EDELWEISS GROUP HEALTH INSURANCE POLICY ENDORSEMENT WORDINGS

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ENDORSEMENT WORDINGS

(SOMETHING TO READ ALONG WITH YOUR POLICY!)

These endorsements as we call them, should be considered and attached as part of your Policy No. _____, unless of course they go against the terms and conditions of the Policy.

Extn No. 1: Family Floater (Indemnity Cover) - – Hospitalization

Good choice, family is everything! You've chosen to give the insured person the family floater facility for the hospitalisation covered under Benefit d1 of the Policy and any endorsements which are limited to the Hospitalization Sum Insured as more specifically mentioned in the relevant endorsement, and you have paid an extra premium for this facility. We're sure the insured person will be grateful. This family floater facility can be used up to the sum insured.

A Family Floater basically means that all the people named in the Policy are covered by a single sum insured. The sum insured, which is stated in the Policy Schedule is the maximum that can be paid during the Policy period, putting together all the claims for all those covered.

The Primary Insured Person means the first insured person named in the Policy (typically, this is your employee). The others covered by the Policy are called secondary members.

All other terms and conditions of the Policy remain unchanged.

Extn No. 2: Pre & Post Hospitalization time period (Indemnity Cover) - – Hospitalization

You've taken good care of the before and after, too! You've paid us an additional premium to change the Pre and Post Hospitalisation period. We've changed it to the period that you asked for.

All other terms and conditions of the Policy remain unchanged.

Extn No. 3: Pre-existing Disease Exclusion Waiver (Indemnity Cover) - – Hospitalization

So what if the insured person already had an illness or condition? You've paid us an extra premium to remove Exclusion e.i.3 from the Policy. We've done so, and agree to waive this exclusion even for new insured persons who may join the Policy later, once the agreed additional premium is paid.

This exclusion includes a complete waiver for pre-existing diseases, for 1 year, 2 years or 3 years , as mentioned in the Policy Schedule.

Extn No. 4: Deletion of 30 days Waiting Period (Indemnity Cover) - – Hospitalization

No waiting is great news! You've paid us an extra premium to remove Exclusion e.i.1.i from the Policy. Thank you! We've done so, and agree to waive this exclusion even for new insured persons who may join the Policy later, once the agreed additional premium is paid.

Extn No. 5: Deletion of Two Year and 90 days waiting period (specific waiting period) (Indemnity Cover)- – Hospitalization

No waiting is great news! You've paid us an extra premium to remove Exclusion e.i.1.ii and e.i.2 from the Policy. We've done so, and agree to waive this exclusion even for new insured persons who may join the Policy later, once the agreed additional premium is paid.

Extn No. 6: Out-Patient/ OPD Treatment (Indemnity Cover)

You've paid us an extra premium to include consultations, medicines, tests, and minor procedures for medical treatment taken on an Out-Patient, up to the amount and sub limit mentioned in the Policy Schedule.

A. Consultation Cover: because the right opinion matters!

We will pay for the Medical Expenses incurred during the Period of Cover for any of the following consultations with or pay for a second opinion from a Medical Practitioner or Healthcare Professional empanelled with our Health Service Provider / Network Provider, in relation to any Illness contracted or Injury suffered by the Insured Person during the Period of Cover. Based on the information given by the Insured Person while availing any of the facilities under this Cover, medicines including over-the-counter medicines, or other suggestions may be given. We will not be liable for medicines or responsible for any misinformation given, or for the medical advice given by the doctor.

Choosing to use this Coverage is totally the Insured Person's choice and is at his/her own risk. The Insured Person is free to choose services under this Coverage, and, once availed of, take a call on whether or not to act on the medical advice/ / suggestions received in whole or in part.
While taking the services under this Cover, the Insured Person can still visit any other independent Medical Practitioner and take the treatment advised by that doctor.

The Policy Certificate will give in writing if there is any limit on the number of consultations which may be taken under this Coverage and if any specific consultations are covered or excluded.

1. GP Consultation with a general doctor, who for the purpose of this Base Benefit, is a Registered Doctor and manages the types of Illnesses that show up in different ways at an early stage of development, but may need a doctor's intervention .
2. Specialist Consultation with a specialist doctor, i.e. an expert doctor in any one or more types of medicine, including specialization in, cardiology, diabetology, endocrinology, ENT, gastroenterology, general surgery, gynecology /obstetrics, internal medicine, nephrology, neurology, ophthalmology, orthopedics, pediatrics, psychiatry, urology, dietitian, nutritionist, dermatology and pulmonology.
3. Physiotherapy Consultation with a doctor qualified to treat any Illness, Injury, or Deformity by physical methods such as massage, heat treatment, and exercise.
4. AYUSH Consultation with a doctor specializing in given AYUSH treatment in any particular mode.
5. Dental Consultation with a dentist who is qualified to treat illnesses of the teeth and gums, particularly the repair and extraction of teeth and the planting of artificial teeth.
6. Counseling Session with a doctor for providing help in dealing with issues such as personal and lifestyle imbalance, speech impairment, and problems related to mental illness.

