1. Preamble

This is a contract of insurance between **Policyholder** and **Max Bupa Health Insurance Company Limited** which is subject to the payment of the full premium in advance and the terms, conditions and exclusions to this **Policy**. This **Policy** has been issued on the basis of the **Disclosure to Information Norm**, including the information provided by **Policyholder** in respect of the **Insured Person/s** in the Proposal and the **Information Summary Sheet**.

The Policyholder/ Insured Person shall on his expense, inform the Company immediately of any change in the address, nature of job, state of health, or of any other changes affecting him or any Insured Person.

Note: The terms listed in Section 9 (Definitions & Interpretation) and used elsewhere in the Policy in Initial Capitals and Bold shall have the meaning set out against them in Section 9 wherever they appear in the Policy.

For the purpose of this policy the following Basic Benefits shall be available only if specified to be applicable in the **Policy Schedule/ Certificate of Insurance**, subject to the terms, conditions; limitations and exclusions mentioned in the Policy and as shown in the **Policy Schedule/ Certificate of Insurance** as per the eligibility for the insurance plan opted for**.**

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2. Benefits available under the Policy

a. The Benefits available under this **Policy** are described below.
b. The **Policy** covers the **Insured Person** during the **Policy/Coverage Period** for the **Reasonable and Customary Charges** incurred towards medical treatment taken by the **Insured Person** during the Policy/ Coverage Period for an Illness, Injury or conditions described in the sections below, if it occurs/ manifest or diagnosed during the **Policy / Coverage Period.**
c. The Benefits listed in the sections below will be payable subject to the terms, conditions and exclusions of this **Policy** and the availability of the **Sum Insured** and any limits specified in the **Policy Schedule/ Certificate of Insurance** as applicable under the Plan in force
d. All claims for any benefits under the Policy must be made in accordance with the process defined under Section 6 (Claim process & Requirements)

2.1 Inpatient Care

The **Company** will indemnify the **Medical Expenses** incurred on the **Insured Person's Hospitalization** during the **Policy/ Coverage Period** following an **Illness** or **Injury** that occurs during the **Policy/ Coverage Period**, provided that:

a. The **Hospitalization** is **Medically Necessary** and advised and follows **Evidence Based Clinical Practices** and Standard Treatment Guidelines.
b. The **Medical Expenses** incurred are **Reasonable and Customary Charges** for one or more of the following:
    i. **Room Rent**;
    ii. Nursing charges for **Hospitalization** as an **Inpatient** excluding private nursing charges;
    iii. **Medical Practitioners'** fees, excluding any charges or fees for **Standby Services**;
    iv. Physiotherapy, investigation and diagnostics procedures directly related to the current event which lead to hospitalization / admission;
    v. Medicines, drugs as prescribed by the treating **Medical Practitioner**;
    vi. Intravenous fluids, blood transfusion, injection administration charges and /or consumables;
    vii. Operation theatre charges;
    viii. The cost of prosthetics and other devices or equipment, if implanted internally during **Surgery**;
    ix. **Intensive / Critical Care Unit** charges.
c. If the **Insured Person** is admitted in the **Hospital** in a room category / **Room Rent** higher than the eligibility as specified in the Policy **Schedule/Certificate of Insurance**, then the **Company** shall be liable to pay only a pro-rated portion of the total **Associated Medical Expenses** (including surcharge or taxes thereon) in proportion of the difference between the **Room Rent** actually incurred against the entitled room category / **Room Rent.**

2.2 Pre-hospitalization Medical Expenses

The **Company** will indemnify the **Insured Person's Pre-hospitalization Medical Expenses** incurred following an **Illness** or **Injury** that occurs during the **Policy/ Coverage Period** provided that:

a. The **Company** has accepted a claim for **Inpatient Care** under Section 2.1 (**Inpatient Care**) above.
b. The **Company** will not be liable to pay **Pre-hospitalization Medical Expenses** for more than 30 days immediately preceding the **Insured Person's** admission to **Hospital** for **Inpatient Care** or such expenses incurred prior to inception of the **First Policy** with the **Company**.
c. **Pre-hospitalization Medical Expenses** can be claimed under the **Policy** on a **Reimbursement** basis only.
d. **Pre-hospitalization Medical Expenses** incurred on Physiotherapy will also be payable provided that such Physiotherapy is **Medically Necessary** and advised by the treating **Medical Practitioner.**

2.3 **Post-hospitalization Medical Expenses**

The **Company** will indemnify the **Insured Person's Post-hospitalization Medical Expenses** incurred following an **Illness** or **Injury** that occurs during the **Policy Period** as advised by the treating **Medical Practitioner** provided that:

a. The **Company** has accepted a claim for **Inpatient Care** under Section 2.1 (**Inpatient Care**) above.
b. The **Company** will not be liable to pay **Post-hospitalization Medical Expenses** for more than 60 days immediately following the **Insured Person's** discharge from **Hospital**.
c. **Post-hospitalization Medical Expenses** can be claimed under the **Policy** on a **Reimbursement** basis only.
d. **Post-hospitalization Medical Expenses** incurred on Physiotherapy will also be payable provided that such Physiotherapy is **Medically Necessary** and advised by the treating **Medical Practitioner.**

2.4 **Day Care Treatment**

The **Company** will indemnify the **Medical Expenses** incurred on the **Insured Person's Hospitalization** for any **Day Care Treatment** during the **Policy Period** following an **Illness** or **Injury** that occurs during the **Policy Period** provided that:

a. The **Day Care Treatment** is **Medically Necessary** and follows the written advice of a **Medical Practitioner**.
b. The **Medical Expenses** incurred are **Reasonable and Customary Charges** for any procedure where such procedure is undertaken by an **Insured Person** as **Day Care Treatment**.
c. The following procedures will be covered as **Day Care Treatment** under this benefit as they each require a period of specialized observation or care after completion of the procedure:
    i. Stereotactic radiotherapy, radiotherapy, chemotherapy and immunotherapy for cancer (approved immunosuppressant drugs will be payable only if administered as a part of these procedures)
    ii. Renal dialysis (Erythropoietin for chronic renal failure will be payable only if administered as a part of this procedure)
    iii. The **Company** will not cover any **OPD Treatment** and **Diagnostic Services** under this Benefit.

2.5 **Living Organ Donor Transplant**

The **Company** will indemnify the **Medical Expenses** incurred for a living organ donor's **Inpatient** treatment for the harvesting of the organ donated provided that:

a. The donation conforms to The Transplantation of Human Organs Act 1994 and amendments thereafter and the organ is for the use of the **Insured Person**.
b. The recipient **Insured Person** has been **Medically Advised** to undergo an organ transplant.
c. The **Company** has accepted the recipient **Insured Person's** claim under Section 2.1 (**Inpatient Care**).
d. **Medical Expenses** incurred are **Reasonable and Customary Charges**.

The **Company** shall not be liable to make any payment in respect of:

a. The living organ donor's stay in a **Hospital** that is needed for them to donate their organ.
b. Stem cell donation except for **Bone Marrow Transplant**.

c. **Pre-hospitalization Medical Expenses** or **Post-hospitalization Medical Expenses** of the organ donor.
d. Screening or any other **Medical Expenses** of the organ donor.
e. Costs directly or indirectly associated with the acquisition of the donor's organ.
f. Transplant of any organ/tissue where the transplant is **Experimental/Investigational or Unproven Treatment**.
g. Expenses related to organ transportation or preservation.
h. Any other medical treatment or complication in respect of the donor, consequent to harvesting

2.6 **Emergency Ambulance**

The **Company** will indemnify the **Reasonable and Customary Charges** for ambulance expenses incurred to transfer the **Insured Person** by surface transport following an **Emergency** provided that:

a. The medical condition of the **Insured Person** requires immediate ambulance services from the place where the **Insured Person** is injured or is ill to a **Hospital** where appropriate medical treatment can be obtained or from the existing **Hospital** to another **Hospital** with advanced facilities as advised by the treating **Medical Practitioner** for management of the current **Hospitalization**.
b. This benefit is available for one transfer per **Hospitalization**.
c. The ambulance service is offered by a healthcare or ambulance **Service Provider**.
d. The **Company** has accepted a claim under Section 2.1 (**Inpatient Care**) above.
e. The **Company** will cover expenses up to the amount specified in the Policy **Schedule/ Certificate of Insurance**

The **Company** will not make any payment under this Benefit if the **Insured Person** is transferred to any **Hospital** or diagnostic centre for evaluation purposes only

3. Claim Cost Sharing Options

The following claim cost sharing options shall apply under the **Policy** as per the plan as specified in the **Policy Schedule/Certificate of Insurance** and shall apply to all **Insured Persons**.

