
iii. If the amount to be claimed exceeds the *Sum Insured* under a single *Policy* after considering the *Deductible*(s) or *Co-Payment*, the *Policyholder* shall have the right to choose insurers from whom he/she wants to claim the balance amount.
iv. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen *Policy*.

b. In case of Multiple Group Seasonal Byte Policies

Indemnity Plan – In case of multiple Group Seasonal Byte policies from Us by the policyholder, *We* will deduct the amount paid under such policy from the amount payable under this policy and balance amount will be payable upto the sum insured.

Daily Benefit Plan / Benefit Plan In case of multiple Group Seasonal Byte policies from Us by the policyholder, *We* will accept claim under the respective policies independently.

v. **Payment of Interest**: In case of delay in the payment beyond the stipulated timelines, **We** shall be liable to pay interest at a rate of two percent (2%) above the **Bank Rate** or as per the applicable / extant **IRDAI** regulation. Such interest shall be paid from the date of receipt of the last relevant and necessary document from the Insured /claimant by insurer till the date of actual payment.

j. PAYMENT TERMS

a. The payments under this Policy shall only be made in Indian Rupees within India.

b. We will only make payment to the ***Insured Person*** / Policyholder under this Policy. The receipt of payment by the ***Insured Person*** / Policyholder shall be considered as a complete discharge of Our liability against any claim under this Policy. In the event of Your death, ***We*** will make payment to the Nominee / Assignee (as named in the ***Policy Schedule/*** Certificate of Insurance). In case where a Nominee(s)/Assignee has not been mentioned in the Proposal Form, the claim payment shall be made as per Indian succession law.

c. If premium is payable in instalments and not paid on or before the due date then ***We*** will not pay for any claim that occurs during the relaxation period unless the instalment premium is paid by You within the relaxation period. ***We*** shall have the rights to recover and deduct the pending instalment premium towards the ***Insured Person*** who has claimed prior to the instalment due date from the claim amount due under the Policy.

k. **PAYOUT OPTIONS -** Policy with Benefit Plan (2B) shall terminate on the occurrence of the covered specified illness and shall be paid as per the pay-out option selected in the Proposal Form and specified in the Policy Schedule/ Certificate of Insurance.

i. Option 1 – 100% Sum Insured as Payout.

a. We will pay 100% Sum Insured as lumpsum on first Hospitalization due to diagnosis of Specified illness or,

b. In case, Insured Person is first diagnosed with Specified Illness and is not required to undergo hospitalisation, then We will pay a lumpsum amount equal to the sum insured or Rs 10,000/- whichever is lower only once in a Policy Year and the Balanced sum insured (if any) as Lump sum upon hospitalization due to diagnosis of Specified Illness for the second time during the policy year.

ii. Option 2 – 150 % Sum Insured as Payout .

a. We will pay 100% Sum Insured as lumpsum on first Hospitalization due to diagnosis of Specified illness or In case, Insured Person is first diagnosed with Specified Illness and is not required to undergo Hospitalization, then We will pay a lumpsum amount equal to the sum insured or Rs 10,000/- whichever is lower only once in a Policy Year and the Balanced sum insured (if

any) as Lump sum upon first hospitalization due to diagnosis of Specified Illness during the policy year.

b. We will pay 50% of Sum Insured as lumpsum on Second Hospitalization, if any, due to diagnosis of Specified illness during the policy year provided the specified illness is diagnosed after 6 months of first claim

Refer the illustration in Annexure – III for better understanding.

I. TPA RELATED INFORMATION – (Applicable for Indemnity Plan)

For intimation of claim, submission of claim related documents and any claim related query, *You* can contact *TPA* through:

Region	TPA Details	TPA Contact Details
WEST DADRA & NAGAR HAVELI DAMAN & DIU GOA GUJARAT MADHYA PRADESH MAHARASHTRA	**PARAMOUNT HEALTH SERVICES & INSURANCE TPA PRIVATE LIMITED** Plot No. A-442, Road No. 28, MIDC Industrial Area, Wagle Estate, Ram Nagar, Near Vitthal Rukhmani Mandir, Thane (W), Maharashtra 400604 www.paramounttpa.com	**Email** - dhfl.insurance@paramounttpa.com **Toll Free** - 1800 2256 01
SOUTH ANDAMAN & NICOBAR ISLANDS ANDHRA PRADESH KARNATAKA KERALA LAKSHADWEEP TAMIL NADU TELANGANA PUDUCHERRY	**FAMILY HEALTH PLAN INSURANCE TPA LTD** No:8-2-269/A/2-1 To 6, 2nd Floor, Srinilaya Cyber Spazio, Road No.2, Banjara Hills, Hyderabad, Telangana - 500034 www.fhpl.net	**Email** - dhfl.insurance@fhpl.net **Toll Free** - 1800 599 2488
EAST & NORTH ARUNACHAL PRADESH ASSAM BIHAR CHHATTISGARH JHARKHAND MANIPUR MEGHALAYA MIZORAM NAGALAND ODISHA SIKKIM TRIPURA	**RAKSHA HEALTH INSURANCE TPA PRIVATE LIMITED** C/O Escorts Corporate Centre, 15/5, Mathura Road, Faridabad - 121003 Haryana www.rakshatpa.com	**Email** -dhfl.insurance@rakshatpa.com **Toll Free** - 1800 180 1555

WEST BENGAL CHANDIGARH DELHI HARYANA HIMACHAL PRADESH JAMMU & KASHMIR PUNJAB RAJASTHAN UTTAR PRADESH UTTARAKHAND		

6. GRIEVANCE REDRESSAL PROCEDURE

At DHFL General Insurance, ***We*** want your relationship with insurance to soar beyond what you've experienced yet. To understand, appreciate, and enjoy insurance—we're here for you. However, if you aren't satisfied—please feel free to connect with ***Us*** on the following channels.

a. Call ***Us*** on our Toll Free 1800-123-0004 (From 8 am to 8 pm) for any queries that you may have!
b. Email your queries to mycare@dhflinsurance.com.
c. For Senior Citizens, ***We*** have a special cell and our Senior Citizen customers can email ***Us*** at seniorcare@dhflinsurance.com for priority resolution
d. Visit our website www.dhflinsurance.com to register & track your queries
e. Please walk in to any of our branches or partner locations
f. You can also dispatch your letters to ***Us*** at:
DHFL General Insurance Limited
402, 403 & 404, A & B Wing, 4th Floor, Fulcrum,
Sahar Road, Next to Hyatt Regency,
Andheri (East),
Mumbai, Maharashtra – 400 099

We request you to please mention your complete details : Full Name, Policy Number and Contact Details in all your communications, to enable our customer experience expert to connect with you and provide you with quickest possible solution.

We'll make sure to acknowledge your service request within 3 working days—and try and resolve it to your satisfaction within 15 working days. That's a promise!

Escalation

Level 1 : While ***We*** attempt to give you best-in-class and prompt resolution for any concerns—sometimes it may not be perfect. If you felt that you weren't offered a perfect resolution, please feel free to share your feedback to our Customer Experience team at Manager.CustomeExperience@dhflinsurance.com

Level 2 : If you still are not happy about the resolution provided then you may please write to our Head Customer Experience and Grievance Redressal Officer at Head.CustomerExperience@dhflinsurance.com or contact GRO at 022 - 40018100.

Level - 3: If you are not happy with the resolution, you may approach IRDAI by calling on the Toll Free no. 155255 (or) 1800 4254 732. You can also register an online complaint on the website http://igms.irda.gov.in.

If your concern remains unresolved after having followed the above escalation procedure, then you may please approach the Insurance Ombudsman for Redressal. To know who your Insurance Ombudsman is—simply refer to the list below/overleaf.