B. Pharmacy Cover: make sure you take your meds!

We will pay for buying medicines (including over-the-counter medicines), drugs, medical consumables, prosthetics, medically necessary spectacles or cochlear implants, external medical aids, vaccinations, vitamins, tonics or other related products as given in the Policy Schedule from a Network Provider, as long as these are advised by a doctor for any Illness during the Insured Person's Period of Cover.

C. Diagnostic Cover: knowing is everything.

We will pay the costs of Outpatient diagnostics tests including but not limited to biochemistry, hematology, immunology, microbiology, serology, pathology, x-ray, ultrasound and TMT for the Insured Person from a Network Provider during the Period of Cover.
The Policy Schedule will have in writing any limit on the type of medical tests which may be taken under this Coverage and if the Insured Person is required to have a written prescription from a doctor in advance to carry out these tests for any Illness contracted or Injury suffered by the Insured Person during the Period of Cover.

D. Minor Procedures: it's not too small if it's troubling you!

We will pay the cost for any Medical Procedure related to any specialties, including dental procedures, at a Network Provider for any Illness of the Insured Person during the Period of Cover. For this cover, Medical Procedure means: Surgical Procedure and/or non-Surgical Procedure(s) for treatment of an Illness, including but not limited to audiometry, application of cast, cast removal, injection administration, wound switching, retinoscopy, biopsy, drainage of abscess, and any other procedures which can be done on an outpatient basis, except Day Care Treatment and not needing any Hospitalization, performed by a Network Provider.
The Policy Schedule cum Certificate will tell you if there is any limit on the nature and type of Medical Procedures which may be taken under this Coverage.

This Sum Insured is over and above the Hospitalization Sum Insured applicable for In-patient Hospital Services as specified in the Policy Schedule.
• The Insured Person can take OPD Treatment under this Benefit within India. OPD cover will be given by a Network Provider, and we'll try our best to let you get cashless treatment, too.
• Any unused benefits cannot be carried forward to the next Policy Year

Extn No.7 Maternity Treatment Expenses Cover (Indemnity Cover) with 9 months waiting period.

Motherhood will now have an added joy – no expenses of childbirth! You've paid us an extra premium to cover Maternity Treatment expenses. We will reimburse/provide cashless cover to the Primary Insured or spouse / partner, who is mentioned as an Insured Person for maternity costs, benefits during the Policy Period, subject to the following
a) Payment of Maternity Medical Expenses/treatment related to childbirth(including complicated deliveries and caesarian sections incurred during Hospitalization
b) Charges for lawful terminations of pregnancy (abortions) during the Policy Period. This benefit will have a waiting period of nine months from the start of the first Policy with us, for all Insured Person/s who have been continuously covered under this extension or earlier policies under such Scheme issued under the terms & conditions governing Edelweiss general insurance company limited.. Medical expenses of the newborn baby immediately after birth, while in hospital.in connection with any hospitalization treatment
Please note that this benefit will apply only for the first two babies. If the Insured Person already has two children, he/she cannot use this benefit. Of course, if the couple is doubly blessed and has twins from the second delivery, we will still cover all charges.

c) Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule, which is over and above the Hospitalization Sum Insured for In-Patient Hospital Services.
d) We will cover the charges for any hospitalisation caused by involuntary medical termination of pregnancy (abortion), as per MTP Act, 1971 (amended) and other applicable laws and rules.
e) A waiting period of 9 months shall apply to any employee and their dependents, who join the Policy after this cover comes into effect.

Extn No.8 Maternity Treatment Expenses Cover (Indemnity Cover) without 9 months waiting period.

Motherhood will now have an added joy – no expenses of childbirth! You've paid us an extra premium to cover Maternity Treatment expenses. We will reimburse/provide cashless cover to the Primary Insured or legal spouse/ partner, who is mentioned as an Insured Person for maternity costs subject to the following:
a) Payment of Maternity Medical Expenses/treatment related to childbirth (including complicated deliveries and caesarian sections)
b) Charges for lawful terminations of pregnancy (abortions) during the policy period. This benefit will have no waiting period.
c) Medical expenses of the newborn baby immediately after birth, while in hospital.
Please note that this benefit will apply only for the first two babies. If the Insured Person already has two children, he/she cannot use this benefit. Of course, if the couple is doubly blessed and has twins from the second delivery, we will still cover all charges.
d) Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule, which is over and above the Hospitalization Sum Insured for In-Patient Hospital Services.
e) We will cover the charges for any hospitalisation caused by involuntary medical termination of pregnancy (abortion), as per MTP Act, 1971 (amended) and other laws and rules.

