

INDUSIND HEALTH SURROGATE AND OOCYTE DONOR RIDER - POLICY WORDING

PREAMBLE

- i. This Policy is a contract of insurance issued by IndusInd General Insurance Company Limited (hereinafter called the 'Company') to the proposer mentioned in the schedule to cover the person named in the schedule (hereinafter called the 'Insured Person'). The policy is based on the statements and declaration provided in the proposal form for this Rider and is subject to receipt of the requisite premium
- ii. It is agreed and understood that this Rider can be bought along with the Base Policy and cannot be bought in isolation or as separate product.
- iii. Termination of the Base Policy shall lead to termination of this Rider.

OPERATIVE CLAUSE

If during the policy period the Insured Person is required to be hospitalized for treatment of an illness or injury at a Hospital/ Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically necessary, expenses towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured opted and Cumulative Bonus (if any) specified in the Schedule.

DEFINITIONS

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

3.1. STANDARD DEFINITIONS

1. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Any One Illness** means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where treatment has been taken.
3. **AYUSH Treatment** refers to hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
4. **An AYUSH Hospital** is a healthcare facility wherein medical/ surgical/Para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
 - a) Central or State Government AYUSH Hospital or
 - b) Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/ Central Council for Homeopathy; or
 - c) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine,

registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

- i. Having at least 5 in-patients beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iv. Maintaining daily records of the patient and making them accessible to the insurance company's authorized representative.
5. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
 - i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
 - ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
 6. **Bank Rate:** means bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.
 7. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period
 8. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured person in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.
 9. **Complainant** means a **Policyholder** or prospect or any beneficiary of an insurance policy who has filed a **Complaint or Grievance** against the **Company** or a **Distribution Channel**.
 10. **Complaint or Grievance** means written expression (includes communication in the form of electronic mail or other electronic scripts), of dissatisfaction by a Complainant with insurer
 11. **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.
 12. **Congenital Anomaly** refers to a condition(s) which is present