OMBUDSMAN AND ADDRESSES: Refer the link http://ecoi.co.in/ombudsman.html

S. No.	CONTACT DETAILS	JURISDICTION OF OFFICE
1	**AHMEDABAD** Office of the Insurance Ombudsman. Jeevan Prakash Building, 6th Floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079 - 25501201 / 02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu
2	**BENGALURU** Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka
3	**BHOPAL** Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	States of Madhya Pradesh and Chattisgarh.
4	**BHUBANESHWAR** Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	State of Orissa

5	**CHANDIGARH** Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 - D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh.
6	**CHENNAI** Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	State of Tamil Nadu and Union Territories - Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
7	**DELHI** Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in	State of Delhi
8	**GUWAHATI** Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
9	**HYDERABAD** Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	States of Andhra Pradesh, Telangana and Union Territory of Yanam - a part of the Union Territory of Pondicherry

10	**JAIPUR** Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	State of Rajasthan
11	**ERNAKULAM** Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry
12	**KOLKATA** Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	States of West Bengal, Bihar, Sikkim and Union Territories of Andaman and Nicobar Islands
13	**LUCKNOW** Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	District of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varansi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sulanpur, Maharajganj, Santkabirnagar, Azamgarh, Kaushinagar, Gorkhpur, Deoria, Mau, Chandauli, Ballia, Sidharathnagar.

14	**MUMBAI** Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	States of Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
15	**NOIDA** Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@ecoi.co.in	States of Uttaranchal and the following Districts of Uttar Pradesh:. Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozabad, Gautam Budh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
16	**PATNA** Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	States of Bihar and Jharkhand
17	**PUNE** Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@ecoi.co.in	States of Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

IRDAI Regulation No 17: This Policy is subject to regulation 17 of IRDAI (Protection of Policyholder's Interests) Regulation 2017or any amendment thereof from time to time.

7. ANNEXURES

I. OPTIONAL COVERS

A. **EXTRA ILLNESSES** – Coverage for ***Specified Illness*** as stated under Section 2 stands extended to the illness(es) mentioned in the ***Policy Schedule/ Certificate of Insurance*** for all Insured Persons covered under this Policy.

B. **DELETION / REDUCTION IN INITIAL WAITING PERIOD**

Deletion – 15 days Initial Waiting Period (3.1) under Section 3 stands deleted as specified in the ***Policy Schedule/ Certificate of Insurance*** for all Insured Persons covered under this Policy.

Extension – 15 days Initial Waiting Period (3.1) under Section 3 stands extended to the duration as specified in the Policy Schedule for all Insured Persons covered under this Policy.

C. **DELETION / REDUCTION IN PRE-EXISTING *Specified Illness* WAITING PERIOD**

Deletion – 90 days Waiting Period (3.2) under Section 3 stands deleted as specified in the ***Policy Schedule/ Certificate of Insurance*** for all Insured Persons covered under this Policy.

Reduction - 90 days Waiting Period (3.2) under Section 3 stands reduced to the duration as specified in the Policy Schedule for all Insured Persons covered under this Policy.

D. **OPD TREATMENT**

OPD CONSULTATIONS INCLUDING AYUSH - *We* will reimburse the Reasonable and Customary charges related to the medical expenses incurred towards the medically necessary treatment taken on Outpatient basis –

i. MEDICAL PRACTIONER EXPENSES
We will reimburse the Medical expenses incurred for the consultation service of ***Medical Practitioner*** for Outpatient Treatment.

ii. DIAGNOSTIC TESTS
We will reimburse the Medical expenses incurred for laboratory investigations and /or Diagnostic examinations , if recommended by the treating ***Medical Practitioner.***

iii. PHARMACY
We will reimburse the Medical expenses incurred for purchase of medicines from a pharmacy , if prescribed by the treating Medical Practitioner/ Specialist.

E. HOME CARE TREATMENT

TREATMENT AT HOME - ***We*** will reimburse the Reasonable and Customary charges related to the medical expenses incurred towards the medically necessary treatment taken at home if –

a. The severity of ***Specified Illness*** of ***Insured Person*** is such that it requires continuous care and observation and can be managed at home and the treating ***Medical Practitioner*** has recommended for such treatment at home; and
b. Such treatment is certified by treating ***Medical Practitioner*** as non-Emergency.
c. For this coverage, medically necessary treatment includes:

   i. Fees of Medical Practitioner/ Specialists;
   ii. Private Qualified Nurse charges
   iii. Investigation & Diagnostic procedures;
   iv. Medicines, Drugs and Consumables;
   v. Blood, Oxygen;
   vi. Non- Medical Expenses (Refer Annexure - 1 for complete list)

d. Such treatment shall be applicable for the period of 30 days from the date of diagnosis of specified illness.