Extn No.9 Baby Day One Cover (Indemnity Cover)

You've paid us an extra premium to cover the new born babies of Insured Persons from Day 1. That's so thoughtful of you. Of course, a sufficient advance deposit will have to be kept with us for this cover. You or the Insured Person can also extend the liability of this cover if you choose to. You can choose from:
1) Covering each baby from Day 1, but only up to the Maternity Sum Insured, up to a maximum of three children.
OR
2) Covering each baby from Day 1, up to the full Sum Insured, up to a maximum of three children.
This coverage allows the child to be covered under the Policy from birth. Otherwise, the minimum age for an Insured Person has to be 91 days.

Extn No.10 Baby Covered after 90 days (Indemnity Cover)

You've paid us an extra premium to cover the babies of Insured Persons from the age of 91 days. That's so thoughtful of you. Of course, a sufficient advance deposit will have to be kept with us for this cover. You or the Insured Person can also extend the liability of this cover if you choose to.
You can cover each baby from Day 91, up to the full Sum Insured, up to a maximum of three children.

Extn No 11. Pre and Post Natal Expenses Cover (Indemnity Cover)

Talk about making a mother-to-be feel special! You've paid us an extra premium to cover the Insured Persons or their spouse /partner for pre-natal care from conception till delivery and post-natal inpatient for care 45 days after childbirth, up to the maternity sub limit specified in the Policy Schedule.
This cover includes pre and post-natal medical expenses as an Out-patient, including but not limited to expenses for antenatal check-ups, doctor's consultations for monitoring of during the pregnancy and any complications, arising therefrom up to 5% of the maternity sub-limit specified in the Policy Schedule

Extn No 12. Emergency Ambulance Expenses (Indemnity Cover)

Getting to hospital on time means getting better faster! You've paid us an extra premium to cover the cost of ambulance charges (either Reimbursement or Cashless) for the Insured Person. Please note that such an ambulance transfer should be recommended by the doctor, and is subject to these conditions:
1. The trip should be from the place of the medical emergency to the nearest hospital; and/or
2. It can also be from one hospital to another, where the required care is not available at the first hospital following an emergency.
3. Trip to another hospital or test centre only for check-ups and tests are not covered.
4. The Company has accepted the recipient Insured Person's claim under Benefit d.1 (Hospitalization Expenses).
5. The maximum limit up to Rs. 10,000/- per person applies for the individual Sum Insured and per family for the floater sum insured.

Extn No 13. Additional Sum Insured for Hospitalization due to Critical illness

Disaster can strike anyone, anytime. You've paid us an extra premium to cover the Insured Persons against critical illnesses too. It's a wise move, considering how common these once-rare diseases have become.
The additional Sum Insured under this extension will be available only once the original Sum Insured has been used up, and is subject to the below conditions:
(a) The Insured Person experiences a Critical Illness specifically listed and defined in this Policy; and
(b) The Insured Person is being diagnosed and treated for the first time for this Critical Illness; and
(c) Critical Illness coverage is available for Individual/floater Policy up to the Sum Insured as mentioned in the Policy Schedule

List of "Critical Illness"

1) Cancer of Specified Severity
2) Myocardial infarction (First heart attack of specific severity
3) Open chest coronary artery bypass graft (CABG)
4) Open heart replacement or repair of heart valves
5) Coma of specified severity
6) Kidney Failure Requiring Regular Dialysis
7) Stroke resulting in permanent symptoms
8) Major organ/Bone marrow transplant
9) Permanent Paralysis of limbs
10) Multiple sclerosis with persisting symptoms
11) Angioplasty
12) Benign brain tumor
13) Blindness
14) Deafness
15) End Stage lung failure
16) End Stage liver failure
17) Loss of Speech
18) Third degree Burns

C1- CANCER OF SPECIFIED SEVERITY

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 all malignant tumours, including leukemia, lymphoma and sarcoma.

The following are excluded

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN 2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix. All tumors in the presence of HIV infection.

C2- MYOCARDIAL INFARCTION (First Heart Attack of specific severity)

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

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

C3- OPEN CHEST CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or a minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist

II. The following are excluded

i. Angioplasty and/or any other intra-arterial procedures

C4- OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

The actual undergoing of s open-heart valve surgery to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve The diagnosis of the valve abnormality must be supported by an echocardiography and the realization if surgery has to be confirmed by a specialist medical practitionerCatheter-based techniques, including but not limited to balloon valvotomy/valvuloplasty are excluded.