3.1 **Co-payment**

Co-payment as specified in the **Policy Schedule/Certificate of Insurance** shall be applicable on the amount payable by the **Company.** Co-payment shall not be applicable in case as per the **Policy Schedule/ Certificate of Insurance** there is a specific limit applicable for any particular disease.

4. Waiting Periods

All the **Waiting Periods** shall be applicable individually for each **Insured Person** and claims shall be assessed accordingly. The **Company** shall not be liable to make any payment under this **Policy** directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

4.1 **Pre-existing Diseases:**

All **Pre-existing Diseases** shall not be covered until 48 months of continuous coverage have elapsed since the inception of the **First Policy** with the **Company**.

4.2 **Initial Waiting Period (30 days):**

All the benefits under the **Policy** and any treatment taken unless the treatment needed is the result of an **Accident or Emergency** that occurs during the **Policy/ Coverage Period** will be subject to a **Waiting Period** of 30 days since the inception of the **First Policy** with the **Company**.

5. PERMANENT EXCLUSIONS

Under this **Policy** the **Company** shall not be liable to make any payment against the claim that is directly or indirectly caused by, based on, arising out of, related to or howsoever attributable to any of the following unless specifically mentioned elsewhere in the **Policy**.

5.1 **Ancillary Hospital Charges**

Charges related to a **Hospital** stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, RMO charges, night charges, registration, documentation and filing, surcharges. Service charges levied by the **Hospital** shall not be covered.

5.2 **Artificial life maintenance**
Artificial life maintenance, including life support machine used to sustain a person, who has been declared brain dead, as demonstrated by:
a. Deep coma and unresponsiveness to all forms of stimulation;
b. Absent pupillary light reaction;
c. Absent oculovestibular and corneal reflexes; or
d. Complete apnea

5.3 **Behavioral, Neurodevelopmental and Neurodegenerative Disorders:**
a. Disorders of adult personality including gender related problems, gender change;
b. Disorders of speech and language including stammering, dyslexia;
c. All Neurodegenerative disorders including Dementia, Alzheimer's disease and Parkinson's disease;
d. Other medical services for behavioral, neurodevelopmental delays and disorders.

5.4 **Circumcision:**
Circumcision unless necessary for the treatment of a disease or necessitated by an **Accident**.

5.5 **Complementary & AYUSH Treatments:**
Any form of **Complementary & AYUSH treatments**.

5.6 **Conflict & Disaster:**
Treatment for any injury or illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.

5.7 **External Congenital Anomaly:**
Screening, counseling or treatment related to external **Congenital Anomaly**.

5.8 **Convalescence & Rehabilitation:**
Hospital accommodation when it is used solely or primarily for any of the following purposes:
a. Any services provided for the purpose of **Convalescence, Rehabilitation and Respite Care** other than for receiving eligible treatment of a type that normally requires a stay in **Hospital**.
b. 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.
c. Hospice care - Any services for people who are terminally ill to address medical, physical, social, emotional and spiritual need.

5.9 **Cosmetic and Reconstructive Surgery:**
a. Any treatment undergone purely for cosmetic or psychological reasons to improve appearance, unless such treatment is **Medically Necessary** as a part of reconstructive procedure related to cancer or treatment for **Injury** resulting from **Accidents** or burns, and is required to restore functionality.
b. Gynaecomastia, Abdominoplasty, blepharoplasty, mammoplasty, Chemical Peel, Rhinoplasty, Otoplasty, Liposuction and Lipectomy will not be payable even if it is a medical necessity in case of **Accident** or burn or cancer or any other disease.

5.10 **Dental/oral treatment:**
Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and Gingiva except for **Inpatient Hospitalization** due to an **Accident.**

5.11 **Drugs and dressings for OPD Treatment or take-home use**
Any drugs or surgical dressings that are provided or prescribed in the case of OPD Treatment, or for an Insured Person to take home on leaving Hospital, for any condition, except as included in Post-hospitalization Medical Expenses.

5.12 **Eyesight & Optical Services:**
We will not pay for any treatment to correct refractive errors of the eye, unless required as the result of an **Accident**. **We** will not pay for routine eye examinations, contact lenses, spectacles or laser eye sight correction.

5.13 **Experimental/Investigational or Unproven Treatment:**
a. Services including device, treatment, procedure or pharmacological regimens which are considered as experimental, investigational or unproven.
b. **Medical Devices**, Vascular or Coronary Stents: Biodegradable (bioresorbable, bioabsorbable) polymer drug eluting stents will be considered as experimental and investigational for all purpose.
c. Stem Cell Transplant: Any stem cell transplant other than for **Bone Marrow Transplant**.

5.14 **Hazardous Activities:**
Any claim relating to **Hazardous Activities** unless declared beforehand and agreed by the **Company**.

5.15 **HIV, AIDS, and related complex:**
Any condition directly or indirectly caused by or associated with Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), including any condition that is related to HIV or AIDS.

5.16 **Hospitalization not justified:**
Admission solely for the purpose of Physiotherapy, evaluation, investigations, diagnosis or observation services or not consistent with standard treatment guidelines (as defined by Clinical Establishments (Registration and Regulation) Act 2010 and amendments thereafter) or **Evidence Based Clinical Practices**.

5.17 **Inconsistent, Irrelevant or Incidental Diagnostic procedures:**
Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the current diagnosis and treatment even if the same requires confinement at a **Hospital**.

5.18 **Mental and Psychiatric Conditions:**
Treatment related to symptoms, complications and consequences of mental **Illness**, mood disorders, psychotic and non-psychotic disorders.

5.19 **Non-Medical Expenses:**
a. Items of personal comfort and convenience.
   i. Personal attendant or beauty services, cosmetics, toiletry items, guest services and similar incidental expenses or services.
   ii. Issue of medical certificate and examinations as to suitability for employment or travel or any other such purpose.
   Any charges incurred to procure any treatment/**Illness** related documents pertaining to any period of **Hospitalization**/**Illness**.
b. External or Ambulatory Devices
   i. External and or durable medical/non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD or infusion pump.
   ii. Ambulatory devices such as walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, diabetic foot wear, glucometer /thermometer and similar items and also any medical equipment which is subsequently used at home.

5.20 **Obesity and Weight Control Programs:**
Services including medical treatment and **Surgical Procedures** and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

5.21 **OPD Treatment:**
Any OPD Treatment is not covered

5.22 **Off- label drug or treatment:**

Use of pharmaceutical drugs for an unapproved indication or in an unapproved age group, dosage, or route of administration as regulated and approved by Central Drugs Standard Control Organization (CDSCO)

5.23 **Puberty and Menopause related Disorders:**
Treatment for any symptoms, **Illness**, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing.

5.24 **Reproductive medicine & other Maternity Expenses: Any assessment or treatment method for**:

a. Birth Control
Any type of contraception, sterilization, abortions, voluntary termination of pregnancy or family planning;
b. Assisted Reproduction
Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI, Gestational Surrogacy;
c. Sexual disorder and Erectile Dysfunction.
Treatment of any sexual disorder including impotence (irrespective of the cause) and sex changes or gender reassignments or erectile dysfunction;
d. Any costs or expenses related to pregnancy, complications arising from pregnancy or medical termination of pregnancy unless caused by an accident.

However, the above exclusions do not apply to treatment for ectopic pregnancy.

5.25 **Sexually transmitted Infections & diseases:**
Screening, prevention and treatment for sexually related infection or disease.

5.26 **Sleep disorders:**
Treatment for any conditions related to disturbance of normal sleep patterns or behaviors.

5.27 **Substance related and Addictive Disorders:**
Notwithstanding anything said to the contrary anywhere under this Policy Treatment and complications related to disorders of intoxication, dependence, abuse, and withdrawal caused by drugs and other substances such as alcohol, opiods or nicotine.

5.28 **Unlawful Activity:**
Any condition occurring either as a result of breach of law by the Insured Person with criminal intent.