e. Quick Steps to follow in case of a claim under this coverage -
   1. Insured Person is diagnosed with Specified illness by Treating Medical Practitioner.
   2. Treating medical practitioner certifies the condition as non-emergency and recommends for treatment at home which requires observation & care from time to time.
   3. Insured Person incurs medical expenses as described in 7 E)c) above.
   4. Once the treatment is completed, Insured person to take original documents from the respective healthcare provider(s) and submit the claim documents to Us / TPA as defined in Section 5)e).

F. **CRITICAL ILLNESS** - ***We*** will pay the lumpsum amount as specified in the ***Policy Schedule/ Certificate of Insurance*** against each Insured Person, provided that:

a) The ***Insured Person*** is diagnosed as suffering from irreversible end stage organ failure due to ***Specified Illness*** or complication arising from it during the Policy Year; and
b) The Specified Illness is diagnosed as a first incidence subject to the waiting period or
c) The Specified Illness is diagnosed as new incidence subject to the Pre-existing specified illness waiting period; and
d) The ***Insured Person*** survives at least fifteen (15) days as "survival period" following such Diagnosis.
e) This benefit is payable once during the Policy Year.

We will not make any payment if:

a) The ***Insured Person*** has already made a claim for the same Organ Failure.

II. NON-MEDICAL EXPENSES

SR NO	ITEMS	Payable /Non-Payable
I	TOILETRIES/COSMETICS/PERSONAL COMFORT OR CONVENIENCE ITEMS/SIMILAR EXPENSES	
1	HAIR REMOVAL CREAM	Payable - for site preparation
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	MOISTURISER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Payable for 1 (Qty) only in surgical cases of Thoracic or Lumbar Spine
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Payable
26	EYE SHEILD	Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Only sterile gown is payable in surgical cases, otherwise not payable

31	LEGGINGS	Payable in cases of Varicose Veins and DVT if the claim is payable as per the Policy
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Payable for 1 (Qty) only for Fracture of upper arm cases
59	WEIGHT CONTROL PROGRAMS / SUPPLIES / SERVICES	Not payable, unless specified in policy
60	COST OF SPECTACLES / CONTACT LENSES / HEARING AIDS ETC	Not payable, unless specified in policy
61	HOME VISIT CHARGES	Not payable, unless specified in policy
62	DONOR SCREENING CHARGES	Not Payable
63	ADMISSION / REGISTRATION CHARGES	Not Payable
64	HOSPITALISATION FOR EVALUATION / DIAGNOSTIC PURPOSE	Not Payable

65	EXPENSES FOR INVESTIGATION / TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable
66	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges
67	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS	Payable under OT Charges
68	MICROSCOPE COVER	Payable under OT Charges
69	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER	Payable under OT Charges
70	SURGICAL DRILL	Payable under OT Charges
71	EYE KIT	Payable under OT Charges
72	EYE DRAPE	Payable
73	X-RAY FILM	Payable under Radiology Charges
74	SPUTUM CUP	Payable under Investigation Charges, not as consumable
75	BOYLES APPARATUS CHARGES	Payable under OT Charges
76	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
77	ANTISEPTIC OR DISINFECTANT LOTIONS	Not Payable - Part of Dressing charges
78	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
79	COTTON	Not Payable - Part of Dressing charges
80	COTTON BANDAGE	Not Payable - Part of Dressing charges
81	MICROPORE / SURGICAL TAPE	Not Payable - Part of Dressing charges
82	BLADE	Not Payable
83	APRON	Not Payable - Part of ***Hospital*** Services/ Disposable linen to be part of OT/ICU charges
84	TORNIQUET	Not Payable (service Is Charged by Hospitals Consumables Cannot Be Separately Charged)
85	ORTHOBUNDLE, GYNAEC BUNDLE	Not Payable - Part of Dressing charges
86	URINE CONTAINER	Not Payable
II	**ELEMENTS OF ROOM CHARGE**	
87	LUXURY TAX	Part of Room charge not payable separately
88	HVAC	Part of Room charge not payable separately