C5- COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i. no response to external stimuli continuously for at least 96 hours;
   ii. life support measures are necessary to sustain life; and
   iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

C6- KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

C7- STROKE RESULTING IN PERMANENT SYMPTOMS

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

II. The following are excluded:
   i. Transient ischemic attacks (TIA)
   ii. Traumatic injury of the brain
   iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

C8- MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:
   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:
   i. Other stem-cell transplants
   ii. Where only islets of langerhans are transplanted

C9- PERMANENT PARALYSIS OF LIMBS

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

C10- MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE and HIV are excluded

C11- ANGIOPLASTY

I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50% of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

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

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

C12- BENIGN BRAIN TUMOR

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist. i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded:

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

C13- BLINDNESS

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

II. The Blindness is evidenced by:

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

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

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

C14- DEAFNESS

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing" in both ears

C15- END STAGE LUNG FAILURE

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

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

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

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

iv. Dyspnea at rest.

C16- END STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

C17- LOSS OF SPEECH

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, and Throat (ENT) specialist.

II. All psychiatric related causes are excluded.

C18- THIRD DEGREE BURNS

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

Extn No 14. Hospital cash allowance (Benefit)

Even today, for some things only cash will do. You've paid us an extra premium to give us the Insured person a fixed amount of cash, for a maximum of 7 days of stay in a hospital for each Policy year for each continuous and completed period of 24 hours of Hospitalization of the Insured person. We will definitely make this cash available, under the following conditions:

1. The hospitalisation is for more than 3 continuous days.
2. The Company will be liable to pay from the 4th day till the 10th day for a block of continuous Hospitalization arising from Any One Illness or Accident.
3. The Company has accepted the Insured Person's claim under Benefit d.1 (Hospitalization Expenses). The amount limit is minimum Rs. 500/- and maximum up to Rs. 5000/- per day.

Extn No 15. Recovery Benefit (Benefit)

You've paid us an extra premium to pay a fixed amount for a maximum of 10 days' overnight stay in a hospital. Thank you! We will definitely pay this amount, under the following conditions:

1. The hospitalisation is for more than 10 continuous days.
2. We will pay from the 11th to the 20th day, for non-stop hospitalisation needed for one illness or accident.
3. The Company has accepted the recipient Insured Person's claim under Benefit d.1 (Hospitalization Expenses).The amount limit is minimum Rs. 500/- and maximum up to Rs. 5000/- per day

Extn No 16. Assistance Services in India: when you need help, we're right here!

These services are the Insured Person's for the asking when he/she is more than 150 kilometres away from home (the address last known), is within Indian territory, and has not been away from that address for more than 90 days. The services would be given by us through our panel Service Provider, with prior intimation and acceptance by the Company. No claims for reimbursement are accepted: - Exclusion .e.ii.21 given in the base Policy is valid for all Insured Persons covered under this benefit. This benefit may be extended to mid-term joiners and their dependants, on payment of additional premium.

a) Medical Referral: a call is all it takes.

The Insured Person can call our operations centre staff twenty-four hours a day, every day of the year, and rely on help in multiple languages.

b) Emergency Medical Evacuation: let's go further!

When a medical facility is not close to the Insured Person, as advised by the Service Provider's doctor and the Insured Person's doctor, we/our Service Provider will arrange transport under due medical supervision, to the nearest medical facility which can give the needed care within India.

c) Medical Repatriation: there's no place like home.

We/our Service Provider will arrange for the Insured Person to be taken back home in India or to a medical facility near home, under medical supervision, when our Service Provider's doctor and the Insured Person's doctor says that such travel is medically necessary and the Insured Person is medically cleared for travel.

d) Medical Monitoring: keeping a close watch.

Our doctor will check the Insured Person's condition and will (i) stay in regular touch with the attending doctor and/or hospital and (ii) pass on the necessary information to family members.

e) Compassionate Visit: someone close, close by!

When an Insured Person is hospitalised for more than seven (7) continuous days and is traveling in India without a companion, our Service Provider will arrange for a family member or friend to travel economy class to visit the Insured Person. The family member or friend has to arrange for all the travel documents needed.

f) Return of Mortal Remains: the final journey.

In the case of an Insured Person's death away from home but within India, we/our Service Provider will arrange and pay for the return of mortal remains to an authorised funeral home close to the Insured Person's home in India.

g) Second Medical Opinion: always better to double-check

Our Service Provider will arrange for a second medical opinions for an eligible Insured Person in the following cases: (i) when the medical condition is undiagnosed by a treating physician; (ii) when an additional medical opinion is needed following an original diagnosis; and (iii) when a course of treatment is needed based on a current state. The service only includes a medical opinion and does not include personal visits or follow-up discussions for taking the course of treatment advised.

