Kshema Group Health Insurance Policy

Policy wordings

Section I Operative Clause

WHEREAS You the Insured named in the Schedule chose this **Kshema Group Mediclaim Insurance Policy** and have applied to us, **Kshema General Insurance Limited** for insurance cover as stated in this Policy. You further gave us the information about yourself through written Proposal form and/or Digital Proposal and/or RFQ from the intermediary and/or manually and based on your confirmation that the information submitted is true and correct and having received the premium paid by you, we promise to provide you insurance as stated in the Policy Schedule subject to the terms, conditions, provisions and exclusions set out in this Policy or as contained in any endorsement that may be issued.

Proposal, Policy wording, Policy schedule, Declarations and any Endorsements thereto shall be considered one document and any word or expression to which a specific meaning has been attached in any of them shall bear such meaning throughout unless specified otherwise.

Throughout this policy, the words "You", "Your", "Yourself" refer to the named insured shown in the policy schedule. The words "We, "Us", "Our" and "Company" refer to Kshema General Insurance Limited. Other words and phrases that appear in bold letter have, for the purpose of this Policy, a special meaning which can be read in the Definitions section.

Section II Definitions

The terms defined below and at other junctures 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) **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2) **Age or Aged means** "Age as on last birthday" as determined on the date of first Policy issuance or at Renewal.
3) **Ambulance means** a road vehicle operated by a licensed / authorized service provider and registered under RTA as ambulance and equipped for the transport and paramedical treatment of the person requiring medical attention.
4) **Any One Illness means** continuous period of illness, and it includes relapse within forty-five days from the date of last consultation with the hospital where treatment has been taken.
5) **Authority** means the Insurance Regulatory and Development Authority of India established under sub section 1 of section 3 of IRDA Act 1999.
6) **Ayush** refers to the medical and /or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
7) **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.

8) Ayush Hospital is a healthcare facility wherein medical/surgical/Para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   i. Central or State Government AYUSH Hospital or
   ii. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   iii. AYUSH Hospital, standalone or co-located with inpatient 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:
      a. Having at least 5 in-patients' beds.
      b. Having qualified AYUSH Medical Practitioner in charge round the clock.
      c. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out.
      d. Maintaining daily records of the patient and making the accessible to the insurance company's authorized representative.
9) Ayush Treatment refers to the medical and /or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
10) Break in Policy means the period of gap that occurs at the end of the existing Policy Period, when the premium due for renewal of the Policy is not paid on or before the premium renewal date specified in the Policy Schedule/Certificate of Insurance or within the subsequent Grace Period.
11) Cashless Facility means a facility extended by us or TPA on behalf of us to you where the payments, of the costs of treatment undergone by you in accordance with the policy terms and conditions, are directly made to the network provider by us to the extent pre-authorization is approved.
12) Company means Kshema General Insurance Limited.
13) Complainant means you or any beneficiary of an insurance policy who has filed a Complaint or Grievance against the Company or a Distribution Channel.
14) Condition Precedent means a Policy term or condition upon which Our liability under the Policy is conditional upon.
15) Co-payment is a cost-sharing requirement under a health insurance policy that provides that the insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured
16) Congenital Anomaly refers to a condition which is present since birth, and which is abnormal with reference to form, structure or position.
   i. Congenital Internal Anomaly means a Congenital Anomaly which is not in the visible and accessible parts of the body.
   ii. Congenital External Anomaly means a Congenital Anomaly which is in the visible and accessible parts of the body.
17) Day Care Centre means any institution established for Day Care Treatment of Illness and / or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criterion as under:
   i. has qualified nursing staff under its employment.

ii. has qualified Medical Practitioner (s) in charge.
iii. has 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.

18) Day Care treatment - means medical treatment, and/or Surgical Procedure which is:
i. undertaken under General or Local Anaesthesia in a Hospital / Day Care Centre in less than 24 hrs because of technological advancement, and.
ii. which would have otherwise required Hospitalization of more than 24 hours.

Note: Treatment normally taken on an Out-patient basis is not included in the scope of this definition.

19) Dependent / Family means for the purposes of this Policy, it shall include anyone of the family members as mentioned below:
i. legally wedded spouse
ii. Parents and Parents- in law
iii. maximum six dependent children (i.e. biological or adopted) between the age of 3 months to 25 years. If the child is above 25 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals. In case of girl age restriction is waived
iv. Any other dependent where there is insurable interest.

20) Domiciliary Hospitalization means medical treatment for an illness/ disease/ injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
a) the condition of the patient is such that he/ she is not in a condition to be moved to a hospital, or
b) The patient takes treatment at home on account of non-availability of room in a hospital.

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

22) Disclosure of information Norm: The policy shall be void and all premiums paid thereon shall be forfeited by us in the event of misrepresentation, mis-description, or nondisclosure of any material fact.

23) Emergency Care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a Medical Practitioner to prevent death or serious long-term impairment of your health.

24) Emergency Assistance Service Provider means any organization or institution appointed by us for providing services to you for an insurable event under this Policy and as mentioned in the Policy Schedule.

25) Epidemic means the occurrence of more cases of a disease than would be expected in a community or region spreading rapidly during a given time period; and declared as such by the appropriate Government Authority in India.

26) Hospital means any institution established for In-patient care and Day care treatment of disease / 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 Schedule of Section 56(1) of the said Act, or under such relevant Regulation in the state or country in which it operates; 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 those towns having a population of less than 10 lakh and 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 shall make these accessible to the Company's authorized personnel.

Hospital does not include:

- A Convalescent, nursing, or rest home or facility, or a home for the aged; rejuvenation or health resort.
- A place mainly providing Custodial, Educational, or Rehabilitative Care; or
- A facility mainly used for the treatment(s) of drug addicts or alcoholics.

27) **Hospitalization means** admission in a hospital for a minimum period of continuous 24 hours . or more.
28) **Illness means** a sickness or a disease or pathological condition leading to the impairment of normal physiological function requires medical treatment.
    i. Acute Condition means a disease, illness or injury that is likely to responed 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.
    ii. Chronic Condition means a disease, illness, or injury that has one or more of the following characteristics.
        a. it needs ongoing or long-term monitoring through consultations, examinations, checkups, and / or tests.
        b. it needs ongoing or long-term control or relief of symptoms.
        c. it requires rehabilitation for the patient or for the patient to be special trained to cope with it.
        d. it continues indefinitely.
        e. 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, and visible and evident means which is verified and certified by a Medical Practitioner.
30) **In-Patient Care/Treatment** means an Insured Person who is admitted to Hospital and stays there for a minimum period of 24 hours.
31) **Insured / Insured Person means** the name/s of the members/ employees of the entity shown in the schedule of the Policy whose details are intimated to Us and requisite premium is received by Us.
32) **Intensive Care Unit means** an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
33) **ICU (Intensive Care Unit) Charges means** the amount charged by a Hospital towards ICU expenses on a per day basis 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) **Medical Advice means** any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.
35) **Medical Expenses means** those expenses that you 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 you had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
36) **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 you for which hospitalisation has been advised.
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.