89	HOUSE KEEPING CHARGES	Part of Room charge not payable separately
90	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of Room charge not payable separately
91	TELEVISION AND AIR CONDITIONER CHARGES	Payable under Room charges
92	SURCHARGES	Part of Room charge not payable separately
93	ATTENDANT CHARGES	Not Payable - Part of Room charges
94	IM IV INJECTION CHARGES	Part of Nursing charges, not payable seperately
95	CLEAN SHEET	Part of Laundry/ Housekeeping not payable separately
96	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by ***Hospital*** is payable
97	BLANKET / WARMER BLANKET	Not Payable - Part of Room charges
III	**ADMINISTRATIVE OR NON-MEDICAL CHARGES**	
98	ADMISSION KIT	Not Payable
99	BIRTH CERTIFICATE	Not Payable
100	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
101	CERTIFICATE CHARGES	Not Payable
102	COURIER CHARGES	Not Payable
103	CONVENYANCE CHARGES	Not Payable
104	DIABETIC CHART CHARGES	Not Payable
105	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
106	DISCHARGE PROCEDURE CHARGES	Not Payable
107	DAILY CHART CHARGES	Not Payable
108	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
109	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
110	FILE OPENING CHARGES	Not Payable
111	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
112	MEDICAL CERTIFICATE	Not Payable
113	MAINTAINANCE CHARGES	Not Payable
114	MEDICAL RECORDS	Not Payable
115	PREPARATION CHARGES	Not Payable
116	PHOTOCOPIES CHARGES	Not Payable
117	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable

118	WASHING CHARGES	Not Payable
119	MEDICINE BOX	Not Payable
120	MORTUARY CHARGES	Not payable, unless specified in policy
121	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
IV	**EXTERNAL DURABLE DEVICES**	
122	WALKING AIDS CHARGES	Not Payable
123	BIPAP MACHINE	Device Not Payable. Rental charges for use during ***Hospital*** are payable
124	COMMODE	Not Payable
125	CPAP / CAPD EQUIPMENTS	Device Not Payable. Rental charges for use during ***Hospital*** are payable
126	INFUSION PUMP – COST	Device Not Payable. Rental charges for use during ***Hospital*** are payable
127	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
128	PULSEOXYMETER CHARGES	Device Not Payable. Rental charges for use during ***Hospital*** are payable
129	SPACER	Not Payable
130	SPIROMETRE	Payable
131	SPO2 PROBE	Not Payable
132	NEBULIZER KIT	Device Not Payable. Rental charges for use during ***Hospital*** are payable
133	STEAM INHALER	Not Payable
134	ARMSLING	Payable for 1 (Qty) only for Fracture of upper arm cases
135	THERMOMETER	Not Payable
136	CERVICAL COLLAR	Not Payable
137	SPLINT	Not Payable
138	DIABETIC FOOT WEAR	Not Payable
139	KNEE BRACES (LONG / SHORT / HINGED)	Not Payable
140	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER	Not Payable
141	LUMBO SACRAL BELT	Payable for 1 (Qty) only for Fracture/Surgery Of Lumbar Spine.

142	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, All patients with Paraplegia/Quadriplegia for any reason is payable within Room Limit.
143	AMBULANCE COLLAR	Not Payable
144	AMBULANCE EQUIPMENT	Not Payable
145	MICROSHEILD	Not Payable
146	ABDOMINAL BINDER	Payable for 1 (Qty) only for Post Surgery Patients of Major Abdominal Surgery Including TAH, LSCS, Incisional Hernia Repair, Exploratory Laparotomy for intestinal Obstruction, Liver Transplant Etc.
V	**ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION**	
147	BETADINE \ HYDROGEN PEROXIDE \ SPIRIT \ DISINFECTANTS ETC	Payable under ***Hospital*** services
148	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES	Not Payable
149	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES	Patient Diet provided by ***Hospital*** is payable
150	SUGAR FREE TABLETS	Payable - Sugar free variants of admissable medicines are not excluded
151	CREAMS POWDERS LOTIONS (Toileteries are not payable,only prescribed medical pharmaceuticals payable)	Payable when prescribed
152	DIGESTION GELS	Payable when prescribed
153	ECG ELECTRODES	Payable
154	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
155	HIV KIT	Payable - payable Pre operative screening
156	LISTERINE / ANTISEPTIC MOUTHWASH	Payable when prescribed
157	LOZENGES	Payable when prescribed
158	MOUTH PAINT	Payable when prescribed
159	NEBULISATION KIT	Payable for IPD patients
160	NOVARAPID	Payable when prescribed
161	VOLINI GEL / ANALGESIC GEL	Payable when prescribed
162	ZYTEE GEL	Payable when prescribed