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- since birth, and which is abnormal with reference to form, structure or position.
- a. **Internal Congenital Anomaly**
Congenital anomaly which is not in the visible and accessible parts of the body
 - b. **External Congenital Anomaly**
Congenital anomaly which is in the visible and accessible parts of the body
13. **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
 14. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
 15. **Day Care Centre** means any institution established for day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:
 - i. Has qualified nursing staff under its employment;
 - ii. Has qualified medical practitioner (s) in charge;
 - iii. Has a fully equipped operation theatre of its own where surgical procedures are carried out
 16. Maintains daily records of patients and shall make these accessible to the Company's authorized personnel. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
 - i. Undertaken under general or local anaesthesia in a hospital/ day care centre in less than twenty four hours because of technological advancement, and
 - ii. Which would have otherwise required a hospitalisation of more than twenty four hours.
Treatment normally taken on an out-patient basis is not included in the scope of this definition.
 17. **Dental Treatment** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.
 18. **Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
 19. **Distribution Channels**, intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such insurer, **Distribution Channels**, intermediaries, insurance intermediaries or other regulated entities.
 20. **Explanation:** An inquiry or request would not fall within the definition of the "Complaint" or "Grievance".
 21. **Emergency Care:** Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.
 22. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
 23. **Hospital** means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:
 - i. Has qualified nursing staff under its employment round the clock;
 - ii. Has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
 - iii. Has qualified medical practitioner (s) in charge round the clock;
 - iv. Has a fully equipped operation theatre of its own where surgical procedures are carried out
 - v. Maintains daily records of patients and shall make these accessible to the Company's authorized personnel.
 24. **Hospitalisation** means admission in a hospital for a minimum period of twenty four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.
Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.
 - i. **Acute Condition** means 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.
 - ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
 - a) It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
 - b) it needs ongoing or long-term control or relief of symptoms
 - c) It requires rehabilitation for the patient or for the patient to be specially trained to cope with it
 - d) It continues indefinitely
 - e) It recurs or is likely to recur
 25. **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.
 26. **In-Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
 27. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
 28. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivists charges.
 29. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.
 30. **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.
31. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the licence.
32. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
- Is required for the medical management of illness or injury suffered by the insured;
 - Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - Must have been prescribed by a medical practitioner;
 - Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
33. **Network Provider** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.
34. **Non- Network Provider** means any hospital that is not part of the network.
35. **Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.
36. **Out-Patient (OPD) Treatment** means treatment in which the insured visits a clinic/hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a medical practitioner. The insured is not admitted as a day care or in-patient.
37. **Pre-Existing Disease (PED):** means any condition, ailment, injury or disease:
- That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
 - For which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.
38. **Pre-hospitalisation Medical Expenses** means medical expenses incurred during the period of 30days preceding the hospitalisation of the Insured Person, provided that:
- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
 - The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.
39. **Proposal Form** means a form to be filled in by the Prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.
Explanation: "Material Information" shall mean all important, essential and relevant information sought by the Company in the proposal form and other connected documents to enable him to take informed decision in the context of underwriting the risk
40. **Prospectus** means a document either in physical or electronic or any other format issued by the insurer to sell or promote the insurance products
41. **Post-hospitalisation Medical Expenses** means medical expenses incurred during the period of 60days immediately after the insured person is discharged from the hospital provided that:
- Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and
 - The inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.
42. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.
43. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India
44. **Reasonable & Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved
45. **Renewal:** Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
46. **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.
47. **Surgery or Surgical Procedure** means manual and/or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.
48. **Unproven/ Experimental Treatments** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
- 3.2. SPECIFIC DEFINITIONS**
- Age** means age of the Insured person on last birthday as on date of commencement of the Policy.
 - Annexure** means document attached and marked as Annexure to this Policy.
 - Assisted Reproductive Technology (ART) Clinic** means any premises equipped with requisite facilities and medical practitioners registered with the National Medical Commission for carrying out the procedures related to the assisted reproductive technology as per the provisions of The Assisted Reproductive Technology (Regulation) Act, 2021
 - Base Policy:** "Base Policy" means the Insurance Policy issued by Company including its terms and conditions, any annexure, any endorsement if any to which this Rider is attached.
 - Claim** means a demand made by the Insured Person or on his behalf, for payment of Medical Expenses under any other Benefit, as covered under the Policy.
 - Company** means IndusInd General Insurance Company Limited.
 - Insured Person** means person named as such in the schedule, and who is the Surrogate or the Oocyte Donor.
 - Intending Couple** as per the provisions of The Assisted Reproductive Technology (Regulation) Act, 2021 and The Surrogacy (Regulation) Act, 2021
 - Intending Woman** as per the provisions of The Assisted Reproductive Technology (Regulation) Act, 2021 and The Surrogacy (Regulation) Act, 2021
 - Oocyte** means naturally ovulating oocyte in the female genetic tract.

11. **Oocyte Donor** means Oocyte Donor as per the provisions of The Assisted Reproductive Technology (Regulation) Act, 2021
12. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person
13. **Policyholder** means the person who is the Proposer and whose name specifically appears in the Policy Schedule as such. For the purpose of this Policy, the Policyholder shall be one of the Intending Couple or the Intending Woman.
14. **Policy Period** means the period commencing from the Policy Period Start Date of this Rider as specified in Policy Schedule and ending on the Policy Period End Date as specifically appearing in the Policy Schedule or on the date of cancellation of the Policy, whichever is earlier.
15. **Policy Period End Date** means the date and time at which the Policy Period ends as specified in the Policy Schedule.
16. **Policy Period Start Date** means the date and time at which the Policy Period commences as specified in the Policy Schedule.
17. **Policy Schedule** means the Policy Schedule attached to and forming part of Policy
18. **Policy year** means a period of twelve months beginning from the date of commencement of the Policy Period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule
19. **Screening** means the genetic test performed on embryos produced through in-vitro fertilisation.
20. **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit.
21. **Sum Insured** means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person.
22. **Surrogacy** means a practice whereby one woman bears and gives birth to a child for an intending couple with the intention of handing over such child to the Intending Couple after the birth.
23. **Surrogacy Clinic** means centre or laboratory which has been registered under The Surrogacy (Regulation) Act, 2021, conducting assisted reproductive technology services, invitro fertilisation services, genetic counselling centre, genetic laboratory, Assisted Reproductive Technology Banks conducting surrogacy procedure or any clinical establishment, by whatsoever name called, conducting surrogacy procedures in any form
24. **Surrogate Mother/Surrogate** means **Surrogate Mother** as per the provisions of The Surrogacy (Regulation) Act, 2021 and any revisions thereof.
25. **Third Party Administrator (TPA)** means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.
26. **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