37) **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 the scope and jurisdiction of the license.

The Medical Practitioner should not be you or your close Family member. Medical Practitioner for Mental Illness shall be in accordance with The Mental Healthcare Act, 2017. Physician, wherever mentioned under this Policy shall also satisfy the definition of a Medical Practitioner. For the purposes of Worldwide Emergency Cover, the Physician must hold a valid license issued by the appropriate authority of India.

38) **Non-Network Hospital means** any hospital, daycare centre or other provider that is not part of the Company's network.

39) **Network Hospital** means all such hospitals, day care centres or other providers that the insurance company or the designated TPA has mutually agreed with, to provide services like cashless access to policyholders.

40) **OPD Cover** 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.

41) **Pre-Existing Disease (PED):** Pre-Existing Disease means any condition, ailment, injury or disease.
i. That is/are diagnosed by a physician within 24/36 months prior to the effective date of the policy issued by the insurer or its reinstatement or
ii. For which medical advice or treatment was recommended by, or received from, a physician within 24/36 months prior to the effective date of the policy issued by the insurer or its reinstatement.

42) **Pre-hospitalization Medical Expenses means** medical expenses incurred immediately before the Insured Person is Hospitalised, provided that:
i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

43) **Post-hospitalization Medical Expenses means** medical expenses incurred immediately after the insured person is discharged from the hospital provided that:
i. Such medical expenses are incurred for the same condition for which the insured person's hospitalization was required and
ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company

44) **Policy means** these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of covers available to you, what is excluded from the cover and the terms & conditions on which the Policy is issued to you and applicable to the members insured.

45) **Policy Period means** Policy Period means the time during which this Policy is in effect. Such period commences from Start Date and terminates on end Date and specifically appears in the Policy Schedule.

46) **Policy Schedule means** Policy Schedule issued to you in line with the terms and conditions as agreed upon, attached to and forming part of this insurance contract mentioning details including but not limited to, details of you, coverage, sections and benefits applicable, the deductible, the Policy Period, premium paid (including duties, taxes and levies thereon).
47) **Pandemic** means an epidemic of disease that has spread across a large region, for instance multiple continents or worldwide, affecting a substantial number of people; and declared as such by the appropriate Government Authority in India.
48) **Renewal means** the terms on which the contract of insurance can be renewed on mutual consent
49) **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.
50) **Room Rent means** the amount charged by a Hospital towards Room and Boarding expenses.
51) **Sub-limit means** a Pre-defined limit of liability fixed as a specific amount or percentage of the sum insured against the coverage for active insured member or his family for which we shall be liable in case of such treatment is warranted. Any amount incurred over and above such limit shall be born by the insured / insured member on his own. .
52) **Sum Insured means the** total of the base sum insured which is our maximum, total and cumulative liability for all claims during the Policy Period in respect of each member / family as specified in the active list.
53) **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 of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.
54) **Third Party Administrator (TPA) means** a Company registered with the Authority, and engaged by us, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.
55) **Unproven/Experimental treatment means** treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
56) **Waiting period means** a time period during which coverage is not admissible.

Section III Scope of Cover

A. Hospitalization Cover

We will pay the medically necessary and reasonable expenses under below listed Covers on Medically Necessary Hospitalization of an Insured Person / member due to Illness or Injury sustained or contracted during the Period of Insurance subject to terms, conditions and exclusion and restricted to the limits specified against the benefits which are covered under this policy as specified in the policy schedule however not exceeding the sum insured for which the member is covered.

In-Patient Hospitalization

I. Room Rent and boarding charges
II. Intensive Care Unit charges
III. Consultation fees & Nursing charges
IV. Medical Practitioner and Specialists Fees

V. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances charges
VI. Medicines, drugs and consumables
VII. Diagnostic procedures
VIII. The Cost of prosthetic and other medical devices or equipment if implanted internally during a Surgical Procedure.

B. Other coverages and Special Conditions:

1. Room Rent & Proportionate deduction:

If the Insured Person is admitted in a room which is of higher category than the limit specified in the Policy Schedule/ Certificate of Insurance, then the Insured Person shall bear a rateable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon), except pharmacy charges, diagnostic costs, costs of implants & medical devices and consumables expenses, in the proportion of the difference between the Incurred Room Rent and the Room Rent as applicable to the eligible Room Category in that Hospital to the Incurred Room Rent.
Expenses to be borne by Insured Person = {(Associated Medical Expenses) X (Incurred Room Rent– Eligible Room Rent of the Eligible Room Category)} / Incurred Room Rent

2. Inpatient care under Alternative Treatment

We will indemnify the reasonable and customary charges for Medical Expenses incurred by AYUSH treatment methods involving Inpatient Care availed in AYUSH Hospitals up to the limits as mentioned in your policy schedule.

3. Day Care Procedure

We will indemnify the reasonable and customary charges for Medical Expenses incurred on the Insured Person's Day Care Treatment/ Procedure for Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner during the Policy Period.
Conditions:
1. We shall not cover any OPD Treatment and Diagnostic Services under this Benefit.

2. The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to of Sum Insured or as specified in the policy schedule, during the policy period but not limited to the following:

A. Uterine Artery Embolization and HIFU (High Intensity Focused Ultrasound)
B. Balloon Sinuplasty
C. Deep Brain Stimulation
D. Oral Chemotherapy
E. Immunotherapy - Monoclonal Antibody to be given as injection
F. Intra Vitreal Injections
G. Robotic Surgeries
H. Stereotactic Radio Surgeries
I. Bronchial Thermoplasty
J. Vaporisation of the Prostrate (Green Laser Treatment or Holmium Laser Treatment)
K. IONM - (Intra Operative Neuro Monitoring)

L. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

The list of day care treatment is an indicative list and any other treatment which may get included in future shall be covered by the virtue of standard definition of "Day Care Procedure

4. Pre and Post Hospitalization Cover

means Medical Expenses incurred during pre and post hospitalisation defined as number of days preceding or subsequent to your Hospitalisation provided that:

1. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required,
2. The In-patient Hospitalization claim for such Hospitalization is admissible by Us.
3. Pre and Post Hospitalization medical expenses can be claimed under this section on a reimbursement basis only.

5. Ambulance Service

We will cover your Ambulance cost up to the limit as mentioned in your policy schedule in case patient has to be shifted from residence to hospital for admission in Emergency Ward or ICU or from one Hospital to another Hospital by fully equipped ambulance for better medical facilities.

For this claim to be paid, the claim must be admissible under In-patient Treatment or Day Care Procedures of this policy.

