12. Supreme Health Unlimited

12.1 Benefit

Notwithstanding anything within mentioned to the contrary, it is hereby declared and agreed that if the Schedule states that the Supreme Health Unlimited (Rs. 300,000 to Rs. 60,000,000 -for individual basis and maximum up to Rs. 75,000,000 - Family floater basis.) is granted to the Life Assured/Spouse/Children/parents and parent- in- Laws named in the Schedule while the policy is in force, then the Life Assured is entitled to reimburse the expenses incurred during the hospitalization subject to minimum 24 hours continuous hospitalization as a result of an illness or accident based on the applicable plan (individual or floater).The company shall reimburse the expenses incurred subject to the benefit amount mentioned in the Schedule and the terms, conditions, exclusions and definitions described below.

12.2 Benefits Provided

a) The maximum annual benefit amount that can be claimed under the term of the benefit will be limited to 1 time of the Supreme Health Unlimited Sum Assured
b) This plan provides reimbursement for medical expenses incurred as follows

1. Hospitalization Benefit including nursing charges	**Reimbursement of Hospital Room , board and ICU ward charges**
(a) Daily Hospital Room and Board Benefit (i) Maximum room rent per day for treatment within Sri Lanka	Single Private AC Room. In case policy holder opts for a higher than eligible room category, customer will have to pay the difference of room charges if any.
(II) Maximum room rent per day for treatment outside Sri Lanka	Single Private AC Room. In case policy holder opts for a higher than eligible room category, a flat 25% co-payment on the eligible Insurance amount would be applicable. However, customer will have to pay the difference of room charge, if opted for a higher room category.
(b) Daily ICU Hospital Room and Board Benefit (i) Maximum room rent per day for treatment within Sri Lanka	In case policy holder opts for a higher than eligible room category, customer will have to pay the difference of room charges if any .
(ii) Maximum room rent per day for treatment outside Sri Lanka	As per actual. In case policy holder opts for a higher than eligible room category, a flat 25% co-payment on the eligible Insurance amount would be applicable.

2. Surgical Benefit (includes Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees)	As-charged, subject to usual, customary, and reasonable clause.
3. Miscellaneous Hospital Services and Supplies Benefit (Includes Operation Theatre Charges, Anesthesia, Blood, Oxygen, Medicines and Drugs, except non-medical services)	As-charged, subject to usual, customary, and reasonable clause.
4. Ambulance Charges	(i). As-charged, subject to a maximum of 2% of Annual Sum Insured. (ii). Benefit is payable any number of times during the policy year within the limit, subject to the hospitalization claim being admissible and payable only when a licensed ambulance service is used. (iii). Ambulance benefit is not applicable for day care treatments. (iv) Air ambulance services are specifically excluded.
5. Day Care Treatment (Hospitalization as an in-patient for less than 24 hours)	(i) Coverage limited to covered list of day care surgeries. **(List refer under 12.4)** (ii) Out-patient procedures or treatment are not covered under the plan.
6. Pre-Hospitalization Expenses Benefit (applicable for all hospitalizations, irrespective of Private or Public Hospital)	Payable up to 5% of the basic sum insured for 30 days prior to the hospitalization. This benefit is a sub-limit of the Basic sum Insured and are payable only for expenses incurred for management of the diagnosis for which hospitalization was availed and subject to the main claim being admissible under the policy.
7. Post Hospitalization Expenses Benefit (applicable for all hospitalizations, irrespective of Private or Public Hospital)	Payable up to 5% of the basic sum insured for 30 days to postdate of discharge from the hospital. This benefit is a sub-limit of the Basic sum Insured and are payable only for expenses incurred for management of the diagnosis for which hospitalization was availed and subject to the main claim being admissible under the policy.
8. Organ Donor Expenses	Covered within the overall Annual Sum Insured of the donee and payable only for hospitalization expenses for the donor, subject to all other applicable limits & sub-limits of the policy.
9. Prosthesis and Implants	As-charged, subject to a max. Sub-limit of 20% of Basic Annual Sum Insured.

10. Overseas treatment	In case of planned hospitalization, to be pre-intimated to the insurer and pre-authorization is mandatory. Emergency hospitalization needs to be intimated to insurer within 48 hours of hospitalization and in case a higher than eligible room category was opted for, a co-payment of 25% would be applicable on the eligible insurance claim amount.
11. Hospitalization in a non-paying ward (Public Hospitals or similar)	1% of the Basic Annual Sum Insured per day subject to a maximum of Rs. 20,000 per day up to a maximum cap of 30% of Basic Annual Sum Insured per year. Expenses pertaining to the investigations and drugs prescribed by the doctor in relation to the hospitalized condition will be payable maximum up to 70% of the Basic Annual Sum Insured per year.
12. No Claim Bonus Benefit	25% increase in the Basic Annual Sum Insured on an annual basis in case of no claim (Except OPD and optical claims) in the policy year from the individual or any family member within the family floater plan. Maximum NCB benefit can be up to 100% of the initial Basic Annual Sum Insured, without any corresponding increase in premiums. In case of a claim from the individual or any family member within the family floater plan, the NCB benefit will reduce the same way it has been accrued. However, this reduction will not reduce the available sum insured below the Basic Annual Sum Insured of the policy. OPD , Optical , Maternity and Accidental Critical condition cover eligible benefit amounts are not depend on increased sum assured.
13. Restore Benefit	In case of complete exhaustion of the Basic Annual Sum Insured, 100% of additional Basic Annual Sum Insured is available, in case the reason for hospitalization is not related to any of the preceding causes of hospitalization from all family members within the family floater plan. Restore benefit is available only once in a policy year (without any corresponding increase in premiums) and the balance sum insured of the restore benefit is not carried forwarded. Maternity benefit, OPD, Optical cover and Accidental Critical Condition benefit are not restored under this benefit.

14. Dental Care

Actual expenses but not exceeding the maximum cover amount according to the plan. This pay-out is a sub-limit of the annual sum insured. A waiting period of 180 days from the date of policy inception or reinstatement would be applicable for availing this benefit. This benefit is applicable in Sri Lanka only.