Extn No 17. Reimbursement of Organ donor expenses (Indemnity Cover)

You've paid us an extra premium to cover the hospitalisation costs if an Insured Person needs an organ donation. We salute your generosity! We're happy to provide this cover through cashless or reimbursement, under the following conditions:

1. The donation conforms to The Transplantation of Human Organs Act 1994 and its amendments thereafter, and the organ is for the use of the Insured Person.
2. The Insured Person receiving the organ has been advised by a doctor to undergo an organ transplant.
3. The Company has accepted the recipient Insured Person's claim under Benefit d.1 (Hospitalization Expenses).

The maximum cover will be as specified in the Policy Schedule.

Unfortunately, we can't pay for the following:

1. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
2. Screening or any other Medical Expenses of the organ donor.
3. Costs directly or indirectly associated with getting the donor's organ.
4. Transplant of any organ/tissue where the transplant is experimental or investigational.
5. Expenses related to transporting or preserving an organ.
6. Any other medical treatment or complication that happens to the donor after donation.

Extn No 18. Voluntary Co payment

We agree that the Insured Person will pay a part of the treatment cost (a small part, don't worry!) and we will pay the rest, subject to the terms and conditions of the Policy.

Extn No 19. Personal Accident Cover

In consideration of additional premium received by the Company and realization thereof from the Insured/ Insured Person ,the Policy shall provide compensation to the Insured Person, his or her nominee or legal representatives, as the case may be, the sum or sums as set forth in the Tables of Benefits below, subject to the Capital Sum Insured as specified in the Policy Schedule being the maximum liability of the Company towards Injury, solely and directly from Accident and resulting in death or disability within 12 (twelve) calendar months of occurrence of such Injury. The compensation under more than one clause for same period of disability shall not exceed the Capital Sum Insured.

The Insured Person can select any of the coverage options below:

Option I: Accidental death, permanent total disability, permanent partial disability and temporary total disability

Option I: Accidental death, permanent total disability and permanent partial disability.

1. Accidental Death If an Insured Person suffers an Accident during the Policy Period and this is the sole and direct cause of his death within twelve calendar months from the date of the Accident, then We will pay the Capital Sum Insured as mentioned in the Policy Schedule.

Accidental Death – Table of Benefits	
Loss of	% of CSI
Accidental Death	100%

2. Permanent Total Disability

If an Insured Person suffers from an accidental injury during the Policy Period and within twelve calendar months from the date of Accident, which is the sole and direct cause of his Permanent Total Disability in one of the ways detailed in the table below, We will pay the percentage of the Capital Sum Insured shown in the table. In this benefit.

i) Limb means a hand at or above the wrist or a foot above the ankle.

ii) Loss of Limb means physical separation of a limb above the wrist or ankle respectively

Permanent Total Disability – Table of Benefits	
Loss of	**% of CSI**
Limbs (both hands or both feet or one hand and one foot)	100%
Loss of a Limb and an eye	100%
Complete and irrecoverable loss of sight of both eye	100%
Complete and irrecoverable loss of speech & hearing of both ears	100%

3. Permanent Partial Disability

If an Insured Person suffers from an accidental injury during the Policy Period and within twelve calendar months from the date of the Accident this is the sole and direct cause of his Permanent Partial Disability in one of the ways detailed in the table below, then We will pay the percentage of the Capital Sum Insured shown in the table

Permanent Partial Disability – Table of Benefits	
Loss of	% of CSI
Each arm at the shoulder joint	70%
Each arm to a point above elbow joint	65%
Each arm below elbow joint	60%
Each hand at the wrist	55%
Each thumb	20%
Each index finger	10%
Each other finger	5%
Each leg above center of the femur	70%
Each leg up to a point below the femur	65%
Each leg to a point below the knee	50%
Each leg up to the center of tibia	45%
Each foot at the ankle.	40%
Each big toe	5%
Each other toe	2%
Each eye	50%
Hearing in each ear	30%
Sense of smell	10%
Sense of taste	5%
Any other Permanent Partial Disability	Percentage as assessed by the registered medical practitioner

4. Temporary Total Disability

If an Insured Person suffers an accidental injury during the Policy Period which is the sole and direct cause of a Temporary Total Disability which completely prevents him/her from performing each and every duty pertaining to his/her employment or occupation of any description whatsoever, then We will pay a weekly benefit, provided that:

- The temporary total disability is certified by the treating Doctor, and
- We will pay this weekly amount for a maximum of 104 weeks from the date of accident.