5.29 **Treatment received outside India:**
Any treatment or medical services received outside India.

5.30 **Unrecognized Physician or Hospital:**

a. Treatment or **Medical Advice** provided by a **Medical Practitioner** not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central council of Homeopathy.
b. Treatment or **Medical Advice** related to one system of medicine provided by a **Medical Practitioner** of another system of medicine.
c. Treatment provided by anyone with the same residence as an **Insured Person** or who is a member of the **Insured Person's** immediate family or relatives.
d. Treatment provided by **Hospital** or health facility that is not recognized by the relevant authorities in India.
e. Treatment or services received in health hydros, nature cure clinics or any establishment that is not a recognized **Hospital** or healthcare facility.

5.31 **Generally Excluded Expenses**
Any costs or expenses specified in the list of expenses generally excluded at Annexure II.

6. Claims Process & Requirements
The fulfillment of the terms and conditions of this **Policy** (including payment of full premium in advance by the due dates mentioned in the **Certificate of Insurance**) in so far as they relate to anything to be done or complied with by **the Insured Person**, including complying with the following in relation to claims, shall be **Condition Precedent** to admission of the **Company's** liability under this **Policy**

6.1 **Claims Administration:**

a. The directions, advice and guidance of the treating **Medical Practitioner** shall be strictly followed. We shall not be obliged to make any payment that arises out of willful failure to comply with such directions, advice or guidance.
b. **The Company's** representatives must be permitted to inspect the medical and **Hospitalization** records pertaining to the **Insured Person's** treatment and to investigate the circumstances pertaining to the claim.
c. The **Company** and its representatives must be permitted to inspect the medical and **Hospitalization** records pertaining to the **Insured Person's** treatment and to investigate the circumstances pertaining to the claim.
d. The **Company** and its representatives must be given all reasonable co-operation in investigating the claim in order to assess its liability and quantum in respect of the claim.

It is hereby agreed and understood that no change in the **Medical Record** provided under the **Medical Advice** information, by the **Hospital** or the **Insured Person** to the **Company** or its **Service Provider** during the period of **Hospitalization** or after discharge by any means of request will be accepted by the **Company**. Any decision on request for acceptance of change will be at the discretion of the **Company**

6.2 **Claims Procedure:** On the occurrence or discovery of any Injury or Illness that may give rise to a claim under this Policy, the Claims Procedure set out below shall be followed:

a. For Availing Cashless Facility: Cashless Facility can be availed only at the **Company's Network Providers**. The complete list of **Network Providers** is available on the **Company** website and at the **Company's** branches and can also be obtained by contacting the **Company** over the telephone. In order to avail **Cashless Facility**, the following process must be followed:

i. Process for Obtaining Pre-Authorization

A. **For Planned Treatment:**
The **Company** must be contacted to pre-authorize **Cashless Facility** for planned treatment at least 72 hours prior to the proposed treatment. Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date at a **Network Provider**.

B. **In Emergencies**
If the **Insured Person** has been **hospitalized** in an **Emergency**, the **Company** must be contacted to pre-authorize **Cashless Facility** within 48 hours of the **Insured Person's Hospitalization** or before discharge from the **Hospital**, whichever is earlier.

All final authorization requests, if required, shall be sent at least six hours prior to the **Insured Person's** discharge from the **Hospital**.

Each request for pre-authorization must be accompanied with completely filled and duly signed pre-authorization form including all of the following details:

I. The **Policy/ Certificate** Number;
II. Name of the **Policyholder**;
III. Employee No./ Member ID
IV. Name and address of **Insured Person** in respect of whom the request is being made;
V. Nature of the **Illness**/**Injury** and the treatment/**Surgery** required;
VI. Name and address of the attending **Medical Practitioner**;
VII. **Hospital** where treatment/**Surgery** is proposed to be taken;
VIII. Date of admission;
IX. Admission note;
X. Treating doctor certificate for disease / event history with justification of hospitalization.

If these details are not provided in full or are insufficient for the **Company** to consider the request, The **Company** will request additional information or documentation in respect of that request.

When the **Company** has obtained sufficient details to assess the request, the **Company** will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim, applicable **Deductibles** / **Co-payment** and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.

In case of preauthorization request where chronicity of condition is not established as per clinical evidence based information the **Company** may reject the request for preauthorization and ask the claimant to claim as reimbursement. Claim documents submission for reimbursement should not be considered as an admission of liability.

Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date at a **Network Provider** and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, **Hospital**, locations, indications and disease details, match with the details of the actual treatment received. For cashless **Hospitalization**, the **Company** will make the payment of the amount assessed to be due, directly to the **Network Provider**.

The **Company** reserves the right to modify, add or restrict any **Network Provider** for **Cashless Facility** in **the Company's** sole discretion. Before availing **Cashless Facility**, please check the applicable updated list of **Network Providers**.

ii. Reauthorization

Cashless Facility will be provided subject to re-authorization is requested for either change in the line of treatment or in the diagnosis or for any procedure carried out on the incidental diagnosis/finding prior to the discharge from the hospital.

b. For Reimbursement Claims:

For all claims for which **Cashless Facility** have not been pre-authorized or for which treatment has not been taken at a **Network Provider**, the **Company** shall be informed of the claim along with the following details within 48 hours of admission to the **Hospital** or before discharge from the **Hospital**, whichever is earlier:

i. The **Policy** / Certificate number
ii. Name of the **Policyholder**;
iii. Employee No./ Member ID
iv. Name and address of the **Insured Person** in respect of whom the request is being made;
v. Nature of **Illness** or **Injury** and the treatment/**Surgery** taken;
vi. Name and address of the attending **Medical Practitioner**;
vii. **Hospital** where treatment/**Surgery** was taken;
viii. Date of admission and date of discharge;

Any other information that may be relevant to the Illness / Injury / **Hospitalization**.

6.3 **Claims Documentation:** The **Company** shall be provided with the following necessary information and documentation in respect of all claims at **Insured Person's** expense within 30 days of the **Insured Person's** discharge from **Hospital** (in the case of **Pre-hospitalization Medical Expenses** and **Hospitalization Medical Expenses**) or within 30 days of the completion of the **Post-hospitalization Medical Expenses** period (in the case of **Post-hospitalization Medical Expenses**). For those claims for which the use of **Cashless Facility** has been authorised, The **Company** will be provided these documents by the **Network Provider** immediately following the **Insured Person's** discharge from **Hospital**:

a. Claim form duly completed and signed by the claimant.
   Please provide mandatorily following information if applicable
   i. Current diagnosis and date of diagnosis;
   ii. Previous admission/**Surgery** if any.
b. Age/Identity proof document of the **Insured Person** in case of cashless claim (not required if submitted at the time of pre-authorization request) and Proposer in case of **Reimbursement** claim.
   i. Self attested copy of valid **Age** proof (passport / driving license / PAN card / class X certificate / birth certificate);
   ii. Self attested copy of identity proof (passport / driving license / PAN card / voter identity card);

iii. Recent passport size photograph.

c. Cancelled cheque/ bank statement / copy of passbook mentioning account holder's name, IFSC code and account number printed on it of **Policyholder** / nominee (in case of death of **Policyholder**).
d. Original discharge summary.
e. Additional documents required in case of **Surgery**/**Surgical Procedure**.
   i. Bar code sticker and invoice for implants and prosthesis (if used);
f. Original final bill from **Hospital** with detailed break-up and paid receipt.
g. Room tariff of the entitled room category (in case of a **Non-Network** provider and if room tariff is not a part of **Hospital** bill): duly signed and stamped by the **Hospital** in which treatment is taken. (In case the **Insured Person** is unable to submit such document, then The **Company** shall consider the **Reasonable and Customary Charges** of the **Insured Person's** eligible room category of **Our Network Provider** within the same geographical area for identical or similar services.)
h. Original bills of pharmacy/medicines purchased, or of any other investigation done outside **Hospital** with reports and requisite prescriptions.
i. Copy of death certificate (in case of demise of the **Insured Person**).
j. For Medico-legal cases (MLC) or in case of **Accident**
   i. MLC/First Information Report (FIR) copy attested by the concerned **Hospital** / police station (if applicable);
   ii. Original self-narration of incident in absence of MLC / FIR.
k. Original laboratory investigation, diagnostic & pathological reports with supporting prescriptions.
l. Original X-Ray/ MRI / ultrasound films and other radiological investigations.
m. The **Company** may call for any other additional documents if provided documents are not sufficient to arrive at decision.