Plan	Maximum Cover amount (Per Year)	Waiting period
Plan 3 to 6 (Rs. 300,000 to Rs. 750,000)	N/A	–
Plan 7 to 16 (Rs. 1,000,000 to Rs.5,000,000)	Rs 20,000	180 days
Plan 17 to 22 (Rs. 10,000,000 to Rs. 20,000,000)	Rs. 30,000	180 days
Plan 23 to 30 (Above Rs. 30,000,000)	Rs. 50,000	180 days

Exclusions: The Policy shall not cover any claim directly or indirectly from,

1. Scaling and cleaning
2. Mouth guards, gum shields or any dental appliances.
3. Implants and all costs associated with the preparation and fitting of such a device (including crowns and bridges).
4. Bleaching or other tooth whitening and orthodontics.
5. All types of cosmetic treatment, meaning dental treatment not necessary for the establishment or maintenance of oral health.
6. Specialist Treatment, meaning any form of dental care or Treatment beyond the scope of the average competent Dentist.
7. Wisdom teeth extraction, other than those extracted at the Dentist's surgery.
8. Treatment, care, repair to, or in connection with 'tooth jewellery'.
9. Any Treatment required as a result of damage or Injury caused whilst training for, or participating in, contact sports unless recommended mouth protection is worn.
10. Expense for prosthetic organs and equipment, including prosthetic tooth or dental inventions.

15. Maternity Benefit(optional)

Maternity Benefit Chart

This benefit will not be applicable for males and children. Medical expenses of child delivery (normal or surgical delivery) occurring in a registered government or private hospital in Sri Lanka only.

Plan Category	LSCS (Caesarian)	NVD(Normal Delivery
Plan 3 to 4	Not Applicable	Not Applicable
Plan 5 to 8	150,000.00	75,000.00
Plan 9 to 10	200,000.00	100,000.00
Plan 11 to 12	250,000.00	125,000.00
Plan 13 to 14	300,000.00	150,000.00
Plan 15 and above	400,000.00	200,000.00

Lifetime limit of up to 4 deliveries. The mother insured must be above 18 years old and below age 45 years old at the time of delivery.

This benefit does not include any Private Nurse cost.

- A waiting period of 24 months from policy inception / re-instatement / revival (whichever is later) is applicable for the female life to avail this benefit

- Maternity benefit option can be availed only at inception of the policy / Rider

- Maternity benefit option (if availed) cannot be removed / discontinued anytime during the rider tenure

16. Health Check

Applicable from Plan 3 onwards:

After every claim free policy year, 1% of the basic annual sum insured is payable for health check-up at designated hospitals by the company subject to a maximum of Rs. 50,000. Claimed at actual on reimbursement basis subject to the cap.

17. Hospital admission charges	**<u>Sum assured Rs. 300,000 to Rs. 2,000,000:</u>** As-charged, subject to a maximum of Rs. 5000 per hospitalization. **<u>Sum assured Rs. 2,000,000 and above</u>**: As-charged, subject to a maximum of 5% of Basic Annual Sum Assured per year.
18. Deductible option	Deductible options of Rs. 250,000, Rs.500,000, Rs. 1,000,000 and Rs. 2,000,000 as specified in the policy schedule. (Not applicable for plans up to sum assured Rs. 400,000). This option applicable for all covers except maternity, outpatient & routine optical benefit.
19. Optical cover (optional)	After waiting period of two years from policy commencement date or policy revival date 5% of sum assured with maximum limit of Rs. 50,000. Expenses incurred for treatment to correct refractive errors of the eye will be covered. Benefit for fees charged for eye examinations (maximum once per two years)
20. OPD treatment	After the waiting period of one year from policy commencement date or policy revival date, 1% of the sum assured with maximum limit of Rs. 50,000 payable on each year on individual and floater basis Ayurvedic treatment from Government registered hospital is also covered. **(Applicable for the sum assured Rs. 500,000 and above plans only).**
21. Ayurvedic treatment	5% of Sum Insured, subject to a maximum benefit of Rs. 50,000 per policy per year. 24-hour hospitalization is mandatory for this benefit. Waiting period of 180 days. Benefit policy exclusions will be applicable Treatment should be availed on an in-patient basis for a minimum confinement period of 24 hours - Claims to be processed on reimbursement basis at actuals subject to sublimit and cap - The treatment has been undergone in a government hospital or in any institute registered under the Ayurvedic Medical council with a valid registration no. - Claims to be scrutinized for need for treatment and rule out rest-cures / SPA's / rejuvenation

22. Accidental critical condition

Benefit

Accidental Critical Conditions Benefit is payable, in the event of the Life Assured being diagnosed as or undergoing any one of the defined medical events below, subject to terms, conditions and exclusions contained herein.

22.1 Definitions Applicable to Accidental Critical Conditions

"Accident" means an event or contiguous series of events, which are violent, unforeseen, involuntary, external and which causes Bodily Injury.

"Bodily Injury" means physical harm or injury as a result of an Accident leading to a Disability. This must be evidenced by external signs such as contusion, bruise and wound or be confirmed by a Doctor in case of internal injury.

"Pre-existing Condition" is any condition

- of which the Insured was aware, or
- of which the Insured should reasonably have been aware, or
- in respect of which the Insured showed signs or symptoms, or
- which was diagnosed, or
- for which the Insured received medical treatment or medical advice

prior to the effective date of the policy or to any subsequent date of reinstatement or revival of cover.