6. Organ Donor

Hospitalization expenses (excluding cost of organ) incurred on the donor during the course of organ transplant to the insured person. Our liability towards expenses incurred on the donor and the insured recipient shall not exceed the limit as mentioned in your policy schedule

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

i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organs Act (Amended), 1994 and other applicable laws and rules and the organ donated is for the use of the Insured Person, and
ii. We have accepted an inpatient Hospitalization claim for the insured member under In-Patient Hospitalization Treatment

7. Domiciliary Hospitalization

We will indemnify the Reasonable and Customary Charges for Medical Expenses for the Insured Person's Domiciliary Hospitalization during the Policy Period, provided that the condition for which the medical treatment is required for at least twenty-four hours.

Conditions for Domiciliary Hospitalization:

i. The Domiciliary Hospitalization is for Medically Necessary Treatment and is carried out on the written advice of a Medical Practitioner.
ii. Medical Expenses can be claimed under this Section on a Reimbursement basis only and shall be limited as mentioned in your policy schedule or Certificate of Insurance.
iii. Expenses incurred due to following diseases will not be payable:

2. Asthma
3. Bronchitis.
4. Chronic and all types of Dysenteries including Gastro- enteritis.
5. Diarrhoea and all type of Dysenteries including Gastro-enteritis.
6. Diabetes Mellitus and Insipidus
7. Epilepsy
8. Hypertension
9. Influenza, Cough and Cold
10. All Psychiatric or Psychosomatic Disorders.
11. Pyrexia of unknown Origin for less than 10 days.
12. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis.
13. Arthritis, Gout and Rheumatism.

8. OPD Cover

We will indemnify the Reasonable and Customary Charges incurred during the Policy Period for OPD Treatment of the Insured Person with co-payment as mentioned in your policy schedule/certificate of insurance per cover / benefit opted and specified under Policy Schedule/ Certificate of insurance.

Conditions:

i. The Insured Person may purchase Pharmacies prescribed by a Registered Medical Practitioner, as mentioned in the Policy Schedule/Certificate of Insurance.
ii. Our maximum liability for this cover shall be as per the limit/ terms and conditions as specified in Policy Schedule/ Certificate of Insurance.

What is not covered under OPD Treatments

a. Replacing any dental appliance which is lost or stolen.
b. Plastic surgery or cosmetic surgery unless necessary as a part of Medically Necessary Treatment and certified in writing by the attending Medical Practitioner.
c. Cost of frames for the prescribed lenses.
d. Sunglasses, unless medically prescribed by the treating Medical Practitioner.
e. Any lenses including contact lenses, hearing aids

9. Mental Illness

We shall indemnify the Medical Expenses incurred towards treatment of Mental Illness subject to the condition that Treatment shall be undertaken at a Hospital categorized as Mental Health Establishment or at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Mental Health Professional.

The following Mental Illnesses are covered after completion of **48 months** of Continuous Coverage with a sub-limit as mentioned in your policy schedule.

ICD Code	ICD Code Description
F01-F09	Mental disorders due to known physiological conditions
F10-F19	Mental and behavioral disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F60-F69	Disorders of adult personality and behaviour

F70-F79	Intellectual disabilities

Exclusion: Any kind of psychological counselling, cognitive/ family/ group/ behaviour/ palliative therapy or psychotherapy shall not be covered.

Section IV Exclusions

We will not make any payment for any claim in respect of any Insured Person caused by, arising from or attributable to any of the following unless expressly stated to the contrary in this Policy:

i. Exclusions with Waiting Period
   a. Pre-Existing disease
      i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
      ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
      iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
      iv. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.
   b. Specific Disease/ Procedure Waiting Period
      i. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90 Days/ 12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
      ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
      iii. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
      iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion. e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
      v. List of specific diseases/procedures 12 Months Waiting Period:
         a) Any types of gastric or duodenal ulcers;
         b) Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty;
         c) Surgery on all internal or external tumor /cysts/nodules/ polyps of any kind including breast lumps;
         d) All types of Hernia and Hydrocele; v. Anal Fissures, Fistula and Piles;
         e) Cataract;

f) Benign Prostatic Hypertrophy; viii. Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus;
g) Non infective Arthritis, Treatment of Spondylosis / Spondylitis, Gout & Rheumatism; x. Surgery of Genitourinary tract;
h) Calculus Diseases;
i) Sinusitis, nasal disorders and related disorders;
j) Surgery for prolapsed intervertebral disc unless arising from accident;
k) Vertebro-spinal disorders (including disc) and knee conditions;
l) Surgery of varicose veins and varicose ulcers;
m) Chronic Renal failure;
n) Medical Expenses incurred in connection with joint replacement surgery due to Degenerative condition, Age related osteoarthritis and Osteoporosis unless such Joint replacement surgery unless necessitated by Accidental Bodily Injury.

vi. 90 Days Waiting Period:
i. Hypertension, Heart Disease and related complications;
ii. Diabetes and related complications;

vii. First 30 days waiting period
I. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
II. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
III. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

ii. Investigation & Evaluation:
a. Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded.
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

iii. Rest Cure, rehabilitation and respite care
Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
v. 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.
vi. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

iv. Obesity/Weight control:
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
i. Surgery to be conducted is upon the advice of the doctor.
ii. The surgery/procedure conducted should be supported by clinical protocols.
iii. The member has to be 18 years of age or older and
iv. 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:
   1. Obesity related cardiomyopathy.
   2. coronary heart disease.
   3. severe sleep apnoea.
   4. uncontrolled type2 diabetes.

v. Change-of-Gender treatments:
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

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

vii. Hazardous or Adventure Sports:
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.

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

ix. Excluded Providers
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.

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

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

xii. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure.

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

xiv. Sterility and Infertility
Expenses related to sterility and infertility. This includes:
a. Any type of contraception, sterilization.
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI.

c. Gestational Surrogacy.
d. Reversal of sterilization.

xv. Maternity
   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.

xvi. Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons/materials or War or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, Nuclear, Chemical or Biological attack or weapons, radiation of any kind.

xvii. Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide.

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

xix. Treatment outside India.

xx. Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition").

xxi. Congenital external diseases, defects or anomalies.

xxii. Stem cell harvesting.

xxiii. Investigative treatments for analysis and adjustments of spinal sub luxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities).

xxiv. Circumcision (unless necessitated by Illness or Injury and forming part of treatment).

xxv. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.

xxvi. Vaccination including inoculation and immunisations (Except post Animal bite treatment).

xxvii. Non-Medical expenses such as Food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges and other such items. Full list of Non-Medical expenses is attached and available at www.kshema.co.
The provision or fitting of hearing aids, spectacles or contact lenses.

xxviii. Any treatment and associated expenses for alopecia, baldness including corticosteroids and topical immunotherapy wigs, toupees, hair pieces, any non-surgical hair replacement methods, Optometric therapy.

xxix. Any treatment or part of a treatment that is not of a Reasonable and Customary charge, not Medically Necessary; treatments or drugs not supported by a prescription.