6.4 **Claims Assessment & Repudiation:**

a. At the **Company** discretion, the **Company** may investigate claims to determine the validity of a claim. All costs of investigation will be borne by the **Company** and all investigations will be carried out by those individuals/entities that are authorized by the **Company** in writing.
b. The **Company** shall settle or repudiate a claim within 30 days of the receipt of the last necessary information and documentation set out above. In case of any suspected fraud, the last "necessary" document shall include the receipt of the investigation report from the **Company** investigator/representatives. In case of delay in payment, the **Company** shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by the **Company**.
c. Payment for **Reimbursement** claims will be made to the **Insured Person**. In the unfortunate event of **Insured Person's** death, the **Company** will pay the Nominee named in the **Certificate of Insurance** or **his** legal heirs or legal representatives holding a valid succession certificate.
d. All admissible claims under this **Policy** shall be assessed by the **Company** in the following progressive order:-
   i. If a room has been opted in a **Hospital** for which the room category is higher than the eligible limit as applicable for that **Insured Person** as specified in the Policy **Schedule/ Certificate of Insurance**, then the **Associated Medical Expenses** payable shall be pro-rated as per the applicable limits in accordance with Section 2.1c.
   ii. **Co-payment** (if applicable) shall be applicable on the amount payable by the **Company** as specified in the **Policy Schedule/ Certificate of Insurance**

The claim amount assessed in Section 6.4 d above would be deducted from the amount mentioned against each benefit and **Sum Insured** as specified in the Policy **Schedule/ Certificate of Insurance**.

6.5 **Delay in Claim Intimation:**

If the claim is not notified to the **Company** within the stipulated time as mentioned in the above sections, then the **Company** shall be provided the reasons for the delay, in writing. the **Company** will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

7. Portability Option

If the **Insured Person** has exercised the **Portability** Option at the time of **Renewal** of **Policyholder's Group Health Insurance** policy to a suitable similar **Policy** or Individual health Insurance policy or a

Family Floater policy with the **Company** by submitting application and the completed **Portability** form with complete documentation at least 45 days before the expiry of **Insured Person** previous **Coverage Period**, then the **Insured Person** will be provided with credit gained for **Pre-existing Diseases** in terms of **Waiting Periods** and time bound exclusions up to the existing **Sum Insured** and cover subjected to Board approved Underwriting guidelines and in accordance with the existing guidelines of the **IRDAI.**

8. General Terms and Conditions

8.1 **Cancellation/Termination:**

a. **Cancellation by Policyholder/ Insured Person: Policyholder**/ **Insured Person** may terminate this **Policy** by giving 30 days prior written notice to the **Company.** The **Company** shall cancel the **Policy** for the balance of the **Policy/Coverage Period** and refund the premium (exclusive of service tax) for the unexpired term as mentioned herein below, provided that no claim has been made under the **Policy** by or on behalf of any **Insured Person**:

Policy in-force up to	**Policy Term 1 year**	**Policy Term 2 years**
	Refund Premium (%)	**Refund Premium (%)**
Up to 90 days	100%	100%
91 to 365 days	Pro-rata refund basis the number of days left in policy term	Pro-rata refund basis the number of days left in policy term
366 to 455 days	Not applicable	25%
456 to 545 days	Not applicable	12%
Exceeding 545 days	Not applicable	0%

b. Automatic Cancellation:

i. Individual Policy Coverage:

The **Policy** coverage shall automatically terminate in the event of death of the **Insured Person**.

ii. Refund:

A refund in accordance with the table in Section 8.1 (a) shall be payable if there is an automatic cancellation of the **Policy** provided that no claim has been made under the **Policy** by or on behalf of any **Insured Person.**

c. Cancellation by the Company:

The **Company** may terminate the **Policy/coverage** during the **Policy/ Coverage Period** by sending 30 days prior written notice to Policyholder/**Insured Person** address shown in the **Certificate of Insurance** without refund of premium (for cases other than non cooperation) if:

i. **Insured Person** or any person acting on behalf of either has acted in a dishonest or fraudulent manner under or in relation to this **Policy**; and/or
ii. **Insured Person** has not disclosed the **Material Facts** or misrepresented in relation to the **Policy**; and/or
iii. **Insured Person** has not co-operated with the Company. In such cases, premium will be refunded on pro-rata basis provided that no claim has been paid under the **Policy** for any **Insured Person**.

For avoidance of doubt, it is clarified that no claims shall be admitted and/or paid by the **Company** during the notice period in case of cancellation by the Company.

d. Cancellation in case of Credit Linked Cases:

In addition to the above, in cases the policy is linked to the credit/ loan tenure, the coverage will continue till the end of loan tenure, closure of the loan or policy period whichever is earlier. The Policyholder/Insured Person shall inform the Company of such closure of the loan immediately in order to cancel the policy/ coverage.

8.2 **Renewal of Policy**

This **Policy** is **Renewable** for life however this **Policy** will automatically terminate at the end of the **Policy Period** or **Grace Period** and the **Company** is under no obligation to give intimation in this regard.

a. Grace Period

This Policy shall ordinarily be renewable for lifelong and subject to payment in advance of the total premium at the rate in force at the time of renewal and subject to the Policy is renewed within the Grace period of 30 days from date of Policy expiry. Unless renewed as herein provided, this Policy shall automatically be terminated at the expiry of the period for which premium has already been paid

b. Renewal Promise:

Renewal of the **Policy** will not ordinarily be denied other than on grounds of moral hazard, misrepresentation or fraud or non-cooperation by the **Policyholder**.

8.3 **Nomination**

a. The **Insured Person** is mandatorily 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 the **Insured Person** death.
b. Any change of nomination shall be communicated to the **Company** in writing and such change shall be effective only when an endorsement on the **Policy** is made by the Company.

8.4 **Complete discharge**

Payment made by the **Company** to the Policyholder or adult **Insured Person** or the Nominee of the **Insured Person** or the legal representative of the **Insured Person**, as the case may be, of any benefit under this **Policy** shall in all cases be complete and construe as an effectual discharge in favour of the **Company.**

8.5 **Records to be maintained:**

As a **Condition Precedent,** the **Policyholder/ Insured Person** shall keep an accurate record containing all relevant medical records and shall allow the **Company** or its representative(s) to inspect such records. The **Policyholder/ Insured Person** shall furnish such information as we may require under this **Policy** at any time during **the Policy Period/ Coverage Period**.

8.6 **Authorization to obtain all pertinent records or information:**

As a **Condition Precedent** to the payment of benefits, **Company** and/or **the Company's Service Provider** are authorized by the **Insured Person** to obtain all pertinent records or information from any **Medical Practitioner**, **Hospital**, clinic, insurer, individual or institution to assess the validity of a claim submitted by or on behalf of any **Insured Person**.

8.7 **Fraudulent claims**

If a claim is in any way found to be fraudulent, or if any false statement, or declaration is made or used in support of such a claim, or if any fraudulent means or devices are used by the **Policyholder**/**Insured Person** or anyone acting on behalf of the **Policyholder**/**Insured Person** or any false or incorrect **Disclosure to Information Norms** to obtain any benefit under this **Policy**, then the **Company** may reserve the right to cancel the **Policy** and all benefits under the **Policy** shall be forfeited and all sums paid under this **Policy** shall be repaid to the **Company** by **Policyholder and/or the Insured Person** who shall be jointly liable for such repayment.

8.8 **Policy Disputes**

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

8.9 **Territorial Jurisdiction**

All benefits are available in India only, and all claims shall be payable in India in Indian Rupees only

8.10 **Arbitration**

a. In event of any dispute between the **Policyholder** and the **Company** upon the quantum payable under this Policy such dispute shall, be referred to the Arbitration by three Arbitrators for resolution/decision. One Arbitrator each, of the three Arbitrators shall be appointed by both

Policyholder and the **Company** respectively and both the appointed Arbitrators shall appoint the third and the presiding Arbitrator. The two arbitrators respectively shall be appointed in writing by the **Company** and the **Policyholder** within 30 days after having been required so to do in writing by the other party. The arbitration process shall be subject to Arbitration and Conciliation Act, 1996, as amended from time to time.

b. In case either the **Company** or the **Policyholder** refuses or fails to appoint an arbitrator within 30 days after receipt of notice in writing requiring an appointment, the other party shall be at liberty to appoint a sole arbitrator.
c. It is expressly stipulated and declared that it shall be a **Condition Precedent** to any right of action or suit upon this **Policy** that remedy of Arbitration is exhausted first.
d. The venue of the arbitration proceedings shall be at Our Corporate Office which is currently situated at; B-1/I-2, Mohan Cooperative Industrial Estate, Mathura Road, New Delhi-110044.
e. It is clearly agreed and understood that no difference or dispute shall be referred to arbitration as herein before provided if the **Company** has disputed or rejected liability under or in respect of this Policy.