163	VACCINATION CHARGES	Not payable, unless specified in policy
VI	**PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE**	
164	AHD	Not Payable - Part of Hospital's internal Cost
165	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
166	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
VII	**OTHERS**	
167	VACCINE CHARGES FOR BABY	Not payable, unless specified in policy
168	TPA CHARGES	Not Payable
169	VISCO BELT CHARGES	Payable for surgical cases like thoracic and lumbar spine
170	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
171	EXAMINATION GLOVES	Not Payable
172	KIDNEY TRAY	Not Payable
173	MASK	Not Payable
174	OUNCE GLASS	Not Payable
175	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not Payable
176	OXYGEN MASK	Not Payable
177	PAPER GLOVES	Not Payable
178	PELVIC TRACTION BELT	Payable for 1 (Qty) only for Of PIVD Requiring Traction.
179	REFERAL DOCTOR'S FEES	Not Payable
180	ACCU CHECK (Glucometery / Strips)	Not Payable
181	PAN CAN	Not Payable
182	SOFNET	Not Payable
183	TROLLY COVER	Not Payable
184	UROMETER, URINE JUG	Not Payable
185	AMBULANCE	Not payable, unless specified in policy
186	TEGADERM / VASOFIX SAFETY	Payable
187	URINE BAG	Payable
188	SOFTOVAC	Not Payable
189	STOCKINGS	Payable in cases of Varicose Veins and DVT if the claim is payable as per the Policy

III. ILLUSTRATIONS

Scenario 1	**Description of Case**	Insured Person, 35-year-old, having a Benefit Plan with Sum Insured of ₹ 50,000 & Lumpsum payout of 100%. Let's understand how payout of Fixed Cash Benefit will happen in benefit plan.
	Policy Period	01-Jan-2019 to 31-Dec-2019
	Sum Insured	₹ 50,000
	Lumpsum Payout Option	100% = ₹ 50,000
	1st Claim	Diagnosed with Dengue on 01-Feb-2018 without hospitalisation
	Amount Paid by Us	₹ 10,000 (as a sublimit amount in case of diagnosis of Dengue without hospitalisation).
	2nd Claim	Hospitalisation due to Dengue on 01-Nov-2018
	Amount Paid by Us	₹ 40,000 (being the balance sum insured after payment of ₹ 10,000 in 1st claim)

Scenario 2	**Description of Case**	Insured Person, 35 yr old, having a Benefit Plan with Sum Insured of ₹ 50,000 & Lumpsum payout of 150%. Let's understand how payout of Fixed Cash Benefit will happen in benefit plan.
	Policy Period	01-Jan-2019 to 31-Dec-2019
	Sum Insured	₹ 50,000
	Lumpsum Payout Option	150% = ₹ 75,000 { i.e. 100 % SI payout on first illness + 50% SI payout on second illness (if diagnosed after 6 months of first claim within policy period)}
	1st Claim	Diagnosed with Dengue on 01-Feb-2018 without hospitalisation
	Amount Paid by Us	₹ 10,000 (sublimit amount in case of diagnosis of Dengue without hospitalisation).
	2nd Claim	Hospitalisation due to Dengue on 01-Oct-2018
	Amount Paid by Us	₹ 65,000 (₹ 40,000 : remaining SI during 1st claim) + (₹ 25,000 = 50% SI on 2nd illness)