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

xxxi. Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively). prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial

asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident.

xxxii. The cost of spectacles, contact lenses, hearing aids, crutches, wheelchairs, dentures, artificial teeth and all other external appliances, and/or devices unless specifically covered.

xxxiii. Expenses incurred on Items for personal comfort like television, telephone, etc. incurred during hospitalization and which have been specifically charged for in the hospitalisation bills issued by the hospital.

xxxiv. External medical equipment of any kind used at home as post hospitalisation care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition.

xxxv. Dental treatment or surgery of any kind unless required as a result of Accidental Bodily Injury to natural teeth requiring hospitalization treatment. 14. Convalescence, general debility, "Run-down" condition, rest cure, Congenital external illness/ disease/ defect.

Section V General Conditions

1. 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.

2. Non-Disclosure or Misrepresentation

If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the Proposal Form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person, is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

Cancelled ab initio from the inception date or the Renewal date (as the case may be), or the Policy may be modified by Us at Our sole discretion, upon 30 day notice by sending an endorsement to Your address shown in the Policy Schedule/Certificate of Insurance, and the claim under such Policy if any, shall be prejudiced.

We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/ Misrepresentation of Pre-existing Diseases subject to your prior consent

a) Permanently exclude the disease/ condition and continue with the Policy
b) Incorporate additional waiting period of not exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.
c) Levy underwriting loading from the first year of issuance of Policy or renewal, whichever is later. The above options will not prejudice the rights of the Company to invoke cancellation.
d) The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any Material Fact by the Policyholder.

b. Cancellation:

We can cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

You can cancel this policy by giving 7 days' written notice and in such an event, we shall i. refund proportionate premium for unexpired Policy Period, if the term of Policy up to one year and there is no Claim (s) made during the Policy Period.

ii. refund premium for the unexpired Policy Period, in respect of policies with term more than 1 year and risk coverage for such Policy years has not commenced.

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

The Company, may revise or modify the terms of the Policy including the premium rates. You shall be notified three months before the changes are affected.

d. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, we will intimate you about the same 90 days prior to expiry of the Policy.

ii. You 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.

e. Nomination

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

f. Multiple Policies

a. Indemnity Policies:

A Policyholder can file for Claim settlement as per his/her choice under any Policy. The Insurer of that chosen Policy shall be treated as the primary Insurer. In case the available coverage under the said Policy is less than the admissible Claim amount, the primary Insurer shall seek the details of other available policies of the Policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the Policy conditions, without causing any hassles to the Policyholde

b. Benefit based Policies:

On occurrence of the Insured event, the Policyholders can Claim from all Insurers under all policies.

g. Claim Settlement

i. We shall settle or reject a Claim, as the case may be, within 15 days from the date of receipt of last necessary document.

ii. However, where the circumstances of a Claim warrant an investigation in Our opinion 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, We shall settle or reject the Claim within 45 days from the date of receipt of last necessary document.

h. Complete Discharge

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

i. Package Service Expenses

As defined under the policy will be payable only if prior approval for the said package service is provided by Administrator / Insurer upon the request of the Insured Person or Insured.

j. Geography

This Policy only covers expenses for Medical Treatment taken within India only.

k. Insured Person

Only those persons named as the Insured Person in the Schedule shall be covered under this Policy. The details of the Insured Person are as provided by Insured. A person may be added as an Insured Person during the Policy Period after Insured's Proposal has been accepted by Insurer, an additional premium has been paid and Insurer's agreement to extend cover has been indicated by it issuing an endorsement confirming the addition of such person as an Insured. Cover under this Policy shall be withdrawn from any Insured Person upon such Insured giving 15 days written notice to be received by Insurer.

l. Premium

The premium payable under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of Insurer signed by a duly authorized official of Insurer. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this policy by the Insured person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of Insurer to make any payment under this policy. No waiver of any terms provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorized official of Insurer.

m. Due Care

Where this Policy requires Insured to do or not to do something, then the complete satisfaction of that requirement by Insured or someone claiming on Insured behalf is a precondition to any obligation under this Policy. If Insured or someone claiming on Insured behalf fails to completely satisfy that requirement, then Insurer may refuse to consider Insured claim. Insured will cooperate with Insurer at all times.

n. Free look period

(1) Every Policyholder of new individual health insurance policies except those with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such Policy.
(2) In the event a Policyholder disagrees to any of the Policy terms or conditions, or otherwise and has not made any claim, he shall have the option to return the Policy to the insurer for cancellation, stating the reasons for the same.
(3) Irrespective of the reasons mentioned, the Policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.
(4) A request received by insurer for cancellation of the Policy during free look period shall be processed and premium shall be refunded within 7 days of receipt of such request, as stated at sub regulation (3) above.

o. Mechanism for continuity of coverage for Individual members covered under the group insurance:

In the event of the group policy under which the Insured Person is a covered member and which is being discontinued or not renewed or Insured person leaving the group on account of resignation/termination or otherwise, the Insured Person has the option of taking a standard individual health policy of the Insurer without any benefit of continuity of cover for any additional benefits that the Insured Person may have enjoyed under the group policy and for which additional premium has been charged. In such an event, all the waiting periods as stipulated under the Individual Health policy will be applicable with due adjustment for the Uninterrupted period in completed years for which the Individual was covered under the Group Health policy issued by us. However, any such benefit would be restricted to the maximum of his eligibility of sum insured under the Individual health policy or the sum insured enjoyed by the individual under the Group Health policy whichever is lower. Also, all the underwriting rules and regulations of our Individual health policy would be applicable for acceptance of such risk.

p. Unhindered access

The Insured/Insured person shall extend all possible support & co-operation including necessary authorisation to the insurer for accessing the medical records and medical practitioners who have attended to the patient

q. Renewal of Policy:

The Company shall be under no obligation to renew the Policy/Coverage on expiry of the period for which premium has been paid. The Company reserves the right to offer revised rates, terms and conditions at renewal based on claim experience and a fresh assessment of the risk. This Policy may be renewed only by mutual consent and subject to payment in advance of the total premium at the rate in force at the time of renewal. The Company, however, shall not be bound to give notice that the Policy is due for Renewal or to accept any Renewal premium. Unless renewed as herein provided, this Policy shall automatically terminate at the expiry of the Policy Period/ Coverage Period.

r. Fraud

If any claim made by you, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this Policy, but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who have made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.
For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true.
b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact.
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent.

We will not only 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.

s. Migration

You will have the option to migrate the Policy to other health insurance products / plans offered by Us, by applying for migration of the policy at least 30 days before the Policy Renewal date. If such person/s is presently covered and has been continuously covered without any lapses under any health insurance product / plan offered by Us, You will get the accrued continuity benefits to the extent of the Sum Insured, Specific Waiting Periods, Waiting Period for Pre-Existing Diseases, Moratorium period, provided the Policy was renewed continuously without break.