"Specialist" Medical specialist "appointed by the company", who is required to confirm the disability / diagnosis / surgery

22.2 Accidental Conditions Covered and definitions:

Coma, Major Head Trauma, Major Burns, Paralysis , Deafness (loss of hearing) , Loss of speech

Definitions:

1. Coma

A definite diagnosis of a state of unconsciousness caused due to an accident with no reaction or response to external stimuli or internal needs, which:

- results in a score of 8 or less on the Glasgow coma scale for at least 96 hours,
- requires the use of life support systems, and
- results in a persistent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The diagnosis must be confirmed by a Consultant Neurologist.
For the above definition, the following are not covered:

- Medically induced coma
- Any coma due to sickness, self-inflicted injury, alcohol or drug use

2. Major Head Trauma
A definite diagnosis of a disturbance of the brain function as a result of traumatic head injury. The head trauma must result in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.
Activities of Daily Living are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
- Feeding oneself – the ability to feed oneself when food has been prepared and made available.
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
- Getting between rooms – the ability to get from room to room on a level floor.
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis must be confirmed by a Consultant Neurologist or Neurosurgeon and supported by typical imaging findings (CT scan or brain MRI).
For the above definition, the following are not covered:

- Any major head trauma due to self-inflicted injury, alcohol or drug use

3. Major Burns
Burns that involve destruction of the skin through its full depth to the underlying tissue (third-degree burns) and covering at least 20% of the body surface as measured by "The Rule of Nines" or the "Lund and Browder Chart". The diagnosis must be confirmed by a Specialist.
For the above definition, the following are not covered:

- Third-degree burns due to self-inflicted injury
- Any first- or second-degree burns

4. Paralysis
Total and irreversible loss of muscle function to the whole of any 2 limbs as a result of accident to the spinal cord or brain. Limb is defined as the complete arm or the complete leg. Paralysis must be present for more than 3 months, confirmed by a Consultant Neurologist and supported by clinical and diagnostic findings.
For the above definition, the following are not covered:

- Paralysis due to self-harm or psychological disorders
- Guillain-Barré-Syndrome
- Periodic or hereditary paralysis

5. Deafness (Loss of Hearing)
A definite diagnosis of a permanent and irreversible loss of hearing in both ears as a result of accidental injury. The diagnosis must be confirmed by a Consultant ENT

specialist and supported by an average auditory threshold of more than 90 db at 500, 1000 and 2000 hertz in the better ear using a pure tone audiogram.

6. Loss of Speech
A definite diagnosis of the total and irreversible loss of the ability to speak as the result of accident. The condition has to be present for a continuous period of at least 6 months. The diagnosis must be confirmed by a Consultant ENT Specialist.
For the above definition, the following are not covered:

- Loss of speech due to psychiatric disorders

22.3 Conditions

1. Cover shall begin immediately after issuance of the Supreme Health Unlimited benefit.
2. Cover shall cease at the lower of age at maturity of the underlying policy or age 75 years exact.
3. Coverage amount would be as per the plan taken subject to 1 times of SA (Not Increased due to No claim bonus) with a maximum cap of Rs. 10 million.
4. Survival period is 30 days i.e., the insured must survive at least 30 days after the accident occurs
5. The covered condition should occur within 90 days from the date of the Accident and the same shall be reported to the Company within 30 days from the date of the first diagnosis of the covered condition
6. The benefit is payable at one time during the policy term and 100% of Sum Assured as a lump sum payment
7. The benefit shall be payable upon the occurrence of one of the specified medical events and after the acceptance of liability the accidental critical condition cover shall terminate.
8. Total accidental critical condition cover under all policies shall not exceed Rs.10 million per individual at any time.
9. An accidental Critical condition must be diagnosed by a specialist medical practitioner and must be supported by clinical and other reports acceptable to the Company.
10. The disability shall be permanent
11. A deferment period of 6 months shall also be applicable during which the continuation of the disability is documented and at the end of which is deemed as irreversible/ permanent by an appropriate specialist appointed by the company.

22.4 Exclusions

Accidental Critical Conditions shall not be paid to the insured person directly or indirectly as a result of (any of the following)

1. If the insured dies within 30 days of the diagnosis of the covered CI;

2. Pre-Existing Disease: Pre-existing Disease means any condition, ailment, injury or disease: a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

3. Intentional self-inflicted injury, suicide or attempted suicide, while sane or insane.

4. For any medical conditions suffered by the life assured or any medical procedure undergone by the life assured, if that medical condition or that medical procedure was caused directly or indirectly by influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescriptions of a registered medical practitioner.

5. Engaging in or taking part in hazardous activities*, including but not limited to, diving or riding or any kind of race; martial arts; hunting; mountaineering; parachuting; bungee-jumping; underwater activities involving the use of breathing apparatus or not; *Hazardous Activities mean any sport or pursuit or hobby, which is potentially dangerous to the Insured Member whether he is trained or not;

6. Participation by the insured person in a criminal or unlawful act with criminal intent.

7. For any medical condition or any medical procedure arising from nuclear contamination; the radioactive, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.

8. For any medical condition or any medical procedure arising either as a result of war, invasion, act of foreign enemy, hostilities (whether war be declared or not), armed or unarmed truce, civil war, mutiny, rebellion, revolution, insurrection, terrorism, military or usurped power, riot or civil commotion, strikes or participation in any naval, military or air force operation during peace time;

9. For any medical condition or any medical procedure arising from participation by the insured person in any flying activity, except as a bona fide, fare-paying passenger and aviation industry employee like pilot or cabin crew of a recognized airline on regular routes and on a scheduled timetable.