A. Risk Categorization

Risk Group I:

Doctors, Lawyers, Accountants, Architects, Consulting engineers, Teachers, Bankers, Builders, Contractors, Engineers on site engaged in superintending functions only, Veterinary Doctors, business owners wherein the business is not dealing in hazardous goods or not involving manual labor, Persons engaged in clerical functions & administrative functions and such other persons engaged in occupations of similar hazard listed above.

Risk Group II:

Professional Athletics & Sportsmen, Wood working Machinists, Workers, Mechanics, Drivers, and Manual labourers (except those falling under Group III) & such other persons engaged in occupation of similar hazard listed above.

Risk Group III:

Persons working in underground mines, explosives, magazines, workers involved in electrical installation with high tension supply, demolition workers, Jockeys, Circus personnel, Persons engaged in activities like racing on wheels or horseback, big game hunting, mountaineering, winter sports, skiing, ice hockey, ballooning, hand gliding, river rafting, polo, persons working as Air Crew and Ship Crew, and such other persons engaged in occupation of similar hazard listed above.

Where a group of heterogeneous persons are covered, the risk group consideration will be based on the occupation of individual members, where detailed occupational information is available or on the occupation of majority of group members where more than 50% of the group can be classified as belonging to any of the risk groups above. Acceptance of group and loading up to 50% may will be apply as per the underwriting decision and risk group criteria.

C. Special Exclusions applicable to this Endorsement

In addition the General Exclusions listed in the Policy attached this endorsement section shall not cover:

a. In the event the Insured Person is a victim of culpable homicide, i.e. where he dies due to act committed against him, which act is committed with the intention of causing death or with the intention of causing Accidental Injury as is likely to cause death, or with the knowledge that such act is likely to cause death.

b. Any claim of the Insured Person

(i) from intentional self-injury, suicide or attempted suicide

(ii) Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl-12

(iii) Hazardous or Adventure sports - Code- Excl-09

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

(iv) directly caused by venereal disease, insanity

c. Death or disability resulting directly or indirectly caused by, contributed to or aggravated or prolonged by child birth or from pregnancy excluding ectopic pregnancy.

d. Breach of law- Code- Excl-I0

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

e. Any claim arising out of war, civil war, invasion, insurrection, revolution, act of foreign enemy, hostilities (whether War be declared or not), rebellion, mutiny, use of military power or usurpation of government or military power

f. Any claim arising out of Insured Person(s) serving in any branch of the Military or Armed Forces of any country during war or warlike operations.

g. Any claim caused by or contributed to or arising from -

(i) ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel and for the purposes hereof, combustion shall include any self-sustaining process of nuclear fission; or

(ii) nuclear weapons material

h. Any loss whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular Scheduled airline or Air Charter Company.

i. We shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose us to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

The above limit is over and above the Hospitalization Sum Insured applicable for In-patient Hospital Services.

Extn No 20. Wellness and prevention: it's always better than a cure!

You've paid us an additional premium to provide services that help the Insured Person(s) stay in better health and improve their quality of life. The Insured Persons can enjoy these wellness benefits, only if the Group has opted for such benefit(s) at the time of buying this Policy. The benefits will be available on cashless basis only.

GENERAL CONDITIONS APPLICABLE Wellness and preventive care

1. Where any of the services given under this Section are arranged by Us through our Network Providers, we will not be responsible for any loss or damage caused by any opinion, actual or alleged mistakes, omissions and representations made by the Network Provider. Information about the benefits, as well as tips on general health, will be sent through various modes of communication.
2. The Insured Person is free to choose whether or not to take services under this Section, and, if taken, whether or not to act on the advice received.
3. Based on the information given by the Insured Person while taking any of the features under wellness, medicines, including over-the-counter medicines or other suggestions, may be given or suggested. We will not be responsible for this information and advice.
4. The Insured Person should get help from a doctor when interpreting these suggestions and applying them to his/her life/ medical condition. If the Insured Person has any concerns about his/her health, he/she should consult a doctor immediately.
5. After taking services under this Section, the Insured Person is free to visit other independent doctors and start/continue any treatment advised by these doctors.
6. The services we offer under this Section will be on a 'best effort' basis.

We're happy to do more for your employees, and here are some of the ways we help them stay healthier:

A. Outpatient Consultation: You're never 'out' of our thoughts!

This policy offers Outpatient Consultation to the Insured Person. However, this can only be taken on a cashless basis through us or our Network Provider.