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.)

t. Portability

You 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. If such person/s is presently covered and has been continuously covered without any lapses under any health insurance Policy with an Indian General/Health insurer, You will get the accrued continuity benefits to the extent of the Sum Insured, if any, specific Waiting Periods, Waiting Period for Pre-Existing Disease, Moratorium period, provided the Policy was renewed continuously without break.

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.)

u. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance Policy, no Policy and claim shall be contestable by the Insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first Policy. 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

v. Disclaimer

If Insurer shall disclaim liability to the Insured for any claim hereunder and if the Insured shall not within 12 calendar months from the date of receipt of the notice of such disclaimer notify Insurer in writing that he does not accept such disclaimer and intends to recover his claim from Insurer then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

w. Arbitration

If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to decision of a sole arbitrator in writing by the parties or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of the arbitrators comprising of two arbitrators, one appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

a. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this policy.
b. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

Section VI Claims Procedure

The fulfilment of the terms and conditions of this Policy (including the realization of premium by their respective due dates) in so far as they relate to anything to be done or complied by you, including complying with the following steps, shall be the Condition Precedent to the admissibility of the Claim. Upon the discovery or happening of any disease or Illness / Injury that may give rise to a Claim under this Policy, then as a Condition Precedent to the admissibility of the Claim, you shall undertake the following:

1. Claim Intimation

In the event of any Disease or Illness / Injury or occurrence of any other contingency which has resulted in a Claim or may result in a Claim covered under the Policy, you must notify to the TPA/Company either at the call centre (1800 572 3013) or in writing immediately (customer.support@kshema.co) in the event of:

i. Planned Hospitalization, you will intimate such admission at least 48 hours prior to the planned date of admission.
ii. Emergency Hospitalization, you will intimate such admission within 24 hours of such admission. The following details are to be provided to the TPA/Company at the time of intimation of Claim:
   a. Policy Number
   b. KYC Documents
   c. Health Card issued by us
   d. Name of the Policyholder
   e. Name and Address of the Insured Person in whose relation the Claim is being lodged.
   f. Nature of Illness / Injury
   g. Name and address of the attending Medical Practitioner and Hospital
   h. Date of Admission to Hospital or proposed date of admission to hospital for Planned Hospitalization
   i. Any other information as requested by the Company.
   j. MLC/FIR copy/certificate regarding abuse of Alcohol/intoxicating agent if applicable (in case of an injury).

2. Procedure for Cashless and Reimbursement of Claims

i. **Cashless:** Cashless facility is available only at a Network Hospital. You can avail Cashless facility at the time of admission into any Network Hospital, by presenting the health card as provided by the TPA / Company with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by us).

To avail Cashless facility, the following procedure must be followed by you:

a. **Pre-authorization:** Prior to Hospitalization, you must call the call centre of the TPA/Company and request authorization by way of submission of a completed Pre-authorization form at least 48 hours before a planned Hospitalization and in case of an emergency situation, within 24 hours of Hospitalization.
b. The TPA/we will process your request for authorization immediately but not later than 1 hour after having obtained accurate and complete information for the Illness/ Injury for which Cashless facility for Hospitalization is sought by you and the TPA/we will confirm such Cashless authorization / rejection in writing or by other means.
c. If the procedure above is followed and your request for Cashless facility is authorized, you will not be required to pay for the Hospitalization Expenses which are covered under this Policy and fall within our liability (within the authorized limit). Original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.
d. We/TPA (On behalf of us) reserves the right to review each Claim for Hospitalization expenses and coverage will be determined according to the terms and conditions of this Policy. You, in any event, be required to settle all other expenses directly with the Hospital.
e. Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital for Illness or Injury which are covered under the Policy.
f. There can be instances where the TPA/We may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case you may be required to pay for the treatment and submit the Claim for reimbursement to the TPA/us which will be considered subject to the Policy Terms & Conditions.

g. You are required to submit the documents with the Network Hospital.

Note: Under Cashless facility, the TPA/We may authorize upon your request for direct settlement of admissible Claim as per agreed charges & terms and conditions between Network Hospital and the TPA/us. In such cases, the TPA/we will directly settle all eligible amounts as per the Policy Terms & Conditions with the Network Hospital to the extent the Claim is covered under the Policy. We, at our sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, you are required to check the applicable list of Network Hospital on our website.

3. ii. Re-imbursement: In case of any Claim under the Benefits, where Cashless facility is not availed, the list of documents shall be provided by you, to TPA/us immediately but not later than 30 days of discharge from the Hospital, at your expense to avail the Claim.Your responsibility
   a. Forthwith intimate / file / submit a Claim in accordance with this Policy.
   b. If so, requested by the TPA/Emergency Assistance Service Provider/Us, you will have to submit himself for a medical examination by the TPA/Emergency Assistance Service Provider /Us nominated Medical Practitioner as often as it considers reasonable and necessary. The cost of such examination will be borne by us.
   c. You are required to check the applicable list of Network Hospitalization the TPA/Emergency Assistance Service Provider /our website or call centre before availing the Cashless services.
   d. In case where initial covered medical expenses were not expected to exceed the deductible but subsequently found to be exceeding the opted deductible, notification must be done immediately along with the copy of intimation made to another Insurer.
   e. On occurrence of an event which will lead to a Claim under this Policy, you shall:
      - Allow the Medical Practitioner or any of our representatives to inspect the medical and Hospitalization records, investigate the facts and examine you.
      - Assist and not hinder or prevent our representatives in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.
      - If you do not comply with the provisions of these conditions all benefits under this Policy shall be forfeited at our option.

. Penal Interest Provision :

1) The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

2) In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2o/o above the bank rate.

3) However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

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

(Explanation: Bank Rate means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due)

4. Claim Documents

You should submit to the TPA/Emergency Assistance Service Provider/Company/Network Hospital (as applicable) the following documents for or in support of the Claim, substantiating expenses up to and above the Deductible amount:

i. Duly completed and signed Claim Form, in original
ii. Medical Practitioner's referral letter advising Hospitalization.
iii. Medical Practitioner's prescription advising drugs /diagnostic tests / consultation.
iv. Original bills, receipts and discharge card from the Hospital / Medical Practitioner
v. Original bills from pharmacy / chemists
vi. Original pathological / diagnostic test reports and payment receipts
vii. Ambulance receipt and bill
viii. First Information Report/ Final Police Report, if applicable
ix. Postmortem report, if applicable

We may call for any other document required by us to assess the Claim. When original bills, receipts, prescriptions, reports and other documents are given to any other insurer or to the reimbursement provider, verified photocopies attested by such other insurer/reimbursement provider along with an original certificate of the extent of payment received from them needs to be submitted.

Note:

- Claim once paid under one Benefit cannot be paid.
- again, under any other benefit
- All invoices / bills should be in your name.