12.2.1 Benefit Schedule & Geographical Coverage

Benefit Schedule	Geographical Coverage	Annual Overall Limit (AOL) - Basic Annual Sum Insured in Rs.
Plan 3	Sri Lanka, India, Singapore, Thailand and Malaysia	300,000
Plan 4	Sri Lanka, India, Singapore, Thailand and Malaysia	400,000
Plan 5	Sri Lanka, India, Singapore, Thailand and Malaysia	500,000
Plan 6	Sri Lanka, India, Singapore, Thailand and Malaysia	750,000
Plan 7	Sri Lanka, India, Singapore, Thailand and Malaysia	1,000,000
Plan 8	Sri Lanka, India, Singapore, Thailand and Malaysia	1,500,000
Plan 9	Sri Lanka, India, Singapore, Thailand and Malaysia	2,000,000
Plan 10	Worldwide excluding USA & Canada	2,000,000
Plan 11	Sri Lanka, India, Singapore, Thailand and Malaysia	3,000,000
Plan 12	Worldwide excluding USA & Canada	3,000,000
Plan 13	Sri Lanka, India, Singapore, Thailand and Malaysia	4,000,000
Plan 14	Worldwide excluding USA & Canada	4,000,000
Plan 15	Sri Lanka, India, Singapore, Thailand and Malaysia	5,000,000
Plan 16	Worldwide excluding USA & Canada	5,000,000
Plan 17	Sri Lanka, India, Singapore, Thailand and Malaysia	10,000,000
Plan 18	Worldwide excluding USA & Canada	10,000,000
Plan 19	Sri Lanka, India, Singapore, Thailand and Malaysia	15,000,000
Plan 20	Worldwide excluding USA & Canada	15,000,000
Plan 21	Sri Lanka, India, Singapore, Thailand and Malaysia	20,000,000
Plan 22	Worldwide excluding USA & Canada	20,000,000
Plan 23	Sri Lanka, India, Singapore, Thailand and Malaysia	30,000,000
Plan 24	Worldwide excluding USA & Canada	30,000,000
Plan 25	Sri Lanka, India, Singapore, Thailand and Malaysia	50,000,000
Plan 26	Worldwide excluding USA & Canada	50,000,000
Plan 27	Sri Lanka, India, Singapore, Thailand and Malaysia	60,000,000
Plan 28	Worldwide excluding USA & Canada	60,000,000
Plan 29 (Family Floater)	Sri Lanka, India, Singapore, Thailand and Malaysia	75,000,000
Plan 30 (Family Floater)	Worldwide excluding USA & Canada	75,000,000

Note: Plan 1 and 2 are not allowed under Supreme Health Unlimited version

12.3. Conditions

12.3.1. General Conditions

1. If any claim is made and rejected and no court action or suit commenced within 12 months after such rejection, all benefits under this benefit shall be forfeited.
2. Multiple policies

   At any point of time, if it is found that there are multiple policies obtained by the Assured covering Supreme Health Unlimited provided by this policy and such information on other existing policies is not declared/provided to insurer in the proposal form, the benefit issued thereof stands cancelled *ab initio* and, no liability exists under the policy for the disease/illness contracted by the assured. In case of full and complete declaration of policies held with the company and /or with other insurers, the liability under the policy would be as follows:
   - The maximum liability for the Company would be the Sum Assured of this benefit under all such policies issued to the insured put together subject to maximum allowable limits.
   - If there are benefits with us and also with other insurers, the Company shall not be liable to pay or contribute more than its ratable proportion of any expense incurred towards the covered benefit by the Assured person.
3. Position after a claim

   As from the day of receipt of the claim amount by the Assured/Assured person, the cover for the remainder of the period of insurance shall stand reduced by a corresponding amount/number of days.
4. Right to Inspect

   If required by the Insurer, an agent/representative of the insurer including a physician appointed in that behalf shall in case of any loss or any circumstances that have given rise to a claim to the Assured person be permitted at all reasonable times to examine into the circumstances of such loss. The Assured person shall on being required so to do by the insurer produce all relevant documents relating to or containing reference relating to the loss or such circumstance in his/her possession including presenting himself for examination and furnish copies of or extracts from such of them as may be required by the insurer so far as they relate to such claims and will in any way assist the insurer to ascertain the correctness thereof or the liability of the insurer under this benefit.
5. Examination of Medical records

   Insurer may examine Assured medical records/reports and related documents relating to this benefit at any time during the policy period and up to three years after the policy expiry, or until formal adjustment (if any) and resolution of all claims under this benefit.
6. Premium

   Premium rates are non-guaranteed and can be revised at every policy anniversary with 30 days' notice.

7. Waiting Period

   - 90 days waiting period from the date of policy commencement or date of reinstatement, whichever is later, if cause of claim is not due to an accident
   - One year waiting period applicable for common medical conditions, from the time of inception or reinstatement of the cover.

     Please refer list of 1 year exclusions (12.3.2.11).

Benefit	**Waiting period applicable from date of commencement or date of reinstatement**
Main Rider Benefit	90 days
Optical Cover	2 years
Maternity Cover	2 years
Common medical conditions **(12.3.2.11)**	1 year
OPD Cover	1 year
Dental Care Cover	180 days

12.3.2. Special Conditions

1. Pregnancy related pre and post hospitalization expenses are not covered under this rider unless the optional pregnancy cover is taken.
2. There has to be a minimum 24 hours' continuous stay in hospital during the policy term except for specified day care surgeries.
3. Sum Assured cannot be enhanced during the term of the policy.
4. This benefit is only eligible for Sri Lankans Citizens and permanent residents living in Sri Lanka and with a bona-fide residential address in Sri Lanka. Policy cannot be offered to non-resident Sri Lankans. For overseas treatment plans, coverage for the policy will terminate if the insured resides outside of Sri Lanka for a continuous period of 90 days and above. However, once the policyholder returns back to Sri Lanka, the benefits of the policy will be activated, and the policy benefits will resume as per original terms and conditions.
5. Out-patient treatment or surgical procedures of any kind are covered after waiting period of 1 year from date of commencement or date of reinstatement subject to limitations mentioned in 12.2 "Benefit provided".
6. The diagnosis of the illness should be arrived at for the first time after the expiry of 90 days from the commencement or revival of the policy, but not later than 75th birthday of the Assured.
7. Age limit

- Minimum age at entry for Adults: Age 18 exact.
- Maximum age at entry for Adults: Age 65 exact.
- Minimum Age at entry for Children: Age 3 months old
- Maximum entry age for Children: Age 22 last birthday (for children who are unmarried and are dependent on parents)

- Cover ceasing age for children: Age 23 last birthday (for children who are unmarried and are dependent on parents)
- Cover ceasing age for Adults: Age 75 last birthday.