COVERAGE

The covers listed below are in-built Policy benefits and shall be

available to the Insured Person in accordance with the procedures set out in this Policy.

4.1. HOSPITALISATION EXPENSES

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

- i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital /Nursing Home up to 2% of the sum insured subject to maximum of ₹5000/-, per day.
- ii. Intensive Care Unit (ICU) /Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of ₹ 10,000/- per day.
- iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor/ surgeon or to the hospital
- iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Other expenses

- i. Expenses incurred on treatment of cataract subject to the sub limits
- ii. Dental treatment necessitated due to disease or injury
- iii. Plastic surgery necessitated due to disease or injury
- iv. All the day care treatments
- v. Expenses incurred on road Ambulance subject to a maximum of ₹2000/- per hospitalisation

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment
2. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

4.2. AYUSH TREATMENT

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

4.3. CATARACT TREATMENT

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or ₹40,000/-, whichever is lower, per each eye in one policy year.

4.4. PRE-HOSPITALISATION

The Company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

4.5. POST HOSPITALISATION

The Company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

4.6. MODERN TREATMENT

The following procedures will be covered (wherever medically

indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the Policy Schedule, during the Policy Period:

- i. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
- ii. Balloon Sinuplasty
- iii. Deep Brain stimulation
- iv. Oral chemotherapy
- v. Immunotherapy- Monoclonal Antibody to be given as injection
- vi. Intra vitreal injections
- vii. Robotic surgeries
- viii. Stereotactic radio surgeries
- ix. Bronchical Thermoplasty
- x. Vaporisation of the prostate (Green laser treatment or holmium laser treatment) K.
- xi. IONM - (Intra Operative Neuro Monitoring)
- xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

4.7. The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

5. CUMULATIVE BONUS

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

Notes:

- i. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn

6. WAITING PERIOD

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

6.1. PRE-EXISTING DISEASES (CODE- EXCL 01)

- i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
- ii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- iii. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

This exclusion shall not apply in case of medical complications arising within 6 weeks of childbirth through Surrogacy.

6.2. FIRST THIRTY DAYS WAITING PERIOD (CODE- EXCL 03)

- i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
- ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

- iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

6.3. SPECIFIC WAITING PERIOD (CODE- EXCL 02)

- a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.
- b) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
- c) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- d) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

i. 24 months waiting period

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age-related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. Internal Congenital Anomalies

36 Months waiting period

- 1) Treatment for joint replacement unless arising from accident
- 2) Age-related Osteoarthritis & Osteoporosis

7. EXCLUSIONS

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

7.1. STANDARD EXCLUSIONS

7.1.1. INVESTIGATION & EVALUATION (CODE: EXCL04)

- i. Expenses related to any admission primarily for diagnostics and evaluation purposes
- ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

7.1.2. REST CURE, REHABILITATION AND RESPITE CARE (CODE: EXCL05)

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

- i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
- ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

7.1.3. OBESITY/ WEIGHT CONTROL (CODE: EXCL 06):

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
 - a) Greater than or equal to 40 or
 - b) Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type2 Diabetes

7.1.4. CHANGE-OF-GENDER TREATMENTS (CODE: EXCL 07):

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex

7.1.5. COSMETIC OR PLASTIC SURGERY (CODE: EXCL 08):

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

7.1.6. 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.