8.11 **Notices**

Any notice, direction or instruction given under this **Policy** shall be in writing and delivered by hand, post, or facsimile to:

a. **Policyholder/Insured Person** at the address specified in the **Policy Schedule/Certificate of Insurance** or at the changed address of which the **Company** must receive written notice.
b. The **Company** at the following address:

Max Bupa Health Insurance Company Limited
B-1/I-2, Mohan Cooperative Industrial Estate
Mathura Road, New Delhi-110044
Fax No.: 1800-3070-3333

c. No insurance agents, brokers or other person/entity is authorized to receive any notice on the **Company's** behalf.
d. In addition, the **Company** may send **the Policyholder/Insured Person** other information through electronic and telecommunications means with respect to the **Policy** from time to time.

8.12 **Alteration to the Policy**

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the **Company**, which approval shall be evidenced by a written **Endorsement** signed and stamped by the **Company**.

8.13 **Withdrawal of Product**

This product or any variant/plan under the product may be withdrawn at **the Company's** option subject to change in regulations. In such a case the **Company** shall notify **Policyholder** of any such change at least 3 months prior to the date from which such withdrawal shall come into effect or as may be provided by applicable Law.

8.14 **Customer Service and Grievances Redressal**:

a. In case of any query or complaint/grievance, **Policyholder/ Insured Person** may approach **Our** office at the following address:

Customer Services Department
Max Bupa Health Insurance Company Limited
B-1/I-2, Mohan Cooperative Industrial Estate
Mathura Road, New Delhi-110044
Contact No: 1800-3010-3333
Fax No.: 1800-3070-3333
Email ID: customercare@maxbupa.com

b. In case the **Policyholder/ Insured Person** are not satisfied with the decision of the above office, or have not received any response within 10 days, he may contact the following official for resolution:

Head – Customer Services
Max Bupa Health Insurance Company Limited
B-1/I-2, Mohan Cooperative Industrial Estate
Mathura Road, New Delhi-110044
Contact No: 1800-3010-3333
Fax No.: 1800-3070-3333
Email ID: customercare@maxbupa.com

c. In case the **Policyholder**/ **Insured Person** are not satisfied with **the Company's** decision/resolution, he may approach the Insurance Ombudsman at the addresses given in Annexure I.
d. The complaint should be made in writing duly signed by the complainant or by his/her legal heirs with full details of the complaint and the contact information of the complainant.
e. As per provision applicable law, the complaint to the Ombudsman can be made only if the grievance
   i. Has been rejected by the Grievance Redressal Machinery of the Company;
   ii. Within a period of one year from the date of rejection by the Company;
   iii. If it is not simultaneously under any litigation.

9. Definitions & Interpretation

For the purposes of interpretation and understanding of this **Policy**, the **Company** has defined, herein below some of the important words used in the **Policy** and for the remaining language and the words; they shall have the usual meaning as described in standard English language dictionaries. The words and expressions defined in the Insurance Act 1938, IRDA Act 1999, regulations notified by the **IRDAI** and circulars and guidelines issued by the **IRDAI** shall carry the meanings explained therein.

Note: ***Where 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***

9.1 **Accident** or **Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

9.2 **Age** means age at last birthday.

9.3 **"AYUSH Treatment"** are medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems in the Indian context but excludes allopathic treatment or "modern medicine".

9.4 **Associated Medical Expenses** shall include **Room Rent**, nursing charges for **Hospitalization** as an **Inpatient** excluding private nursing charges, **Medical Practitioners**' fees excluding any charges or fees for **Standby Services**, investigation and diagnostics procedures directly related to the current admission, operation theatre charges and **Intensive / Critical Care Unit** charges.

9.5 **Bone Marrow Transplant** is a condition where the **Insured Person** needs necessary medical treatment to replace malignant or defective bone marrow with normal bone marrow from healthy donors to stimulate the production of formed blood cells.

9.6 **Cancer** means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
Specific Exclusion: All tumors in the presence of HIV infection are excluded.

9.7 **Cashless Facility** means a facility extended by the Company to the Insured Person 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 Company to the extent pre-authorization is approved.

9.8 **Certificate of Insurance** means a certificate issued by **the Company**, and, if more than one, then the latest in time. The **Certificate of Insurance** contains details of the **Policyholder**, **Insured Persons** and the Benefits applicable under the **Policy.**

9.9 **Condition Precedent shall mean a Policy/Coverage term or condition** upon which the **Company** liability under the **Policy is conditional** upon.

9.10 **Congenital Anomaly mea**ns a condition which is present si**nce birth, and wh**ich is abnormal with **refere**nce 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.

9.11 **Convalescence, Rehabilitation and Respite Care** means any care arrangement in a residential setting or in a **Hospital** or any other healthcare facility like health hydros, nature cure clinics, wellness centre, palliative centre for services related to help the physically or cognitively impaired to achieve or regain their maximum functional potential for mobility, self-care and independent living, although not necessarily complete independence.

9.12 **Co-payment** means a cost-sharing requirement under a health insurance policy that provides that the **Policyholder**/**insured Person** will bear a specified percentage of the admissible claim amount. A **Co-payment** does not reduce the **Sum Insured**.

9.13 **Coverage Period** means the period commencing from Coverage start date and hour as specified in the **Certificate of Insurance** and terminating at midnight on the Coverage end date as specified in **Certificate of Insurance.**

9.14 **Day Care Centre** means any institution established for **Day Care Treatment** of **Illness** and/or **Injuries** or a medical set-up within a **Hospital** and which has been registered within the local authorities, wherever applicable, and is under the supervision of a registered and qualified **Medical Practitioner** AND must comply with all the following minimum criteria:
a. has **Qualified Nursing** staff under its employment;
b. has qualified **Medical Practitioner(s)** in charge;
c. has a fully equipped operation theatre of its own where **Surgical Procedures** are carried out;
d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

9.15 **Day Care Treatment** refers to medical treatment, and/or **Surgical Procedure** which is:
a. undertaken under General or Local Anesthesia in a **Hospital**/**Day Care Center** in less than 24 hrs because of technological advancement, and
b. which would have otherwise required a **Hospitalization** of more than 24 hours.

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

9.16 **Dental Treatment** means a treatment related to teeth and structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and **Surgery**.

9.17 **Diagnostic Tests** means investigations, such as X-Ray or blood tests, to determine the cause of symptoms and/or medical conditions.

9.18 **Diagnostic Services** means a broad range of **Diagnostic Tests** and exploratory or therapeutic procedures essential for detection, identification and treatment of medical condition.

9.19 **Disclosure to Information Norm** means the **Policy** shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

9.20 **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 removed to a **Hospital**, or
b. the patient takes treatment at home on account of non availability of room in a **Hospital**.

9.21 **Endorsement** means written evidence of an agreed change in the **Policy/ Certificate of Insurance**

9.22 **Emergency** means a serious medical condition or symptom resulting from **Illness** or **Injury** which arises suddenly and unexpectedly and requires immediate care and treatment by a **Medical Practitioner** to prevent death or serious long term impairment of the **Insured Person's** health.

9.23 **Evidence Based Clinical Practice** (EBCP) means the conscientious, explicit, judicious and reasonable use of modern, best evidence in making decisions about the care of individual patients by integrating the clinical experience and patient's health condition with the best available information to ensure delivery of best patient health outcomes. The goal of EBCP is the integration of: (a) clinical expertise/expert opinion, (b) external scientific evidence, and (c) client/patient/caregiver perspectives to provide high-quality services.

9.24 **First Policy** means the **Policy Schedule/Certificate of Insurance** issued to the **Policyholder/Insured Person** at the time of inception of the **Coverage** mentioned in the **Policy Schedule/ Certificate of Insurance** with the **Company**.