8. Intimation of hospitalization should be done within 48 hours of hospitalization. Intimation prior to admission of the hospitalization is required to avail cashless option.
9. Claims papers should be submitted within 30 days of discharge from hospital.
10. Midterm inclusions are possible only at the time of next policy anniversary date.
11. From the time of inception or reinstatement of the cover, the benefit will not cover following illnesses/ conditions for the duration of first 12 months of the policy. (This exclusion will be deleted after a one year, provided the benefit has been continuously renewed with the company without any break)

S. No.	Name of Surgery / Ailment
1	Medical or Surgical management of DNS, diseases of Tonsils, Adenoids and Sinuses and related conditions (except malignancy).
2	All types of Hernias and Benign Prostatic Hypertrophy.
3	Hydrocoele / Varicocoele / Spermatocoele.
4	Piles / Fissure / Fistula-in-Ano / Rectal Prolapse / Pilonidal Sinus.
5	Treatment of all gynaecological conditions (Such as but not limited to Uterine Fibroid, Dysfunctional Uterine Bleeding, Hysterectomy, Uterine Prolapse, Endometriosis, Adenomyosis Uteri, Ovarian Cyst etc) except those arising from malignancy.
6	Medical or Surgical management of Prolapsed Intervertebral Disc.
7	Skin and all internal cysts/tumors/nodules/ polyps/ganglions/lipomas of any kind unless malignant.
8	Calculus Diseases of any etiology.
9	Peripheral vascular diseases of any etiology, including treatment for Varicose veins.
10	All types of CRF and acute on chronic Renal Failures but not ARF, including Renal Failure due to Diabetes.
11	Osteoporosis / Pathological Fracture / Degenerative Joint Diseases including joint replacement surgeries. However, joint surgeries necessitated due to accidents would not be a part of this exclusion.
12	Cataract, Retinopathy and Retinal detachment.

12.4 Day care procedures

The following are the listed day care procedures and such other surgical operation that necessitate less than 24 hours Hospitalization due to medical/technological advancement / infrastructure facilities and the coverage of which is subject to the terms, conditions and exclusions of the benefit.

Microsurgical operations on the middle ear	
1	Stapedectomy
2	Revision of a stapedectomy
3	Other operations on the auditory ossicles
4	Myringoplasty (Type -I Tympanoplasty)
5	Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
6	Revision of a tympanoplasty
7	Other microsurgical operations on the middle ear
Other operations on the middle & internal ear	
8	Myringotomy
9	Removal of a tympanic drain
10	Incision of the mastoid process and middle ear
11	Mastoidectomy
12	Reconstruction of the middle ear
13	Other excisions of the middle and inner ear
14	Fenestration of the inner ear
15	Revision of a fenestration of the inner ear
16	Incision (opening) and destruction (elimination) of the inner ear
17	Other operations on the middle and inner ear
Operations on the nose & the nasal sinuses	
18	Excision and destruction of diseased tissue of the nose
19	Operations on the turbinates (nasal concha)
20	Other operations on the nose
21	Nasal sinus aspiration
Operations on the eyes	
22	Incision of tear glands
23	Other operations on the tear ducts
24	Incision of diseased eyelids
25	Excision and destruction of diseased tissue of the eyelid
26	Incision of diseased eyelids
27	Operations on the canthus and epicanthus
28	Corrective surgery for entropion and ectropion
29	Corrective surgery for blepharoptosis
30	Removal of a foreign body from the conjunctiva
31	Removal of a foreign body from the cornea
32	Incision of the cornea
33	Operations for pterygium
34	Other operations on the cornea
35	Removal of a foreign body from the lens of the eye
36	Removal of a foreign body from the posterior chamber of the eye
37	Removal of a foreign body from the orbit and eyeball
38	Operation of cataract
Operations on the skin & subcutaneous tissues	
39	Incision of a pilonidal sinus
40	Other incisions of the skin and subcutaneous tissues
41	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues

42	Local excision of diseased tissue of the skin and subcutaneous tissues
43	Other excisions of the skin and subcutaneous tissues
44	Simple restoration of surface continuity of the skin and subcutaneous tissues
45	Free skin transplantation, donor site
46	Free skin transplantation, recipient site
47	Revision of skin plasty
48	Other restoration and reconstruction of the skin and subcutaneous tissues
49	Chemosurgery to the skin
50	Destruction of diseased tissue in the skin and subcutaneous tissues
Operations on the tongue	
51	Incision, excision and destruction of diseased tissue of the tongue
52	Partial glossectomy
53	Glossectomy
54	Reconstruction of the tongue
55	Other operations on the tongue
Operations on the salivary glands & salivary ducts	
56	Incision and lancing of a salivary gland and a salivary duct
57	Excision of diseased tissue of a salivary gland and a salivary duct
58	Resection of a salivary gland
59	Reconstruction of a salivary gland and a salivary duct
60	Other operations on the salivary glands and salivary ducts
Other operations on the mouth & face	
61	External incision and drainage in the region of the mouth, jaw and face
62	Incision of the hard and soft palate
63	Excision and destruction of diseased hard and soft palate
64	Incision, excision and destruction in the mouth
65	Plastic surgery to the floor of the mouth
66	Other operations in the mouth
Operations on the tonsils & adenoids	
67	Transoral incision and drainage of a pharyngeal abscess
68	Tonsillectomy without adenoidectomy
69	Tonsillectomy with adenoidectomy
70	Excision and destruction of a lingual tonsil
71	Other operations on the tonsils and adenoids
72	Trauma surgery and orthopaedics
73	Incision on bone, septic and aseptic
74	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
75	Suture and other operations on tendons and tendon sheath
76	Reduction of dislocation under GA
77	Arthroscopic knee aspiration
Operations on the breast	
78	Incision of the breast
79	Operations on the nipple
Operations on the digestive tract	
80	Incision and excision of tissue in the perianal region
81	Surgical treatment of anal fistulas
82	Surgical treatment of haemorrhoids
83	Division of the anal sphincter (sphincterotomy)