Outpatient Consultation means a visit and consultation with a general medical practitioner, specialist doctor, physiotherapist, dentist or ophthalmologist.

i) Wellness consultation & preventive consultation means any off-site or on-site awareness/training/education program on complete wellbeing, including physical fitness, diet and nutrition, spiritual, occupational, environmental, financial, social and mental wellbeing and safety related parameters, and also vaccinations by relevant Healthcare Professionals.

ii) Lifestyle management programs like how to stop smoking, stress management, etc. to educate the Insured Persons to become more aware of their health and proactively manage it. Each Insured Person will have access to a wellness coach. These programs will be app/web/chat/call based with/without the use of wearable devices.

iii) Disease management programs will be designed to advise Insured Person(s) with any chronic disease or borderline cases such as asthma, diabetes, depression, hypertension, cardiac problems, etc. These programs will help them become more aware about their health and proactively manage it. Each Insured Person will have access to a wellness coach. There will be no cash reimbursement available against this benefit.

iv) Telephonic/Virtual Consultation will mean any consultation given by a doctor through a virtual medium, such as audio, video, online portal, chat or mobile application for a routine health query or for first and second opinions. This will also include consulting a professional expert through a hotline number for any social, mental, emotional, and environmental or other issue faced by the Insured Person which affects his/her wellbeing. This facility is meant to give him/her access to consultations, and is not a substitute for meeting a doctor. Consultation with doctors will be available when needed, through our network providers' helpline. Based on the information given by the Insured Person, medicines, including over-the-counter medicines or other suggestions, may be given. We will not be responsible for any inaccuracy in the advice or information given.

B. Routine Physical & Preventive Health Examination: keep it all in check!

We will cover the cost of routine Physical and Preventive Examinations mentioned in this Policy Schedule during the Period of Cover, on a cashless basis and within India only. For this benefit, Routine Physical and Preventive Examinations will mean on-site or off-site check-ups of all health parameters given below.

Any unutilized benefit will not carried forward to the next Policy Year.

<table>
<tr><th>Set I</th><th>Set II</th></tr>
<tr><td>CBC, ESR + RUA + Lipid Profile + Serum.
Creatinine + HbA1c + ECG</td><td>CBC,ESR + RUA + Lipid Profile + Sr.
Creatinine + HbA1c + ECG</td></tr>
<tr><th colspan="2">Set III</th></tr>
<tr><td colspan="2">CBC,ESR + RUA + Lipid Profile + Sr Creatinine + HbA1c + ECG + LFT</td></tr>
<tr><th>Set IV</th><th>Set V</th></tr>
<tr><td>CBC, ESR + RUA + Lipid Profile + RFT +
HbA1c + LFT + ECG+ Chest X Ray</td><td>CBC, ESR + RUA + Lipid Profile
+RFT+HbA1c+ LFT+ TMT+ Chest X Ray +
Tumour marker</td></tr>
<tr><td colspan="2">RUA (Routine Urine Analysis), CBC, ESR (Complete Blood Count, Erythrocyte Sedimentation Rate), Lipid profile, ECG (Electrocardiogram), Serum Creatinine, HbA1c- Glycosylated Haemoglobin, ECG - Electrocaridiogram, LFT- Lung Function Test, RFT - Renal Function Test, TMT - Tread Mill Test</td></tr>
</table>

Extn No 21. Disease wise Sublimit (indemnity cover)

Voluntary inclusion of sub limits for below disease: (these are all independent add-ons and or a combination of any or all these diseases & customer can select any of the sublimit option from respective diseases.)

Disease	Sub Limits options				
Cataract	20,000	25,000	30,000	35,000	40,000
Hysterectomy	25,000	30,000	35,000	40,000	45,000
Removal of Gall Bladder	25,000	30,000	35,000	40,000	45,000
Surgery for Piles	15,000	20,000	25,000	30,000	40,000
Surgery for Fissure, Fistula	15,000	20,000	25,000	30,000	35,000
Angiography Invasive	15,000	20,000	25,000	30,000	35,000
PTCA	1,40,000	1,50,000	1,60,000	1,70,000	1,80,000
Appendectomy	30,000	35,000	40,000	45,000	50,000
D & C	10,000	12,000	15,000	17,000	20,000
Hernia	25,000	30,000	35,000	40,000	45,000
Deviated Nasal Septum and Sinus	25,000	27,000	30,000	32,000	40,000
Surgery for Renal Stone	35,000	40,000	45,000	50,000	60,000
Prostate Surgery TURP	30,000	35,000	40,000	45,000	50,000
CABG		1,75,000	2,00,000	2,25,000	2,50,000
Bilateral Total Knee / Hip Replacement		2,00,000	2,25,000	2,50,000	2,75,000

Extn No 22. Room rent capping

We agree to cover the Insured Person's hospital room rent up to the percentage and per day amount mentioned in the Policy Schedule. If the room rent is higher than what we have agreed on, the Insured Person will have to pay the difference.
All other terms and conditions of the Policy remain unchanged.