9.25 **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.

9.26 **Hazardous activities** means engaging in speed contest or racing of any kind (other than on foot), professional or competitive sport, bungee jumping, parasailing, ballooning, parachuting, base jumping, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, snow and ice sports or involving a naval military or air force operation.

9.27 **Hospital means any institution** establish**ed for Inpatient Care** and **Day Care Treatment** of I**llness** and / or **Injuries** and which has been registered as a **Hospital with the loca**l **authorit**ies under the Clinical Establishments **(Registration** and R**egulation) Act, 20**10 or **under** the enact**ments sp**ecified under the Schedule of Sectio**n 56(1)** of the said Act OR complies with all minimum criteria as under:

a. has at least 10 **Inpatient** beds in towns having a population of less than 10,00,000 and at least 15 **Inpatient** beds in all other places;
b. has **Qualified Nursing** staff under its employment round the clock;
c. has qualified **Medical Practitioner(s)** in charge round the clock;
d. has a fully equipped operation theatre of its own where **Surgical Procedures** are carried out;
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

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

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

(a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

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

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

9.30 **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**.

9.31 **Information Summary Sheet** means the information and details provided to **Us** or **Our** representatives over the telephone for the purposes of applying for this **Policy** which has been recorded by **Us** and confirmed by **You**.

9.32 **Intensive / Critical 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.

9.33 **Inpatient** means the **Insured Person's** admission for treatment in a **Hospital** for more than 24 hours for a covered event.

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

9.35 **Insured Person/s** means person named as insured in the **Policy Schedule/ Certificate of Insurance**.

9.36 **IRDAI** means the Insurance Regulatory and Development Authority of India.

9.37 **LASER & Light based Treatment means a** procedure that uses focused light emission or amplification for treatment of medical conditions.

9.38 **Material Fact** shall mean and include all important, essential and relevant information in the context of underwriting the risk to be covered by the Company.

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

9.40 **Medical Devices** are devices intended for internal or external use in the diagnosis, treatment, mitigation or prevention of disease or disorder.

9.41 **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.

9.42 **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 his licence and shall not be;

a. Insured Person
b. Member of the family

9.43 **Medical Record** means the collection of information as submitted in claim documentation concerning a **Insured Person's Illness** or **Injury** that is created and maintained in the regular course of management, made by a **Medical Practitioner**s who has knowledge of the acts, events, opinions or diagnoses relating to the **Insured Person's Illness** or **Injury**, and made at or around the time indicated in the documentation.

9.44 **Medically Necessary** treatment means as any treatment, tests, medication, or stay in **Hospital** or part of a stay in **Hospital** which:

a. is required for the medical management of the **Illness** or **Injury** suffered by the insured;
b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c. must have been prescribed by a **Medical Practitioner**;
d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

9.45 **Network Provider** means **Hospital** enlisted by the **Company**, TPA or jointly by the **Company** and TPA to provide medical services to an **Insured Person** by a **Cashless Facility**. **You** can get the updated list of **Network Provider** on **Our** website www.maxbupa.com.

9.46 **Notification of Claim** means the process of notifying a claim to the **Company** or TPA through any of the recognized modes of communication.

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

9.48 **Off-label drug or treatment** means use of pharmaceutical drug for an unapproved indication or in an unapproved age group, dosage or route of administration.

9.49 **Policy** means our contract of insurance with the **Policyholder** providing cover as detailed in this Policy terms and conditions, the proposal form, **Policy Schedule/ Certificate of Insurance**, **Information Summary Sheet** , Endorsement/s, if any and Annexure, which form part of the contract and must be read together.

9.50 **Policy Period** is the period between the inception date and the expiry date of the **Policy** as specified in the **Policy Schedule** or the date of cancellation of this **Policy**, whichever is earlier.

9.51 **Policy Year** means the period of one year commencing on the date of commencement specified in the **Policy Schedule**/ **Certificate of Insurance** or any anniversary thereof.

9.52 **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.

9.53 **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalization of the **Insured Person** is **Hospitalised**, provided that:

a. Such **Medical Expenses** are incurred for the same condition for which the **Insured Person's Hospitalization** was required, and
b. The **Inpatient Hospitalization** claim for such **Hospitalization** is admissible by the Insurance Company.

9.54 **Post-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the **Insured Person** is discharged from the **Hospital**, provided that:

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

b. The **Inpatient Hospitalization** claim for such **Hospitalization** is admissible by the Insurance Company.

9.55 **Portability** means transfer by an individual health insurance policyholder (including family cover) of the credit gained for Pre-existing conditions and time bound exclusions if he/she chooses to switch from one insurer to another.

9.56 **Qualified Nurse means a** person wh**o holds a valid regist**ration from **t**he Nursing Council of I**ndia o**r the Nursing Council of any state in India.

9.57 **Reasonable and Customary Charges means** the charges for services or supplies, which ar**e the standard c**harges 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.

9.58 **Reimbursement** means settlement of claims paid directly by **the Company** directly to the **Policyholder/Insured Person**.

9.59 **Renewal** means the terms on which the contract of insurance can be **Renewed** on mutual consent with a provision of **Grace Period** for treating the **Renewal** continuous for the purpose of gaining credit for pre-existing diseases, time bound exclusions and for all **Waiting Periods**.

9.60 **Robotic Assisted Surgery** refers to a technology used to assist the surgeon in controlling operative field via a terminal and manipulates robotic surgical instruments via a control panel. The use of computers and robotics is intended to enhance dexterity to facilitate microscale operations

9.61 **Room Rent** means the amount charged by a **Hospital** towards Room and Boarding expenses and shall include the **Associated Medical Expenses**.

9.62 **Service Provider** means any person, organization, institution that has been empanelled with **the Company** to provide services specified under the benefits to the **Insured Person**.

9.63 **Standby Services** are services of another **Medical Practitioner** requested by treating **Medical Practitioner** and involving prolonged attendance without direct (face-to-face) patient contact or involvement.

9.64 **Suite Room** means

a. a space available for boarding in a **Hospital** which contains two or more rooms; Or
b. a space available for boarding in a **Hospital** which contains an extended living/dining/kitchen area

9.65 **Sum Insured** means the amount stated in the **Policy Schedule/ Certificate of Insurance** which is **the Company's** maximum, total and cumulative liability for any and all claims during the **Policy Year** in respect of the **Insured Person**.

If the **Policy/Coverage Period** is 2 years, then the **Sum Insured** shall be applied separately for each **Policy Year** in the **Policy Period**.

9.66 **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 or prolongation of life, performed in a **Hospital** or **Day Care Center** by a **Medical Practitioner**.

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

9.68 **Waiting Period** means a time-bound exclusion period related to condition(s) specified in the **Schedule of Insurance Certificate** or the **Policy** which shall be served before a claim related to such condition(s) becomes admissible.

9.69 **We/Our/Us** means Max Bupa Health Insurance Company Limited.

ANNEXURE I

Names of Ombudsman and Addresses of Ombudsmen Centre's

Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C.U. Shah College, Ashram Road, **AHMEDABAD-380 014.** Tel.:- 079-27545441/27546139 Fax : 079-27546142 Email: bimalokpal.ahmedabad@gbic.co.in	Shri Raj Kumar Srivastava, Office of the Insurance Ombudsman, 2nd Floor, Janak Vihar Complex, 6, Malviya Nagar,Opp. Airtel, Near New Market, **BHOPAL(M.P.)-462 003.** Tel.:- 0755-2769201/9202 Fax : 0755-2769203 Email: bimalokpal.bhopal@gbic.co.in
Shri B.N. Mishra, Office of the Insurance Ombudsman, 62, Forest Park, **BHUBANESHWAR-751 009.** Tel.:- 0674-2596455/2596003 Fax : 0674-2596429 Email: bimalokpal.bhubaneswar@gbic.co.in	Shri Manik Sonawane Office of the Insurance Ombudsman, S.C.O. No.101-103,2nd Floor, Batra Building, Sector 17-D, **CHANDIGARH-160 017.** Tel.:- 0172-2706468/2705861 Fax : 0172-2708274 Email: bimalokpal.chandigarh@gbic.co.in
Shri Virander Kumar, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, **CHENNAI-600 018.** Tel.:- 044-24333668 /24335284 Fax : 044-24333664 Email: bimalokpal.chennai@gbic.co.in	Smt. Sandhya Baliga, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, **NEW DELHI-110 002.** Tel.:- 011-23237539/23232481 Fax : 011-23230858 Email: bimalokpal.delhi@gbic.co.in
Insurance Ombudsman, Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road, **GUWAHATI-781 001 (ASSAM).** Tel.:- 0361-2132204/5 Fax : 0361-2732937 Email: bimalokpal.guwahati@gbic.co.in	Shri G.Rajeswara Rao, Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, **HYDERABAD-500 004.** Tel : 040-65504123/23312122 Fax: 040-23376599 Email: bimalokpal.hyderabad@gbic.co.in
Shri P.K.Vijayakumar, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, **ERNAKULAM-682 015.** Tel : 0484-2358759/2359338 Fax : 0484-2359336	Shri K.B. Saha, Office of the Insurance Ombudsman, Hindustan Building. Annexe, 4th Floor, C.R. Avenue, **KOLKATA-700 072.** Tel : 033-22124339/22124340 Fax : 033-22124341