84	Other operations on the anus
85	Ultrasound guided aspirations
86	Sclerotherapy etc.
87	Laparoscopic cholecystectomy
Operations on the female sexual organs	
88	Incision of the ovary
89	Insufflation of the Fallopian tubes
90	Other operations on the Fallopian tube
91	Dilatation of the cervical canal
92	Conisation of the uterine cervix
93	Other operations on the uterine cervix
94	Incision of the uterus (hysterectomy)
95	Therapeutic curettage
96	Culdotomy
97	Incision of the vagina
98	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
99	Incision of the vulva
100	Operations on Bartholin's glands (cyst)
Operations on the prostate & seminal vesicles	
101	Incision of the prostate
102	Transurethral excision and destruction of prostate tissue
103	Transurethral and percutaneous destruction of prostate tissue
104	Open surgical excision and destruction of prostate tissue
105	Radical prostate vesiculectomy
106	Other excision and destruction of prostate tissue
107	Operations on the seminal vesicles
108	Incision and excision of per prostatic tissue
109	Other operations on the prostate
Operations on the scrotum & tunica virginals testis	
110	Incision of the scrotum and tunica virginals testis
111	Operation on a testicular hydrocele
112	Excision and destruction of diseased scrotal tissue
113	Plastic reconstruction of the scrotum and tunica virginals testis
114	Other operations on the scrotum and tunica virginals testis
Operations on the testes	
115	Incision of the testes
116	Excision and destruction of diseased tissue of the testes
117	Reconstruction of the testis
118	Implantation, exchange and removal of a testicular prosthesis
119	Other operations on the penis
Operations on the spermatic cord, epididymis und ductusdeferen	
120	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
121	Excision in the area of the epididymis
122	Epididymectomy
123	Reconstruction of the spermatic cord
124	Reconstruction of the ductus deferens and epidididymis

125	Other operations on the spermatic cord, epididymis and ductus deferens
Operations on the penis	
126	Operations on the foreskin
127	Local excision and destruction of diseased tissue of the penis
128	Amputation of the penis
129	Plastic reconstruction of the penis
130	Other operations on the penis
Operations on the urinary system	
131	Cystoscopical removal of stones
Other Operations	
132	Lithotripsy
133	Coronary angiography
134	Haemodialysis
135	Radiotherapy for Cancer
136	Cancer Chemotherapy

12. 5 Exclusions

The Company shall not be liable to make any payment if hospitalization or claims are attributable to, or based on, or arise out of, or are directly or indirectly connected to any of the following:

1. Pre-existing condition

   Benefits will not be available for any condition, whether diagnosed or not, ailment or injury or related condition(s) for which Insured has been diagnosed, received medical treatment, had signs and / or symptoms, prior to inception of Insured's first Policy with HNB Assurance. It would also mean any direct or indirect complications arising out of pre-existing conditions, whether known or unknown to the Insured. Pre-existing conditions need to be explicitly disclosed and accepted by the insurer at the time of proposal.

2. Epidemics/Pandemics recognized by WHO or Government of the country. Government screening programs (or similar) are not covered by this benefit, except Covid-19. Quarantine is excluded.

3. War, invasion, acts of foreign enemies, acts of terrorism, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority.

4. Injury or disease directly or indirectly caused by or contributed to by nuclear reaction/weapons/materials, radiation or chemical contamination.

5. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or as may be necessitated due to an accident.

6. Cosmetic or anesthetic treatments of any description, treatment or surgery for change of gender, Lasik treatment for refractive error, any form of plastic

surgery (unless necessary for the treatment of illness or accidental bodily injury).

7. The cost of spectacles, contact lenses, hearing aids, crutches, wheelchairs, dentures, artificial teeth and all other external appliances, prosthesis and/or devices, unless specified otherwise by the Company.

8. Expenses incurred on items for personal comfort like television, telephone, etc. incurred during hospitalization and which have been specifically charged for in the hospitalization bills issued by the hospital/nursing home.

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

10. Convalescence, general debility, "Run-down" condition, rest cure, internal congenital anomaly, external congenital anomaly, birth defects.

11. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent resisting arrest.

12. Any complications arising out of, or ailments requiring treatment due to, use or abuse of any substance, drug or alcohol and treatment for de-addiction.

13. Any condition directly or indirectly caused by or associated with Human Immunodeficiency Virus or variant/mutant viruses and or any syndrome or condition of a similar kind commonly referred to as AIDS.

14. Venereal disease or any sexually transmitted disease or sickness.

15. Treatment arising from or traceable to pregnancy, childbirth including caesarian section, miscarriage, abortion or complications of any of this, including pre and post-natal expenses, unless specified otherwise by the Company.

16. Any fertility, sub fertility or assisted conception operation or sterilization procedure and related treatment and voluntary termination of pregnancy.

17. Vaccinations or inoculations of any kind.

18. Vitamins, tonics, nutritional supplements unless forming part of the treatment for injury or disease as certified by the attending medical practitioner

19. Surgery to correct deviated septum and hypertrophied turbinate unless necessitated by an accidental body injury and proved to our satisfaction that the condition is a result of an accidental injury.

20. Treatment for any mental illness/disease or psychiatric or psychological ailment / condition.

21. Non-prescribed drugs and medical supplies, hormone replacement therapy.

22. Any treatment required arising from Assured's participation in any hazardous activity including but not limited to all forms of skiing, scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing , engaging in hunting, racing of all kinds, steeple chasing, polo playing, mountaineering, winter sports or ice hockey etc. unless specifically agreed by the insurer.

23. Genetic disorders and stem cell implantation / surgery/storage.

24. Expenses incurred at Hospital or Nursing Home primarily for diagnosis irrespective of 24 hours Hospitalization without diagnosis of any disease that require follow up treatment covered under this Policy. This would also include stay in a hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner, or undertaking of treatment which ordinarily can be given without Hospitalization.