List of Documents required for Reimbursement claims

a. Completely filled claim form, duly signed (by claimant/proposer) and stamped (by Hospital)
b. Government approved Photo ID & Age Proof
c. Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents
d. Copy of the Hospital's Registration Certificate/ Hospital Registration number in case of Hospitalization in any non-network hospital of Kshema General Insurance or certificate from Hospital authorities providing facilities available including number of beds.
e. Discharge Card / Day Care Summary / Transfer Summary
f. Final hospital bill with all deposit and final payment receipt and refund receipt(s), if advance amount refunded
g. Invoice with payment receipt and implant stickers for all implants used during surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery
h. All previous consultation papers indicating history and treatment details for current Illness and advice for current hospitalization.
i. All diagnostic reports (including imaging and laboratory) along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre

j. All medicine / pharmacy bills along with prescription by Medical Practitioner
k. MLC / FIR Copy – in Accidental cases only
l. History of alcohol consumption or any intoxication certified by first treating doctor in case of accidental cases.
m. Copy of Death Summary and copy of Death Certificate (in death claims only)
n. Pre and Post-Operative Imaging reports Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress (to be submitted wherever required by the insurer).
o. Invoice for Vaccination and payment receipt
p. KYC documents (in all claims above Rs 1 lakh) - (Ration Card/ Driving License/ Aadhar Card/ Passport /any other Government authorized identity proof of the Claimant carrying name, photograph & address) and duly filled KYC form with 1 signed across passport size coloured photograph of the Claimant ***
q. Duly filled NEFT form with cancelled blank cheque (with IFSC code, A/C number, and name mentioned on cheque leaf)
r. Settlement letter(s), copy (-ies) of payment receipts, and entire certified copy of paid claims in case of partial claim settlement from other insurer. *** In case of death of Insured Person, the same document requirement would be for nominee/ legal heir of Insured Person (NOC in favour of 1 or more than 1 undisputedly selected legal heir(s) by remaining legal heir(s).

5. Payment Terms

i. This Policy covers medical treatment taken within India and payments under this Policy shall be made in Indian Rupees within India.
ii. Claims shall not be admissible under this Policy unless the TPA/ Emergency Assistance Service Provider /we had been provided with the complete documentation / information which we requested to establish its liability for the Claim, its circumstances and its quantum unless you have complied with the obligations under this Policy.
iii. We will not indemnify you for any period of Hospitalization of less than 24 hours or as agreed.
iv. The Sum Insured for you should be reduced by the amount payable / paid under the Benefit(s) and the balance shall be available as the Sum Insured for the unexpired Policy Year.
v. For Cashless Claims, the payment shall be made to the Network Hospital / TPA/ Emergency Assistance Service Provider whose discharge would be complete and final.
vi. For the Reimbursement Claims, we will pay to you.
vii. We will only be liable to pay for such Benefits for which you had specifically claimed in the Claim Form. We shall settle the Claim within 30 days from the date of receipt of last necessary document. However, where the circumstances of a Claim warrant an investigation in our opinion 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, we will settle the Claim within 45 days from the date of receipt of last necessary document.
viii. We will also decide and communicate any rejection of claim within 30 days from the date of receipt of last necessary document. However, where the circumstances of a claim warrant an investigation in our opinion 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, we shall also decide and communicate any rejection of the claim within 45 days from the date of receipt of last necessary document.

Section VII Grievance Redressal Clause

If You have any query or grievance about any matter relating to the Policy, or Our decision on any matter, or the claim, You can address your grievance as follows:

1. For resolution of any query, You may contact the Policy issuing office by writing to Us at Kshema General Insurance Limited, Regd. Office:# 413, 4th Floor, My Home Tycoon, Kundan Bagh, Begumpet, Hyderabad, Telangana, India500016. or email Us at customer.support@kshema.co or through Kshema Application or call us at 1800 572 3013 (toll-free)
2. If You are not satisfied with the resolution provided, You may escalate to our E-mail grievance.cell@kshema.co or gro@kshema.co or call us at 1800 570 2998 (toll-free) or can write to us at Grievance Redressal Office, Kshema General Insurance Limited, Regd. Office:# 413, 4th Floor, My Home Tycoon, Kundan Bagh, Begumpet, Hyderabad, Telangana, India- 500016 or at the sub section "Grievance Redressal" on our website www.kshema.co.

I. 3. If you are not satisfied with the resolution provided by us, you have the option to approach the Insurance Ombudsman for grievance redressal at https://www.cioins.co.in. Alternatively, you may also contact the Insurance Regulatory and Development Authority of India (IRDAI) through the Bima Bharosa Portal at https://bimabharosa.irdai.gov.in or via the IRDAI Grievance Call Centre (IGCC) at toll-free numbers 1800 4254 732 / 155255.Insurance Ombudsman Offices in India:

The contact details of the Insurance Ombudsman offices are as below:

S.No.	Location	Name of Ombudsman	Designation	Office of the Insurance Ombudsman,	Jurisdiction	Telephone No.	Email
1.	AHEMDABAD	Shri k. Vinayak Rao	Insurance Ombudsman	Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001.	Gujarat, Dadra & Nagar Haveli, Daman and Diu.	079 - 25501 201/02	oio.ahmedabad@cioins.co.in
2.	BENGALURU	Ms Neerja Kapur	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.	Karnataka	080 - 26652 048 / 26652 049	oio.bengaluru@cioins.co.in

3.	BHOPAL	Shri Ajay Kumar	Insurance Ombudsman	1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir,Arera Hills Bhopal – 462 011.	Madhya Pradesh, Chhattisgarh.	0755 - 2769201 / 2769202 / 276903	oio.bhopal@cioins.co.in
4.	BHUBANESWAR	Shri Ajay Kumar	Insurance Ombudsman	62, Forest park, Bhubaneswar – 751 009.	Odisha	0674 - 2596461 /2596455/2596429/2596003	oio.bhubaneswar@cioins.co.in
5.	CHANDIGARH	Ms Alka Jha	Insurance Ombudsman	Jeevan Deep Building SCO 20-27, Ground Floor Sector-17 A, Chandigarh – 160 017.	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.	0172-2706468	oio.chandigarh@cioins.co.in
6.	CHENNAI	Shri. K.Vinayak Rao	Insurance Ombudsman	Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018.	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).	044 - 24333668 / 24333678	oio.chennai@cioins.co.in
7.	DELHI	Ms Sunita Sharma	Insurance Ombudsman	2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.	011 - 46013992/2321350 4/23232481	oio.delhi@cioins.co.in

8.	GUWAHATI	Shri. Ajay Kumar Sharma	Insurance Ombudsman	Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM).	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	0361 - 2632204 / 2602205 / 2631307	oio.guwahati@cioins.co.in
9.	HYDERABAD	Ms G Shobha Reddy	Insurance Ombudsman	6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace,A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.	040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325	oio.hyderabad@cioins.co.in
10.	JAIPUR	Shri Satyajeet Rajan	Insurance Ombudsman	Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.	Rajasthan	0141 – 2740363	oio.jaipur@cioins.co.in
11.	KOCHI	Shri Pradeep Kumar Jain	Insurance Ombudsman	10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011.	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.	0484 – 2358759	oio.ernakulam@cioins.co.in
12.	KOLKATA	Shri Ajay Kumar	Insurance Ombudsman	Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072.	West Bengal, Sikkim, Andaman & Nicobar Islands.	033 - 22124339 / 22124341	oio.kolkata@cioins.co.in
13.					Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur,		