Email: bimalokpal.ernakulam@gbic.co.in	Email: bimalokpal.kolkata@gbic.co.in
Shri N.P. Bhagat, Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, **LUCKNOW-226 001.** Tel : 0522 -2231331/2231330 Fax : 0522-2231310 Email: bimalokpal.lucknow@gbic.co.in	Shri A.K. Dasgupta, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), **MUMBAI-400 054.** Tel : 022-26106928/26106552 Fax : 022-26106052 Email: bimalokpal.mumbai@gbic.co.in
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IRDAI Regulation No 5: This Policy is subject to regulation 5 of IRDAI (Protection of Policyholder's Interests) Regulation.

ANNEXURE II		
Standard list of expenses generally excluded ("non-medical expenses") in Hospitalization indemnity policies		
S.No.	Items	Recommendations
A	**Toiletries/ cosmetics/ personal comfort or convenience items**	**Payable/Non Payable**
1	Hair removing cream charges	Not payable
2	Baby charges	(unless specified/indicated) Not payable
3	Baby food	Not payable
4	Baby utilities charges	Not payable
5	Baby set	Not payable
6	Baby bottles	Not payable
7	Bottle	Not payable
8	Brush	Not payable
9	Cosy towel	Not payable
10	Hand wash	Not payable
11	Moisturiser paste brush	Not payable
12	Powder	Not payable
13	Razor	Not payable
14	Towel	Not payable
15	Shoe cover	Not payable
16	Beauty services	Not payable
17	Belts/ braces	Essential and should be paid at least specifically for cases who have undergone surgery of thoracic or lumbar spine.
18	Buds	Not payable
19	Barber charges	Not payable
20	Caps	Not payable
21	Cold pack/hot pack	Not payable
22	Carry bags	Not payable
23	Cradle charges	Not payable
24	Comb	Not payable
25	Disposable razor charges (for site for preparation)	Not payable
26	Eau-de-cologne / room fresheners	Not payable
27	Eye pad	Not payable
28	Eye shield	Not payable
29	Email / internet charges	Not payable
30	Food charges (other than patient's diet provided by hospital)	Not payable
31	Foot cover	Not payable
32	Gown	Not payable
33	Leggings	Essential in bariatric and varicose vein surgery and may be considered for at least these conditions where surgery itself is payable.
34	Laundry charges	Not payable
35	Mineral water	Not payable
36	Oil charges	Not payable
37	Sanitary pad	Not payable
38	Slippers	Not payable
39	Telephone charges	Not payable
40	Tissue paper	Not payable
41	Tooth paste	Not payable
42	Tooth brush	Not payable
43	Guest services	Not payable
44	Bed pan	Not payable
45	Bed under pad charges	Not payable
46	Camera cover	Not payable
47	Care free	Not payable
48	Cliniplast	Not payable
49	Crepe bandage	Payable only treatment warrant usage
50	Curapore	Not payable
51	Diaper of any type	Not payable
52	Dvd, cd charges	Not payable (However If CD is specifically

		sought by Insurer/TPA then payable)
53	Eyelet collar	Not payable
54	Face mask	Not payable
55	Flexi mask	Not payable
56	Gause soft	Not payable
57	Gauze	Not payable
58	Hand holder	Not payable
59	Hansaplast/ adhesive bandages	Not payable
60	Lactogen/ infant food	Not payable
61	Slings	Reasonable costs for one sling in case of upper arm fractures may be considered

S. No.	Items	Recommendations
B	**Items Specifically Excluded in Policies**	**Payable/Non Payable**
1	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
3	Dental treatment expenses that do not require hospitalization	Exclusion in policy unless otherwise specified
4	Hormone replacement therapy	Exclusion in policy unless otherwise specified
5	Home visit charges	Exclusion in policy unless otherwise specified
6	Infertility/ sub-fertility/ assisted conception procedure	Exclusion in policy unless otherwise specified
7	Obesity (including morbid obesity) treatment	Exclusion in policy unless otherwise specified
8	Psychiatric & psychosomatic disorders	Exclusion in policy unless otherwise specified
9	Corrective surgery for refractive error	Exclusion in policy unless otherwise specified
10	Treatment of sexually transmitted diseases	Exclusion in policy unless otherwise specified
11	Donor screening charges	Exclusion in policy unless otherwise specified
12	Admission/registration charges	Exclusion in policy unless otherwise specified
13	Hospitalization for evaluation/ diagnostic purpose	Exclusion in policy unless otherwise specified
14	Expenses for investigation/ treatment irrelevant to the disease for which admitted or diagnosed	Exclusion in policy not payable unless otherwise specified
15	Any expenses when the patient is diagnosed with retro virus + or suffering from /HIV/ aids etc is detected/directly or indirectly	Not payable as per HIV / aids exclusion
16	Stem cell implantation/ surgery & storage	Not payable except bone marrow transplantation where covered by policy

S. No.	Items	Recommendations
C	**Items which form part of Hospital services where separate consumables are not payable but the service is**	**Payable/non payable**
1	Ward and theatre booking charges	Payable under OT charges, not payable separately
2	Arthroscopy & endoscopy instruments	Rental charged by the hospital payable. Purchase of instruments not payable.
3	Microscope cover	Payable under OT charges, not payable separately
4	Surgical blades,harmonic scalpel,shaver	Payable under OT charges, not payable separately
5	Surgical drill	Payable under OT charges, not payable separately
6	Eye kit	Payable under OT charges, not payable separately
7	Eye drape	Payable under OT charges, not payable separately
8	X-ray film	Payable under radiology charges, not as consumable
9	Sputum cup	Payable under investigation charges, not as consumable

10	Boyles apparatus charges	Part of OT charges, not separately
11	Blood grouping and cross matching of donors samples	Part of cost of blood, not payable
12	Antiseptic or disinfectant lotions	Not payable-part of dressing charges
13	Band aids, bandages, sterile injections, needles, syringes	Not payable - part of dressing charges
14	Cotton	Not payable-part of dressing charges
15	Cotton bandage	Not payable-part of dressing charges
16	Micropore/ surgical tape	Not payable-payable by the patient when prescribed, otherwise included as dressing charges
17	Blade	Not payable
18	Apron	Not payable -part of hospital services/disposable linen to be part of OT/ ICU charges
19	Torniquet	Not payable (service is charged by hospitals, consumables cannot be separately charged)
20	Orthobundle, gynaec bundle	Part of dressing charges
21	Urine container	Not payable

S. No.	Items	Recommendations
D	**Elements Of Room Charge**	**Payable/Non Payable**
1	Luxury tax	Policy exclusion - not payable. If there is no policy exclusion, then actual tax levied by government is payable - part of room charge for sub limits
2	Hvac	Part of room charge not payable separately
3	House keeping charges	Part of room charge not payable separately
4	Service charges where nursing charge also charged	Part of room charge not payable separately
5	Television & air conditioner charges	Payable under room charges not if separately levied
6	Surcharges	Part of room charge not payable separately. Paid in case of trust hospital if nursing and service charges are to be charged
7	Attendant charges	Not payable - part of room charges
8	IM/ IV injection charges	Part of nursing charges, not payable
9	Clean sheet	Part of laundry/housekeeping not payable separately
10	Extra diet of patient (other than that which forms not payable if it is policy exclusion. Otherwise patient diet provided by part of bed charge)	Hospital is payable
11	Blanket/warmer blanket	Not payable- part of room charges