25. Treatments taken at any institution which is primarily a rest home or convalescent facility, a place for custodial care, a facility for the aged or alcoholic or drug addicts or for the treatment of psychiatric or mental illness/disease/disorders, even if the institution has been registered as a hospital or nursing home with the appropriate authorities.

26. Treatment by non-allopathic methods, Ayurveda , naturo therapy, acupuncture, aromatherapy and any such similar treatment.

27. Expenses incurred primarily for diagnostics, x-ray or laboratory examinations, other diagnostics studies not consistent with or incidental to diagnosis and treatment of the positive existence or presence of any disease, illness or injury, for which confinement is required at a hospital or nursing home or at home under domiciliary hospitalization as defined.
28. Treatment for obesity, weight reduction or weight management.
29. Medical Practitioner's home visit expenses during pre and post hospitalization period.
30. Hospitalization for donation of any body organs by the Assured including complications arising from the donation of organs, unless specified otherwise by the Company. Cost of donor screening or treatment, unless specifically covered and specified in the benefit.
31. Experimental and unproven treatment.
32. Expenses related to a Hospital stay not expressly mentioned as being covered, including but not limited to expenses for admission, discharge, administration, registration, documentation and filing, service expenses/surcharges.
33. Injuries incurred whilst the Life Assured is travelling in an aircraft other than as a ticket holding passenger in a fully licensed standard type of civil aircraft,

operated by a recognized Air Charter Company or owned by a Commercial or Industrial firm and piloted by a pilot holding a commercial pilot's license.

34. Treatments in health hydro, spas, nature care clinics and the like.
35. Natural Hazards: Earthquake, landslides, floods, tsunami or tidal waves caused by earthquakes or volcanic eruption , cyclones, storms, tempest, hurricanes, tornados & typhoons.
36. Medical expenses incurred due to Ventral / Incisional Hernia unless we have paid the first operation.

12. 6 Definitions

1. "**Accident**" means a sudden unforeseen and involuntary event caused by external and visible means.
2. "**Accidental Bodily Injury**" means any accidental physical bodily harm solely and directly caused by external, violent and visible means which is verified and certified by a medical practitioner but does not include any sickness or disease.
3. "**Any One Illness**" means any continuous period of illness and which includes a relapse within 45 days from the date of discharge from the hospital/nursing home where treatment may have been taken and for which a claim had been made with the insurer. Occurrence of same illness after a lapse of 45 days as stated above will be considered as fresh illness for the purpose of this policy.
4. "**Child Care Benefit**" means the amount paid by the insurer for the attendant escort expenses for each completed day of hospitalization in case of a child below 12 years of age, during the policy period. Escort person includes mother, father, grandfather, grandmother and any immediate family member
5. "**Day Care Expenses**" means the reasonable and customary expenses incurred towards medical treatment for a day care treatments /procedure preauthorized by the officer of HNB ASSURANCE PLC. and done in a hospital/nursing home to the extent that such cost does not exceed the reasonable and customary expenses in the locality for the same day care treatment / procedure.
6. "**Day Care Treatment**" means medical treatment, and/or surgical procedure which are listed in the policy. Any other procedures or surgery not listed in the policy are not payable.
7. "**Dependent Child/Children**" means children / a child (natural or legally adopted), who are/is financially dependent on the Assured or proposer and does not have his / her independent sources of income and aged between 3 months and 18 years who are unmarried and who have not established their own household, and receive the majority of maintenance and support from the Assured.
8. "**Disease / illness**" means a condition affecting the general well-being and health of the body that first manifests itself in the policy period and which requires treatment by a medical practitioner.
9. "**Day**" means completed 24 hours stay in hospital.
10. "**Eligible Hospitalization Expenses**" means the expenses which the Assured/Assured person is entitled for applicable room rent and other

charges as given in the scope of cover under the policy.

11. "**Epidemic Disease**" means a disease which occurs when new cases of a certain disease, in a given human population, and during a given period, substantially exceed what is the normal "expected" incidence rate based on recent experience (the number of new cases in the population during a specified period of time is called the "Incidence Rate").
12. "**External Congenital Anomaly**" means a condition(s) which is present since/during birth is visible and is in an accessible part of the body and which is abnormal with reference to form, structure or position.
13. "**Family definition"**

Individual Basis: Policy holders, Spouse, Maximum of 5 Children , parents and Parent- in – laws

Subject to,

- Individual underwriting.
- Establish the relationship of parents and Parent-in-laws.
- In case of the covering parents, both parents are compulsorily unless one of them is uninsurable.
- In case of the covering parents-in-laws, both parent-in-laws are compulsorily unless one of them is uninsurable.
- Health Declaration - Each Member is answering in the proposal form .
- In case of the covering parents-in-laws, spouse cover is compulsory unless the spouse is uninsurable .

Floater Basis - Maximum up to 9 members out of above list with above conditions.

14. "I**nsurer**" means HNB ASSURANCE PLC
15. "**Hospital/Nursing Home**" means an establishment, which is licensed in accordance with the statutory regulation of the relevant country which has one or more legally qualified doctors and operated for the care and treatment of sick or injured persons, which institution provides in- patient facilities and has the service of registered and qualified nurses. Twenty four (24) hours a day and has facilities for both diagnosis and major surgery, and where daily medical records of patients are maintained. The Company should have the accessibility for such medical records.