7.1.7. BREACH OF LAW (CODE: EXCL 10):

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

7.1.8. EXCLUDED PROVIDERS (CODE: EXCL 11):

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholder/ Insured Person are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.(For updated and detailed list of Excluded Providers refer website- www.indusindinsurance.com)

7.1.9. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof **(CODE: EXCL 12):**

7.1.10.Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as

a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(CODE: EXCL 13)**

7.1.11.Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(CODE: EXCL 14):**

7.1.12.REFRACTIVE ERROR (CODE: EXCL 15)

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

7.1.13.UNPROVEN TREATMENTS-CODE (CODE: EXCL 16)

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

7.1.14.STERILITY AND INFERTILITY (CODE: EXC L7):

Expenses related to sterility and infertility. This includes:

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

7.1.15.MATERNITY EXPENSES (CODE - EXCL 18)

- i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- ii. expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

7.2. SPECIFIC EXCLUSIONS

7.2.1. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

7.2.2. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

- a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.
- b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any illness, incapacitating disablement or death.
- c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.

7.2.3. Any expenses incurred on Domiciliary Hospitalization and OPD treatment.

7.2.4. Treatment taken outside geographical limits of India.

7.2.5. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), Insured Person is not entitled to get the coverage for specified ICD codes.

7.2.6. Any Surrogacy or Oocyte donation procedure carried out outside geographical limits of India.

7.2.7. Screening and processing charges for Surrogacy and Oocyte donation shall not be payable.

7.2.8. Costs associated with surrogacy and Oocyte donation procedure itself and the associated maternity expenses shall not be payable.

CLAIMS PROCEDURE

8.1. PROCEDURE FOR CASHLESS CLAIMS:

- i. Treatment may be taken in a network provider and is subject to pre-authorization by the Company or its authorized TPA.
- ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.
- iii. The Company/ TPA upon getting cashless request form and related medical information from the Insured Person/ network provider will issue pre-authorization letter to the hospital after verification.

The Pre-auth request shall be processed after having obtained accurate and complete information for the Illness/ Injury for which Cashless facility for Hospitalization is being sought and the TPA/Company will confirm such Cashless authorization/ rejection in writing or by other means. There may be initial partial approval of the cashless amount requested which can be enhanced subsequently subject to review of the utilization.

If the procedure above is followed and the request for Cashless is authorized, the Insured Person shall not be required to pay for the Hospitalization Expenses which are covered under this Policy and fall within the Company's liability (within the authorized limit). Original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.

- iv. The TPA/Company reserves the right to review each Claim for Hospitalization Expenses and coverage will be determined according to the terms and conditions of this Policy. The Insured Person shall, in any event, be required to settle all other non-medical and inadmissible expenses, co-payment and / or deductibles (if applicable), directly with the Hospital.
- v. There can be instances where the TPA/Company may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case the Insured Person may be required to pay for the treatment and submit the Claim for reimbursement to the TPA/ Company which will be considered subject to the Policy Terms & Conditions.
- vi. The documents mentioned under 8.4 Documents to be submitted are required to be submitted to the Company.

Note: Under Cashless facility, the TPA/Company may authorize upon the request for direct settlement of admissible Claim as per agreed charges & terms and conditions between Network Hospital and the TPA/Company. In such cases, the TPA/Company will directly settle all eligible amounts as per the Policy Terms & Conditions with the Network Hospital to the extent the Claim is covered under the Policy.

The TPA/Company, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Insured Person is required to check the applicable list of Network Hospital on the TPA/Company's website.

8.2. PROCEDURE FOR REIMBURSEMENT OF CLAIMS

For reimbursement of claims the insured person may submit the

documents to TPA (If applicable)/ Company within the prescribed time limit as specified hereunder.