Extn No 23. LASIK Surgery expenses (indemnity cover)

You've paid us an extra premium to cover the Insured Persons for LASIK surgery, in case of compound myopic astigmatism, to the level of refractive errors specified, As per request by customer/proposer, underwriters will specify below conditions in policy documents provided to customer, to confirm the liability under the policy
Level of refractive errors

- Beyond +/- 0.75 Dioptre
- Beyond +/-3.5 Dioptre

Extn No 24. Infertility Treatment Cover (indemnity cover)

The joy of parenthood is incomparable! We're happy that you have paid us an extra premium to cover the Insured Person for infertility treatment, including Invitro fertilization (IVF), Gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment. This extension would also cover embryo transport, donor ovum and semen and related costs, including collection and preparation, required towards treatment related to infertility and sterilization, up to the amount mentioned in the Policy Schedule. The Insured Person should be between 18 and 50 years old.

This sub limit is a part of the hospitalization Sum Insured for in-patient treatment.

Extn No 25. Recharge of the Sum Insured (indemnity cover)

Sometimes, getting better takes a lot more than we expected. You've paid us an extra premium to Recharge the Sum Insured by 100%, in case the original Sum Insured is all used up in treatment. Subject to the conditions specified below:

1. The Recharge Benefit can be used for Benefit d.1 (Hospitalization Expenses), Benefit d.2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses), Benefit d.3 (Day Care treatment), Benefit d.4(Domiciliary Hospitalization), Benefit d.5 (AYUSH)
2. The Recharge Benefit can be used for the same treatment on which the original Sum Insured was spent.
3. If the Recharge Benefit isn't used, it can't be carried forward to the next year.
4. The No Claim Bonus won't be considered while calculating the Recharge Sum Insured.
5. For Individual policies, the recharged Sum Insured will be available on an individual basis, whereas in case of a Family Floater Policy, it will be available on a floater basis.
6. In case of Portability, the credit for continuity in Sum Insured would be available only to the extent of Sum Insured of the expiring Policy.
7. If the Insured Person has the Restoration Benefit as well, he/she does not need to use this up first for the Recharge Benefit to kick in. If the Sum Insured is used up, we will not take into account the Restoration Sum Insured.

Extn No 26. Restoration of the Sum Insured (indemnity cover)

Sometimes, getting better takes a lot more than we expected. You've paid us an extra premium to restore the Sum Insured by 100%, in case the original Sum Insured is all used up in treatment. This restored Sum Insured cannot be used for the same illness/accident that the Insured Person was treated for during the Policy year.

1. The Restoration Benefit can be used for Benefit d.1 (Hospitalization Expenses), Benefit d.2 (Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses), Benefit d.3 (Day Care treatment), Benefit d.4 (Domiciliary Hospitalization), Benefit d.5 (AYUSH)
2. Restoration can't be used for the first claim the Insured Person makes.
3. If the Restoration Benefit isn't used, it can't be carried forward to the next year.
4. For Individual policies, the restored Sum Insured will be available on an individual basis, whereas in case of a Family Floater Policy, it will be available on a floater basis.
5. For any single claim during a policy year, the maximum you can claim for is Sum Insured.
6. In a Policy year, the amount of all the claims put together should not be more than the total of :
   i. The Sum Insured
   ii. The Restored Sum Insured.

In case of Portability, the credit for continuity in Sum Insured would be available only to the extent of Sum Insured of the expiring Policy, including Restoration

Extn No 27. Corporate Buffer (Indemnity Cover)

You've paid us an extra premium for extra emergencies! In exchange for this, we've set up what is called a Corporate Buffer. This covers the Insured Person (and his/her family) in case the cost of treatment is more than the Sum Insured. This buffer can't be used for the treatment of conditions, or for procedures, which already have a sub-limit under your Policy. Liability of the insurance company will be as per the conditions specified in the policy document

Extn No 28. Cochlear Implant

You've paid us an extra premium to cover the Insured Persons in case he/she needs this procedure.

As per request by customer/proposer underwriters will specify below conditions in policy documents provided to customer, to confirm the liability under the policy.

Acceptance of coverage with,

- Cover upto SI
- Cover with restriction on SI
- Cover with co-pay

Extn No 29. Sleep Apnoea

The extra premium paid by You will cover the Insured Persons in case he/she needs this procedure.

As per request by customer/proposer underwriters will specify below conditions in policy documents provided to customer, to confirm the liability under the policy.

Acceptance of coverage with,

- Cover upto SI
- Cover with restriction on SI
- Cover with co-pay