    The term "Hospital" shall not be construed to include a place for rest cures, convalescence cures, custodial care of sanatorium, home for persons declared incapable of managing their own affairs, homes for the aged, alcoholics, drug addicts, mentally disturbed persons, invalids or persons in need of care.
16. "**Hospitalization**" means the Assured's admission into hospital for a continuous period of not less than 24 hours.
17. "**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

18. "**Internal Congenital Anomaly**" means disease not manifested externally resulting from congenital disorder due to defects in or damage to a developing fetus. It may be the result of genetic abnormalities, the intrauterine (uterus) environment, errors of morphogenesis, or a chromosomal abnormality.
19. "**Medical Expenses**" means reasonable & customary expenses unavoidably and reasonably incurred by the Assured for medical treatment of disease, illness or injury that may be the subject matter of claim as an In-patient in a hospital/nursing home/day care center, and includes the costs of a bed; treatment and care by medical staff; medical procedures; medical practitioner's fees; medicines and consumables etc. as long as these are recommended by the attending medical practitioner and are allowed under the policy.
20. "**Medical Practitioner**" means a person who holds a valid registration from the medical council / licensing authority of the relevant country and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his / her license. The term medical practitioner would include physician, specialist and surgeon. The registered medical practitioner should not be the insured or anyone close family members of the Insured.
21. "**Mental Illness/Disease**" means any mental disease or bodily condition marked by disorganization of personality, mind, and emotions to impair the normal psychological, social or work performance of the individual regardless of its cause or origin.
22. "**Other Insurer**" means any of the registered Insurers other than HNB ASSURANCE PLC.
23. **"Out Patient Department"** means a department where patient is not hospitalized and who is being treated in an office, clinic, or other ambulatory care facility by medical practitioner for illness/disease.
24. "**Organ Donor Expenses**" means the medical expenses for an organ donor's treatment for the harvesting of the organ donated subject to the insurer accepting the inpatient hospitalization claim made by the insured and provided that:
    i. The organ donor is the Assured person's blood relative and the organ donated is for the use of the Assured person, and
    ii. The insurer will not pay the donor's pre- and post-hospitalization expenses or any other medical treatment for the donor consequent on the harvesting;
    iii. All the admissible expenses incurred on the donor/donee, as above, would be within the overall Sum Assured of the Assured person as specified in the policy Schedule.
25. "**Pre-existing Condition**" means any condition, whether diagnosed or not, ailment or injury or related condition(s) for which Assured has been diagnosed, received medical treatment, had signs and / or symptoms, prior to inception of Assured's first life policy with HNB ASSURANCE PLC. It would also mean any

direct or indirect complications arising out of pre-existing conditions whether known or unknown to the Assured.

26. "**Post - Hospitalization Expenses**" means relevant medical expenses incurred during period up to 30 days after discharge from the hospital for disease/illness/accidental bodily injury sustained. Such expenses will be considered as part of claim limited to treatment which is continued after discharge for an ailment / disease / accidental bodily injury not different from the one for which hospitalization was necessary.
27. "**Pre - Hospitalization Expenses**" means relevant medical expenses incurred during period up to 30 days prior to hospitalization on disease/illness/injury sustained. Such expenses will be considered as part of claim limited to treatment which is taken before hospitalization for an ailment / disease / injury not different from the one for which hospitalization was necessary.
28. "**Qualified Nurse**" means a person who holds a valid registration from the Nursing Council of relevant country.
29. "**Reasonable and Customary Expenses**" means a charge which: a) is charged for medical treatment, supplies or medical services that are medically necessary to treat insured's condition; and b) does not exceed the usual level of expenses for similar medical treatment, supplies or medical services in the locality where the expense is incurred; and c) does not include expenses that would not have been made if no insurance existed.
30. "**Surgical Operation**" means manual and/or operative procedures required for treatment of a disease / illness or accidental bodily injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital/nursing home by a medical practitioner.
31. "**Waiting Period**" At no point of time during the term of the Policy, any benefit shall be payable for the claim which occurs or where the Hospitalization for the claim has occurred within 90 days of first benefit offer Date. Waiting period is not applicable for the subsequent continuous uninterrupted renewals of the benefit and Hospitalization due to Accidents.

12.7. Claims

12.7.1 Claims Procedure

1. The Assured shall without any delay consult a doctor and follow the advice and treatment recommended, take reasonable step to minimize the quantum of any claim that might be made under this benefit and intimation to this effect must be forwarded to insurer accordingly.
2. Assured must provide intimation to insurer immediately and in any event within 48 hours from the date of hospitalization. However, the insurer at his sole discretion may relax this condition subject to a justifiable

reason/evidence being produced by the Assured on the reasons for such a delay beyond the stipulated 48 hours up to a maximum period of 7 days.

3. Assured has to file the claim with all necessary documentation within 30 days of discharge from the hospital, and provide insurer with written details of the quantum of any claim along with all the original bills, receipts and other documents upon which a claim is based and shall also give insurer such additional information and assistance as insurer may require in dealing with the claim. In case of delayed submission of claim and in absence of a justified reason for delayed submission of claim, the insurer would have the right of not considering the claim for settlement.
4. In respect of post hospitalization claims, the claims must be lodged within 15days from the completion of post hospitalization treatment subject to maximum of 45 days from the date of discharge from hospital.
5. The Assured shall submit himself for examination by Insurer's medical advisors as often as may be considered necessary by insurer. In such an event the insurer will bear reasonable & customary expenses incurred by the Assured for making himself available for the said examinations.
6. Assured must give all original bills, receipts, certificates, information and evidences from the attending medical practitioner /hospital /diagnostic laboratory as required by insurer.
7. On receipt of intimation from Assured regarding a claim under the benefit, insurer/administrator is entitled to carry out examination and obtain information on any alleged injury or disease requiring hospitalization if and when insurer may reasonably require.

12.7.2 Claims Submission

The Assured should submit the claim documents to the insurer**.** Following is the list of document for claim submission. Additional requirements may be called for depending on the claim

- Duly filled Claim form,
- Original discharge card/certificate/ death summary,
- Copies of prescription for diagnostic test, treatment advise, medical references
- Original set of investigation reports,
- Itemized original hospital bill and receipts , Hospital and related original medical expense receipt , pharmacy bills in original with prescriptions

12.7.3 Claims Processing

On receipt of claim documents from the Assured, the Insurer/Administrator shall assess the admissibility of claim as per the terms and conditions of the benefit. Upon satisfactory completion of assessment and admission of claim, the insurer will make the payment of benefit as per the contract. In case the claim is repudiated insurer will inform the Assured about the same in writing with reason for repudiation.