	LUCKNOW	Shri Ajay Kumar Sharma	Insurance Ombudsman	6th Floor, Jeevan Bhawan, Phase-II,Nawal Kishore Road, Hazratganj, Lucknow - 226 001.	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.	0522 - 4002082 / 3500613	oio.lucknow@cioins.co.in
14.	MUMBAI	Ms Sarojini S Dikhale	Insurance Ombudsman	3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.	Metropolitan Region excluding wards in Mumbai – i.e	022 - 69038800/27/29/31/32/33	oio.mumbai@cioins.co.in

					M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.		
15.	NOIDA	Ms Alka Jha	Insurance Ombudsman	Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301.	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,	0120-2514252 / 2514253	oio.noida@cioins.co.in

					Amroha, Hathras, Kanshiramnagar, Saharanpur.		
16.	PATNA	Ms Neerja Kapur	Insurance Ombudsman	2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001.	Bihar, Jharkhand.	0612-2547068	oio.patna@cioins.co.in
17.	PUNE	Shri Sunil Jain	Insurance Ombudsman	Jeevan Darshan Bldg., 3rd Floor, C.T.S. No's. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030.	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district,Palghar District, Raigad district & Mumbai Metropolitan Region	020-24471175	oio.pune@cioins.co.in
18.	THANE	Shri Umesh Sinha	Insurance Ombudsman	2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West)- 400604	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T."	022-20812868/69	oio.thane@cioins.co.in

*Note: As the above ombudsmen contact details may change from time to time, we suggest you refer https://www.cioins.co.in, for an updated list.

Information about Us

Kshema General Insurance Ltd.

Address: #413, 4th Floor, My Home Tycoon, Kundan Bagh, Begumpet, Hyderabad – 500 016, Telangana, India T: +91 040 2340 9918 | E: info@kshema.co | www.kshema.co.

LIST OF ITEMS IN HOSPITALIZATION

S.no	List of items generally excluded (Non-medical) in Hospital indemnity policy	Suggestions
	Toiletries/Cosmetics/Personal comfort or convenience items	
1.	Hair removal cream	Not payable
2.	Brush	Not payable
3.	Cozy towels	Not payable
4.	Hand wash	Not payable
5.	Moisture paste brush	Not payable
6.	Powder	Not payable
7.	Razor	Payable
8.	Shoe cover	Not payable
9.	Beauty service	Not payable
10.	Belts / Braces	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine.
11.	Buds	Not payable
12.	Barber charges	Not payable
13.	CAPS	Not payable
14.	Coldb pack/ Hot packs	Not payable
15.	Carry bags	Not payable
16.	Cradle charges	Not payable
17.	Comb	Not payable
23	Disposable razors charges (for site preparation)	Payable
24	EAU-DE-COLOGNE/ Room freshers	Not payable
25	Eye pad	Not payable
26	Eye shield	Not payable
27	Email/Internet charges	Not payable

28	Food charges (Other than patient diet provided by the hospital)	Not payable
29	Foot cover	Not payable
30	GOWN	Not payable
18.	Laundry charges	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable
19.	LEGGINS	Not payable
20.	Mineral water	Not payable
21.	Oil charges	Not payable
22.	Sanitary pad	Not payable
23.	Slippers	Not payable
24.	Telephone charges	Not payable
25.	Tissue paper	Not payable
26.	Toothpaste	Not payable
27.	Toothbrush	Not payable
28.	Guest services	Not payable
29.	Bed pan	Not payable
30.	Bed under pad charges	Not payable
31.	Camera cover	Not payable
32.	Clinplast	Not payable
33.	Crepe bandage	Not payable/Payable by the patient
34.	Curapore	Not payable
35.	Diaper of any type	Not payable
36.	DVD, cd charges	Not payable
37.	Eyelet collar	Not payable
38.	Face mask	Not payable
39.	Flexi mask	Not payable
40.	Gause soft	Not payable
41.	Gause	Not payable

42.	Hand holder	Not payable
43.	Hansaplast / Adhesive bandages	Not payable
44.	Infant foods	Not payable
45.	Slings	Reasonable cost for one sling in case of upper arm fractures should be considered
	Conditions Specifically Excluded in the Policy	
11	Weight control; programs/ Supplies / Services	Exclusion in policy unless otherwise specified
2	Cost of spectacles / Contact lenses/ Hearing aids etc.	Exclusion in policy unless otherwise specified
33	Dental treatment expenses that do not require hospitalization	Exclusion in policy unless otherwise specified
	Hormone replacement therapy	Exclusion in policy unless otherwise specified
	Infertility /Subfertility / Assisted conception procedure	Exclusion in policy unless otherwise specified
46.	Obesity (Including morbid obesity) treatment if excluded in policy	Exclusion in policy unless otherwise specified
47.	Psychiatric & psychosomatic disorder	Exclusion in policy unless otherwise specified
48.	Treatment of sexually transmitted disease.	Exclusion in policy unless otherwise specified
49.	Donor screening charges	Exclusion in policy unless otherwise specified
50.	Admission/Registration charges	Exclusion in policy unless otherwise specified
51.	Hospitalization for evaluation / Diagnostic purpose	Not payable - Exclusion in policy unless otherwise specified
52.	Expense for investigation /treatment irrelevant to the disease for which admitted or diagnosed	Not payable as per HIV / AIDS Exclusions
53.	Any expenses when the patient is diagnosed with retro virus or suffering from HIV/AIDS etc. is detected /Directly or indirectly	Not payable except bone marrow transplantation where covered by policy

Items which form part of Hospital Services where separate Consumables are not Payable, but the Service is		
1	Ward and theatre booking charges	Payable under OT charges, not payable separately
2	Arthroscopy and endoscopy instruments	Rental charge by the hospital payable. Purchase of instrument not payable
3	Microscope cover	Payable under OT charges, not payable separately
54.	Surgical blades. Harmonic calpel, Shaver	Payable under OT charges, not payable separately
55.	Surgical drill	Payable under OT charges, not payable separately
56.	Eye kit	Payable under OT charges, not payable separately
57.	Eye Drape	Payable under OT charges, not payable separately
58.	X- ray film	Payable under radiology charges, not as consumable
59.	Sputum cap	Payable under investigation charges, not as consumable
60.	Boyles apparatus charges	Part of OT charges, not separately
61.	Blood grouping and cross matching of donor samples	Part of cost of blood, not payable
62.	Antiseptic or disinfectant lotions	Not payable, part of dressing charge
63.	BAND AIDS, BANDAGES, STERILE INJECTIONS, NEEDLES, SYRINGES	Not payable, part of dressing charge
64.	Cotton	Not payable, part of dressing charge
65.	Cotton bandages	Not payable, part of dressing charge
66.	Microscope/Surgical tape	Not payable – payable by the patient when prescribed, otherwise included as dressing charges