Sr. No.	Type of claim	Prescribed Time Limit
1.	Reimbursement of hospitalization, day care and pre hospitalization expenses	Within fifteen days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

8.3. NOTIFICATION OF CLAIM

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

- i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
- ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

The following details are to be provided to the TPA/Company at the time of intimation of Claim:

- a. Policy Number
- b. Name of the Policyholder,
- c. Name of the Insured Person in whose relation the Claim is being lodged.
- d. Nature of Illness / Injury
- e. Name and address of the attending Medical Practitioner and Hospital
- f. Date of Admission to Hospital or proposed date of admission to Hospital for Planned Hospitalization
- g. Any other information as requested by the Company.

8.4. DOCUMENTS TO BE SUBMITTED

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

- i. Duly Completed claim form, in original
- ii. Photo Identity proof of the patient
- iii. Photo Identity proof of the Intending Couple or Intending Woman
- iv. Medical Practitioner's referral letter advising Hospitalization
- v. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation
- vi. Original bills with itemized break-up
- vii. Payment receipts
- viii. Discharge summary including complete medical history of the patient along with other details.
- ix. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
- x. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
- xi. Sticker/Invoice of the Implants, wherever applicable.
- xii. Indoor case papers
- xiii. Ambulance receipt and bill
- xiv. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, where ever applicable.
- xv. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
- xvi. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
- xvii. Legal heir/succession certificate, wherever applicable
- xviii. Proof of Surrogacy/Oocyte donation including the date of

procedure

- xix. Details of Surrogacy/ART clinic
- xx. Any other relevant document required by Company/TPA for assessment of the claim.

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

8.5. SERVICES OFFERED BY TPA

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy,

The services offered by a TPA shall not include

- i. Claim settlement and claim rejection;
- ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

8.6. PAYMENT OF CLAIM

All claims under the policy shall be payable in Indian currency only.

GENERAL TERMS AND CONDITIONS

9.1. STANDARD GENERAL TERMS AND CONDITIONS

9.1.1. DISCLOSURE TO INFORMATION NORM

The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, misdescription or non-disclosure of any material fact.

9.1.2. CONDITIONS PRECEDENT OF TO ADMISSION OF LIABILITY

The due observance and fulfilment of the terms and conditions of the policy, by the insured person shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

9.1.3. CLAIM SETTLEMENT (PROVISION FOR PENAL INTEREST)

- i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.
- iv. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

9.1.4. COMPLETE DISCHARGE

Any payment to the Insured Person or his/ her nominees or his/ her

legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim

9.1.5. MULTIPLE POLICIES

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

9.1.6. FRAUD

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

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by person named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a insurance Policy: -

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

The company shall not repudiate the policy on the ground of fraud, if the insured person /beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the Insured Person, if alive, or beneficiaries.

9.1.7. CANCELLATION

- a. No cancellation shall be allowed on part of the Policyholder after expiry of the Free Look Period. .
- b. The Company may cancel the Policy at any time on grounds of mis-representation, non-disclosure of material facts, fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of material facts or fraud.

9.1.8. PORTABILITY

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person

is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/ Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

- i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
- ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer--www.irdai.gov.in(Circular- IRDA/HLT/REG/CIR/003/012020, dated 01012020)

9.1.9. RENEWAL OF POLICY

The policy is not ordinarily renewable.

9.1.10. WITHDRAWAL OF POLICY

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the Policy.
- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break

9.1.11. MORATORIUM PERIOD:

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

9.1.12. POSSIBILITY OF REVISION OF TERMS OF THE POLICY INCLUDING THE PREMIUM RATES

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are affected.

9.1.13. FREE LOOK PERIOD

The Free Look Period shall be applicable at the inception of the Rider Policy and not at the time of porting the policy.

The insured shall be allowed a period of thirty days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or
- ii. where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

9.1.14. NOMINATION

The Insured Person is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in

the event of death of the Insured Person. 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. For Claim settlement under reimbursement, the Company will pay the Insured Person. In the event of death of the Insured Person, the Company will pay the nominee (as named in the Policy Schedule/ Policy Certificate/Endorsement (if any) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Insured Person whose discharge shall be treated as full and final discharge of its liability under the policy.