S. No.	Items	Recommendations
E	**Administrative or Non-medical Charges**	**Payable/Non Payable**
1	Admission kit	Not payable
2	Birth certificate	Not payable
3	Blood reservation charges and ante natal booking charges	Not payable
4	Certificate charges	Not payable
5	Courier charges	Not payable
6	Conveyance charges	Not payable
7	Diabetic chart charges	Not payable
8	Documentation charges / administrative	Expenses not payable
9	Discharge procedure charges	Not payable

10	Daily chart charges	Not payable
11	Entrance pass / visitors pass charges	Not payable
12	Expenses related to prescription on discharge	To be claimed by patient under post -hosp where admissible
13	File opening charges	Not payable
14	Incidental expenses / misc. Charges (not explained)	Not payable
15	Medical certificate	Not payable
16	Maintenance charges	Not payable
17	Medical records	Not payable
18	Preparation charges	Not payable
19	Photocopies charges	Not payable
20	Patient identification band / name tag	Not payable
21	Washing charges	Not payable
22	Medicine box	Not payable
23	Mortuary charges	Payable upto 24 hrs, shifting charges not payable
24	Medico legal case charges (MLC charges)	Not payable

S. No.	Items	Recommendations
F	**External Durable Devices**	**Payable/Non Payable**
1	Walking aids charges	Not payable
2	Bipap machine	Not payable
3	Commode not payable	Not payable
4	CPAP/ CPAD equipments device	Not payable
5	Infusion pump - cost device	Not payable
6	Oxygen cylinder (for usage outside the hospital)	Not payable (in case of post-hospitalization expenses, cost of oxygen prescribed payable, but not the cost of the cylinder)
7	Pulse oxymeter charges device	Not payable
8	Spacer	Not payable
9	Spirometre device	Not payable
10	Spo2 probe	Not payable
11	Nebulizer kit	Not payable
12	Steam inhaler	Not payable
13	Arm sling pouch	Not payable
14	Thermometer	Not payable (paid by patient)
15	Cervical collar	Not payable
16	Splint	Not payable
17	Diabetic foot wear	Not payable
18	Knee braces (long/ short/ hinged)	Not payable
19	Knee immobilizer/shoulder immobilizer	Not payable
20	Lumbo sacral belt	Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine
21	Nimbus bed or water or air bed charges	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/ quadriplegia for any reason and at reasonable cost of approximately Rs 200/day
22	Ambulance collar	Not payable
23	Ambulance equipment	Not payable
24	Microsheild	Not payable
25	Abdominal binder	Essential and should be paid at least in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.

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S. No.	Items	Recommendations
G	**Items Payable If Supported By A Prescription**	**Payable/Non Payable**
1	Betadine \ hydrogen peroxide\spirit\detol \savlon\ disinfectants etc	May be payable when prescribed for patient, not payable for hospital use in ot or ward or for dressings ward or for dressings
2	Private nurses charges- special nursing	Not payable if policy excludes; post hospitalization

	charges	nursing charges not payable
3	Nutrition planning charges - dietician charges- diet charges	If policy excludes diet charges - not payable; patient diet provided by hospital is payable
4	Sugar free tablets	Payable -sugar free variants of admissible medicines are not excluded
5	Cream powder lotion (toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
6	Digestive gel/ antacid gel	Payable when prescribed
7	Ecg electrodes	Upto 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
8	Gloves sterilized gloves	Payable / unsterilized gloves not payable
9	Hiv kit	Payable - pre-operative screening
10	Listerine/ antiseptic mouthwash	Payable when prescribed
11	Lozenges	Payable when prescribed
12	Mouth paint	Payable when prescribed
13	Nebulisation kit	If used during hospitalization is payable reasonably
14	Neosprin	Payable when prescribed
15	Novarapid	Payable when prescribed
16	Volini gel/ analgesic gel	Payable when prescribed
17	Zytee gel	Payable when prescribed
18	Vaccination charges	Routine vaccination not payable / post bite vaccination payable

S. No.	Items	Recommendations
H	**Part of Hospital's own costs and not payable**	**Payable/Non Payable**
1	AHD	Not payable - part of hospital's internal cost
2	Alcohol swabes	Not payable - part of hospital's internal cost
3	Scrub solution/sterillium	Not payable - part of hospital's internal cost
4	Vaccine charges for baby	Not payable
5	Aesthetic treatment / surgery	Not payable
6	Tpa charges	Not payable
7	Visco belt charges	Not payable
8	Any kit with no details mentioned [delivery kit, not payable orthokit, recovery kit, etc]	Not payable
9	Examination gloves	Not payable
10	Kidney tray	Not payable
11	Mask	Not payable
12	Ounce glass	Not payable
13	Outstation consultant's/ surgeon's fees	Not payable, except for telemedicine consultations where covered by policy
14	Oxygen mask	Not payable
15	Paper gloves	Not payable
16	Pelvic traction belt	Should be payable in case of PIVD requiring traction as this is generally not reused
17	Referral doctor's fees	Not payable
18	Accu check (glucometery/ strips)	Not payable. Pre-hospitalization or post-hospitalization / reports and charts required/ device not payable
19	Pan can	Not payable
20	Sofnet	Not payable
21	Trolly cover	Not payable
22	Urometer, urine jug	Not payable
23	Ambulance	Payable as per the terms of the policy
24	Tegaderm / vasofix safety	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
25	Urine bag	Payable where medically necessary till a reasonable cost maximum 1 per 24 hrs
26	Softovac	Not payable

27	Stockings	Essential for case like CABG etc. Where it should be paid.
28	Additional room charges/bed charges for attendant	Not payable
29	Attender bed charges	Not payable
30	Investigation charges not related to the diagnosis	Not payable
31	Iv fluid infusion charges	As nursing charges included in the room charges
32	Multiple consultation charges not related to diagnosed ailments	Not payable
33	RMO charges not payable if visit charges are applied.	Not payable
34	Psychiatric consultation charges	Not payable
35	Anti-d/rho clone etc-immunisation for rh negative mother carrying rh positive baby	Payable only in first pregnancy provided gravida status is l-0, if it is l-1 not payable.
36	Maternity related consultations	Not payable
37	Maternity related expenses	Not payable
38	Ac charges	Not payable
39	Attendant/ayah/ward boy charges	Not payable
40	Body wash	Not payable
41	Electricity charges (levied by hospital)	Not payable
42	Establishment charges	Not payable
43	File charges	Not payable
44	Gate pass charges	Not payable
45	Home nursing charges	Not payable
46	Insurance processing charges	Not payable
47	Registration charges/fee	Not payable
48	Water charges (levided by hospital)	Not payable
49	Naturopathy treatment charges	Not payable
50	Non-allopathic treatment charges.	Not payable
51	Yoga charges	Not payable
52	Surgery for correction of eye sight like myopia/hypermetropia/amblyopia/ presbiopia/atigmatism/strabismus, etc	Payable only under policies where ped is covered by way of deletion of the exclusion or by way of entitlement after lapse of specified period of claim free duration
53	Room fresheners	Not payable
54	Loban	Not payable
55	Nebulization mask	Not payable
56	One touch sure strip	Not payable
57	Under pads	Not payable
58	Alpha bed/water bed etc.	Not payable
59	Ambulatory devices like walker/crutches/wheel chair etc.	Not payable
60	Instrument charges where no details of procedure/instrument used is given.	Not payable
61	Bili blanket	Not payable
62	Bills not in proper format/not serially numbered and printed bill.	Not payable
63	Charges paid to organ donors	Not payable
64	Credit bills-no cash paid receipt.	Not payable
65	Duplicate bills.	Not payable
66	Health drinks-horlicks, viva, bournvita and protein powder including lactogen	Admissible only to the extent prescribed
67	No bills for claimed amount	Not payable
68	Ultroid system	Not payable
69	RMO charges	RMO charges not payable if visit charges are applied.
70	Service charges	Not payable if nursing charges are paid
71	IV administration charge	Not payable if nursing charges are paid
72	IV fluid administration charge	Not payable if nursing charges are paid
73	Injection charges	Not payable if nursing charges are paid
74	Administrative charge	Not payable if nursing charges are paid