67.	Blade	Not payable
68.	Apron	Not payable- Part of hospital services/Disposable linen to be a part of OT/ ICU charges
69.	Torniquet	Not payable
70.	Ortho bundle, Gynae bundle	Part of dressing charges
71.	Urine container	Not payable
	Elements of Room Charge	
1	Luxury tax	Actual tax levied by govt is payable. Part of room charged for sub limits.
2	HVAC	Part of room charge not payable separately
3	Housekeeping charges	Part of room charge not payable separately
72.	Service charges where nursing charges also include	Part of room charge not payable separately
73.	Television and air conditioner charges	Payable under room charges, not if separately levied
74.	SUBCHARGES	Part of room charge not payable separately
75.	Attendant charges	Not payable
76.	IM IV INJECTION CHARGES	Not payable
77.	Clean sheet	Part of laundry/housekeeping not payable separately
78.	Extra diet of patient (Other than that which forms part of bed charges)	Patient diet provided by hospital is payable
79.	Blanket/Warmer blanket Administrative or non-medical charges	Not payable
80.	Admission kit	Not payable
81.	Birth certificate	Not payable
82.	Blood reservation charges and ante natal booking charges	Not payable
83.	Certificate charges	Not payable

84.	Courier charges	Not payable
85.	Conveyance charges	Not payable
86.	Diabetic chart charges	Not payable
87.	Documentation charges / Administrative expenses	Not payable
88.	Discharge procedure charge	Not payable
89.	Daily chart charge	Not payable
90.	Entrance pass /Visitor pass charge	Not payable
91.	Expenses related to prescription on discharge	To be claimed by patient under post Hosp where admissible
92.	File opening charges	Not payable
93.	Incidental expenses /Misc. charges (Not explained)	Not payable
94.	Medical certificate	Not payable
95.	Maintenance charges	Not payable
96.	Medical records	Not payable
97.	Preparation charges	Not payable
98.	Photocopies charges	Not payable
99.	Patient identification band / Name tag	Not payable
100.	Washing charges	Not payable
101.	Medicine box	Not payable
102.	Mortuary charges	Payable up to 24 hrs., shifting charges not payable
103.	Medico legal case charges (MLC charges)	Not payable
External Durable Devices		
1	Walking aids charges	Not payable
104. 22	BIPAP MACHINE	Not payable
105. 33	COMMODE	Not payable
106.	CPAP/CAPD Equipment device	Not payable
107.	Infusion pump _ Cost device	Not payable
108.	Oxygen cylinder (For usage outside the hospital)	Not payable

109.	Pulseoxymeter Charges Devices	Not payable
110.	Spacer	Not payable
111.	Spirometer devices	Not payable
112.	Spo2probe	Not payable
113.	Nebulizer Kit	Not payable
114.	Steam Inhaler	Not payable
115.	ARMSLING	Not payable
116.	THERMOMETER	Not payable (paid by patient)
117.	CERVICAL COLLAR	Not payable
118.	SPLINT	Not payable
119.	DIABETIC FOOTWEAR	Not payable
120.	KNEE BRACES (Long/Short/Hinged)	Not payable
121.	Knee immobilizer / Shoulder immobilizer	Not payable
122.	Lumbosacral belt	Essentia and should be paid specifically for cases who have undergone surgery of lumbar spine
123.	Nimbus bed or water or air bed charges	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia / quadriplegia for any reason and at a reasonable cost of approximately Rs. 200 / day
124.	Ambulance collar	Not payable
125.	Ambulance equipment	Not payable
126.	Micro shield	Not payable
127.	Abdominal binder	Essential and should be paid in post-surgery patients of major abdominal surgery including TAH, LSCS. Incisional hernia repair, exploratory

		laparotomy for intestinal liver transplant etc. obstruction
Items Payable if Supported by a Prescription		
1	Betadine/Hydrogen peroxide/Spirit /Disinfectant etc.	My be payable when prescribed for patient , not payable for hospital use in OT or ward or for dressing in hospitals
2	Private nurses' charges – Special nursing charges	Post hospitals nursing charges not payable
3	Nutrition planning charges	Patient diet provided by hospital is payable
128.	Sugar free tablets	Payable – Sugar free variants of admissible medicine are not excluded
129.	Cream powder lotions	Payable when prescribed
130.	Digestion gels	Payable when prescribed
131.	ECG electrodes	Up to 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable
132.	Gloves Sterilized gloves	Payable/ Unsterilized gloves not payable
133.	HIV KITS	Payable - payable preoperative screening
134.	Listerine / Antiseptic mouthwash	Payable when prescribed
135.	Lozenges	Payable when prescribed
136.	Mouth paint	Payable when prescribed
137.	Nebulization kit	If used during hospitalization is payable reasonably
138.	Nova rapid	Payable when prescribed
139.	Volini gel / Analgesic gel	Payable when prescribed

140.	Zyte gel	Payable when prescribed
141.	Vaccination Charges	Routine vaccination not payable / Post bite vaccination payable
	Part of Hospital Own Cost and not Payable	
1	AHD	Not payable – Part of hospitals internal cost
2	Alcohol swabs	Not payable - – Part of hospitals internal cost
3	Scrub solution /Sterillium	Not payable – Part of hospitals internal cost
	Others	
1	Aesthetic treatment /Surgery	Not payable
2	TPA charges	Not payable
3	Visco belt charges	Not payable
142.	Any kit with no details mentioned	Not payable
143.	Examination gloves	Not payable
144.	Kidney tray	Not payable
145.	Mask	Not payable
146.	Ounce glass	Not payable
147.	Outstation consultants/ Surgeon fees	Not payable, except for telemedicine consultation were covered by policy
148.	186 oxygen mask	Not payable
149.	Paper gloves	Not payable
150.	Pelvic traction belt	Should be payable in case of PIVI requiring traction as this is generally not reused.
151.	Referral doctors fees	Not payable
152.	ACCU CHECK	Not payable pre hospitalization or post hospitalization / Reports and charts required / Device not payable
153.	PAN CAN	Not payable
154.	SOFNET	Not payable

155.	TROLLY COVER	Not payable
156.	UROMETER, URINE JUG	Not payable
157.	Ambulance	Not payable
158.	Tegaderm/Vaso fix safety	Payable maximum of 3 in 48 hrs
159.	Urine bag	Payable where medically necessary till a reasonable cost – maximum 2 per 48 hrs.
160.	Softovac	Not payable
161.	Stocking	Essential for case like CABG etc. where it should be paid