9.2. SPECIFIC TERMS AND CONDITIONS

9.2.1. MATERIAL CHANGE

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

9.2.2. RECORDS TO BE MAINTAINED

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy

9.2.3. NOTICE & COMMUNICATION

- i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
- ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
- iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

9.2.4. TERRITORIAL LIMIT

All medical treatment for the purpose of this insurance will have to be taken in India only.

9.2.5. AUTOMATIC CHANGE IN COVERAGE UNDER THE POLICY

The coverage for the Insured Person shall automatically terminate in the case of her (Insured Person) demise.

9.2.6. TERRITORIAL JURISDICTION

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

9.2.7. ARBITRATION

- i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
- ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.
- iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of

expenses shall be first obtained.

Management System <https://igms.irda.gov.in/>

9.2.8. AUTOMATIC TERMINATION

If the Base Policy terminates then the rider attached to the Base Policy shall also terminate.

9.2.9. ENDORSEMENTS (CHANGES IN POLICY)

This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

9.2.10. CHANGE OF SUM INSURED

Sum insured cannot be changed (increased/ decreased) at any time during the Policy Period.

9.2.11. TERMS AND CONDITIONS OF THE POLICY

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document

9.2.12. GOVERNING ACTS

The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of non-compliance with The Assisted Reproductive Technology (Regulation) Act, 2021, The Surrogacy (Regulation) Act, 2021 and any revisions thereof.

REDRESSAL OF GRIEVANCES

In case of any grievance the Insured Person may contact the Company through

Website:	Indusindinsurance.com
Dedicated Senior Citizen helpline:	022-33834185 (paid line)
E-mail:	services@indusindinsurance.com
Fax:	+91 22 3303 4662
Courier:	Any branch office, the correspondence address, during normal business hours.
Write to us at:	IndusInd General Insurance, (Correspondence Only) Correspondence Unit, Winway Building 2nd & 3rd Floor, 11/12 Block No-4, Old no-67, South Takoganj, Indore (M.P.)-452001.

Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance.

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at:

Grievance Redressal Officer

The Grievance Cell,
IndusInd General Insurance Co. Limited
No. 1-89/3/B/40 to 42/ks/301, 3rd floor,
Krishe Block, Krishe Sapphire, Madhapur
Hyderabad – 500 081

Grievance Redressal officer email ID:
Headgrievances@indusindinsurance.com

(For updated details of grievance officer, kindly refer the link.
<https://indusindinsurance.com/Insurance/About-Us/Grievance-Redressal.aspx>

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

The contact details of the Insurance Ombudsman offices have been provided as Annexure-B

Grievance may also be lodged at IRDAI Integrated Grievance

11. TABLE OF BENEFITS

Name	IndusInd Health Surrogate and Oocyte Donor Rider
Product Type	Individual
Category of Cover	Indemnity
Sum Insured	INR 5 Lakhs, 10 Lakhs
Policy Period	1 year for Oocyte Donor 3 years for Surrogate Mother
Eligibility and Application requirements	Female gestational Surrogate or Oocyte donor
Hospitalisation Expenses	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible Time limit of 24 hrs shall not apply when the treatment is undergone in a Day Care Centre.
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered upto sum insured, during each Policy year as specified in the policy schedule.
Pre-Hospitalisation	For 30 days prior to the date of hospitalization
Post Hospitalisation	For 60 days from the date of discharge from the hospital
Sublimit for room/ doctor's fee	1. Room Rent, Boarding, Nursing Expenses all inclusive as provided by the Hospital/ Nursing Home up to 2% of the sum insured subject to maximum of ₹5000/- per day. 2. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital/ Nursing Home up to 5% of the sum insured subject to maximum of ₹10,000/-, per day
Cataract Treatment	Up to 25% of Sum insured or ₹40,000/-, whichever is lower, per eye, under one policy year.
Modern Treatment	Up to 50% of SI, Within S.I
Cumulative bonus	Increase in the sum insured by 5% in respect of each claim free year subject to a maximum of 50% of SI. In the event of claim the cumulative bonus shall be reduced at the same rate.
Waiting Periods	
Pre Existing Disease	36 months Note: This exclusion shall not apply in case of medical complications arising within 6 weeks of childbirth through Surrogacy
Initial Waiting	30 days
Specific Waiting Period	24/36 months

ANNEXURE - A

1. List I - Items for which coverage is not available in the policy

SI No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS / BRACES
5	BUDS
6	COLD PACK / HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGING'S
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPY ES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE

38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG / SHORT / HINGED)
46	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

2. List II — Items that are to be subsumed into Room Charges

No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS

8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET / WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

3. List III — Items that are to be subsumed into Procedure Charges

No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES

7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

4. List IV — Items that are to be subsumed into costs of treatment

No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

ANNEXURE - B

OMBUDSMAN OFFICE			
Office of the Ombudsman	Address	Contact Details	Areas of Jurisdiction
AHMEDABAD	Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 001.	Tel.: 079 - 27546150/27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560078.	Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003.	Tel.: 0755 - 2769201, 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009.	Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017.	Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018.	Tel.: 044 - 24333668 / 24335284 Fax: 044 – 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, UT - Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@cioins.co.in	Delhi
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar Over Bridge, S.S. Road, Guwahati – 781001 (ASSAM).	Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.	Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana and UT of Yanam - a part of UT of Pondicherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.	Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
ERNAKULAM	Office of the Insurance Ombudsman, LIC OF INDIA, 10th Floor, 'Jeevan Prakash', Divisional Office, M. G. Road, Ernakulam, Kochi – 682011.	Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, UT of (a) Lakshadweep, (b) Mahe-a part of UT of Pondicherry.
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, Kolkata - 700 072.	Tel.: 033 - 22124339 / 22124340 Fax: 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, UT of Andaman & Nicobar Islands, Sikkim

LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001.	Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkar Nagar, Sultanpur, Maharajgang, Sant Kabir Nagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharath Nagar.
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.	Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Dist: Gautam Buddh Nagar, U.P. - 201301.	Tel.: 0120 - 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshihar, Etah, Kanoj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Budha Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiram Nagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna - 800 006.	Tel.: 0612 - 2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune - 411 030.	Tel.: 020 - 41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

The updated details of Insurance Ombudsman are available on IRDA website: www.irdai.gov.in, on the website of General Insurance Council: www.gicouncil.in, our website www.indusindinsurance.com

ANNEXURE - C

**INDUSIND GENERAL INSURANCE COMPANY LIMITED - Pre-Authorisation Form
REQUEST FOR CASHLESS HOSPITALISATION HEALTH INSURANCE POLICY**

DETAILS OF THE THIRD PARTY ADMINISTRATOR (To be filled in block letters)

a) Name of TPA / Insurance Company:

b) Phone number:

c) FAX:

TO BE FILLED BY THE INSURED/PATIENT

a) Name of Patient

b) Gender: Male Female

c) Age: Years Y Y / M M

d) Date of birth: D D / M M / Y Y Y Y

e) Contact number:

f) Contact number of attending relative:

g) Insured card ID Number:

h) Policy number / Name of Corporate:

i) Employee ID:

j) Currently do you have any other Mediclaim/Health insurance: Yes No

If yes, company name:

Give details:

k) Do you have a family physician: Yes No

If yes, name of the family physician:

Contact number, if any:

(Please complete declaration on Page 3 of this form)

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

a) Name of the treating doctor:

b) Contact number of the treating doctor:

c) Nature of illness/disease with presenting complaints:

d) Relevant clinical findings:

e) Duration of the present ailment: _____ days

i. Date of first consultation: D D / M M / Y Y Y Y

ii. Past history of present ailment if any:

iii. ICD 10 code:

f) Provisional diagnosis:

g) Proposed line of treatment: Medical management Surgical management Intensive care
 Investigation Non-allopathic treatment

h) If investigation and/or medical management, provide details:

i) Route of drug administration:

j) If surgical, name of surgery:

k) ICD 10 PCS Code:

l) If other treatments, provide details:

m) How did injury occur?

n) In case of accident:	i. Is it RTA:	<input type="radio"/> Yes <input type="radio"/> No	ii. Date of injury:	DD/MM/YYYY
	iii. Reported to police:	<input type="radio"/> Yes <input type="radio"/> No	iv. FIR number:	
	v. Injury/disease caused due to substance abuse/alcohol consumption:			<input type="radio"/> Yes <input type="radio"/> No
	vi. Test conducted to establish this:	<input type="radio"/> Yes <input type="radio"/> No	(If Yes, attach reports)	
o) In case of maternity: <input type="radio"/> G <input type="radio"/> L <input type="radio"/> A				
p) Date of delivery: DD / MM / YYYY				
DETAILS OF PATIENT ADMITTED				
a) Date of admission: DD / MM / YYYY				
b) Time: HH / MM				
c) Is this an emergency/a planned hospitalization event?: <input type="radio"/> Emergency <input type="radio"/> Planned				
d) Expected no. of days' stay in hospital: _____ days				
e) Room type:				
f) Per day room rent + nursing and service charges + patient's diet:				Rs.
g) Expected cost for investigation and diagnostics:				Rs.
h) ICU charges:				Rs.
i) OT charges:				Rs.
j) Professional fees Surgeon + Anaesthetist fees + Consultation charges				Rs.
k) Medicines + Consumables + Cost of implants (if applicable please specify, other hospital expenses):				Rs.
l) All inclusive package charges if any applicable:				Rs.
m) Sum total expected cost of hospitalization:				Rs.
Mandatory: Past history of any chronic illness				If yes, since (month / year)
<input type="radio"/> Diabetes				MM / YYYY
<input type="radio"/> Heart disease				MM / YYYY
<input type="radio"/> Hypertension				MM / YYYY
<input type="radio"/> Hyperlipidemias				MM / YYYY
<input type="radio"/> Osteoarthritis				MM / YYYY
<input type="radio"/> Asthma/COPD/Bronchitis				MM / YYYY
<input type="radio"/> Cancer				MM / YYYY
<input type="radio"/> Alcohol or drug abuse				MM / YYYY
<input type="radio"/> Any HIV or STD/Related ailments				MM / YYYY
Any other ailment give details:				

DECLARATION (Please read very carefully)

We confirm having read, understood and agreed to the Declarations on page 3 of this form:

- a) Name of the treating doctor:
- b) Qualification:
- c) Registration number with state code:

Hospital seal (Must include Hospital ID)

Patient/Insured name and signature

DECLARATION BY THE PATIENT/REPRESENTATIVE:

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer after the discharge. I agree to sign on the final bill & the discharge summary, before my discharge.
2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over and above the limit authorized by the Insurer not governed by the terms and conditions of the policy will be paid by me.
4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect, I forfeit my claim and agree to indemnify the Insurer.
5. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
6. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer.

Patient's/Insured's name: _____

Contact number: _____

Patient's/Insured's signature

HOSPITAL DECLARATION:

1. We have no objection to any authorized Insurance Company official verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured/patient as per the checklist below will be sent to Insurance Company within 7 days of the patient's discharge.
3. All non-medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the Insurance Company, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. WE AGREE THAT INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.

Hospital seal (Must include Hospital ID)

Doctor's signature

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM:

1. Detailed discharge summary and all bills from the hospital
2. Cash memos from the hospitals/chemists supported by proper prescription.
3. Receipts and pathological test reports from pathologists, supported by note from the attending medical practitioner/surgeon recommending such pathological tests.
4. Surgeon's certificate stating nature of operation performed and surgeon's bill and receipt.
5. Certificates from attending medical practitioner/surgeon that the patient is fully cured.