POLICY WORDINGS

Bharti AXA Smart Super Top Up Policy

Preamble & Operative Clause

Bharti AXA General Insurance Company Limited will provide insurance cover to the person(s) named in the Schedule based on the material facts recorded in the proposal and declaration made and agreed premium has been paid and realized in full.

We will pay the insured person(s) in respect of an insured event occurring during the policy period and subject to the Conditions, Sum Insured, Scope of Coverage, Geographical limits, Endorsement, Deductible and Exclusions in the manner and to the extent set forth in this policy.

Definitions

- Any words or expressions defined below have specific meanings ascribed to them wherever they appear in this Policy or Schedule. For purposes of this Policy, please note that references to the singular or masculine include references to the plural or to the female.

- **"Accident"** means sudden, unforeseen and involuntary event caused by external, visible and violent means.

- **"Any one illness"** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital where treatment was taken.

- **"AYUSH"** refers to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
- **"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.

- **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-patient 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 patients and making them accessible to the insurance company's authorized representative.

- **"Aggregate policy deductible"** refers to a specified rupee amount the policyholder needs to pay against medical expenses on cumulative basis under the policy during a policy year before the liability of the Insurer arises.

  In other words, the policyholder will be treated as his/her self-insurer till the medical expenses incurred for one or several events of hospitalization on cumulative basis reaches the threshold deductible limit in specified rupee amount during the policy year. Subsequently, the liability of the insurer arises for any medical expenses incurred that exceeds the specified rupee amount

- **"Break in Policy"** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

- **"Cashless facility"** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

- **"Company/We/Our/Ours"** means Bharti AXA General Insurance Company Limited.

- **"Condition Precedent"** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

- **"Congenital Anomaly"** means a condition which is present 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

- **"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.

- **"Cumulative Bonus"** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

- **"Day care treatment**" means medical treatment, and/or surgical procedure which is:
  - **a)** undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
  - **b)** which would have otherwise required hospitalization of more than 24 hours.

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

- **"Day care centre"** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –
  - **a)** has qualified nursing staff under its employment;
  - **b)** has qualified medical practitioner/s in charge;
  - **c)** has fully equipped operation theatre of its own where surgical procedures are carried out;
  - **d)** maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

- **"Deductible"** means a cost sharing requirement under a health insurance policy that provides that the company will not be liable for a specified rupee amount in case of indemnity sections and for a specified number of days/hours in case of hospital cash section which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

- **"Dependent Child"** means a natural or legally adopted child, aged between 91 days to 23 Years and financially dependent on the Policy holder.
- **"Dental treatment"** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

- **"Disclosure to information norm"** means 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.

- **"Disease"** means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner.

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

- **"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.

- **"Family Floater**" means the Sum Insured shown in the Schedule which represents the Company's maximum liability for any and all claims made by any one Insured and/or all Insured Person(s) together during the Policy Period.

- **"Grace period"** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

- **"Hospital"** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:

    a) has qualified nursing staff under its employment round the clock;
    b) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    c) has qualified medical practitioner(s) in charge round the clock;
    d) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

- **"Hospitalization"** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for Day care treatments, where such admission could be for a period of less than 24 consecutive hours.

- **"ICU (Intensive Care Unit) Charges**" means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

- **"Illness"** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
    b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        I. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
        II. it needs ongoing or long-term control or relief of symptoms
        III. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
        IV. it continues indefinitely
        V. it recurs or is likely to recur

- **"Injury"** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

- **"Inpatient care**" means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

- **"Insured/You/Your "** means the primary Insured who has the highest age amongst other person named in the Schedule of the Policy in case of family floater Policy. In case of an Individual Policy the only member mentioned in the schedule of the Policy shall be referred as "Insured".

- **"Insured Person"** means the person named in the Schedule to the Policy and for whose benefit the insurance is proposed and appropriate premium paid.

- **"Intensive care unit (ICU)**" 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.

- **"Maternity expenses"** means;
  a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
  b) expenses towards lawful medical termination of pregnancy during the policy period.

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

- **"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.

- **"Medically necessary treatment"** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
  a) is required for the medical management of the illness or injury suffered by the insured;

b) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c) must have been prescribed by a medical practitioner;
d) Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

- **"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 its scope and jurisdiction of license.

  The registered practitioner should not be the insured or close member of the family.

- **"Migration"** means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

- **"Network Provider"** means hospitals or health care providers enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an insured by a cashless facility.

- **"Newborn baby"** means baby born during the Policy Period and is aged upto 90 days.

- **"Non-Network**" means any hospital, day care centre or other provider that is not part of the network.

- **"Notification of claim"** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

- **"OPD treatment"** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

- **"Policy Period"** means the period between the inception date and the expiry date specified in the Schedule.
  Policy period can be 1/2/3 year(s) in context of this policy.

- **"Policy"** means this document of Policy describing the terms and conditions of this contract of insurance (basis the statements in the Proposal Form and the Information Summary Sheet), any annexure thereto, including the company's covering letter to the Insured / Insured person if any, the Schedule attached to and forming part of this Policy and any applicable endorsement thereon. The Policy contains details of the scope and extent of cover available to the Insured/Insured Person, the exclusions from the scope of cover and the terms and conditions of the issue of the Policy.

- **"Policy Schedule"** means the document attached to and forming part of this Policy mentioning the details of the Insured Person(s), the Sum Insured, the period, coverage and the limits to which benefits under the Policy are subject to.

- **"Policy Year"** means the duration of each 12 calendar months from the inception date under the policy. Eg., Period of first 12 months shall be termed as **First Policy Year**, period exceeding 12 months upto 24 months shall be termed as **Second Policy Year** and period exceeding 24 months upto 36 months shall be termed as **Third Policy Year**.

- **Portability"** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

- **"Post-hospitalization Medical Expenses"** means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

  a) Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
  b) The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

- **"Pre-Existing Disease"**means any condition, ailment, injury or disease:

a) That is/are diagnosed by a physician within 48/36/24 months prior to the effective date of the policy issued by the insurer or reinstatement 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.

- **"Pre-hospitalization Medical Expenses"** means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
  a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
  b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

- **"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.

- **"Reasonable and Customary charges"** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

- **"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.

- **"Room Rent**" means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

- **"Senior citizen"** means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

- **"Subrogation"** means the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

- **"Sum Insured"** means the sum shown in the Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.

- **"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 from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

- **"Third Party Administrators or TPA''** means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulations,2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those Regulations.

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

Scope of Cover

- **A. Mandatory Section**

I. In-Patient Care Expenses- Necessary & Reasonable expenses incurred during in-patient care for a Medical/Surgical treatment of a Disease/Illness/Injury at any hospital in India on advice of a qualified Medical Practitioner. In-patient Care Expenses include

1) Room Rent/Boarding Expenses
2) Nursing Expenses
3) ICU Charges
4) Medical Practitioner's fees
5) Anesthetist, Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Fees
6) Drugs, Medicines, X-ray & Diagnostic tests.

7) Physiotherapy
8) Cost of Prosthetic devices used intra operatively during the Surgical Procedure.

Any expenses related to Hospitalization for Evaluation/Investigation/ List of Excluded items/ Non Payable items shall not be payable.

II. Domiciliary Hospitalization Expenses- Medical treatment for an Illness/Disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

1. The condition of the Patient is such that he/she is not in a condition to be removed to a Hospital or,
2. The Patient takes treatment at home on account of non-availability of room in a Hospital.

However, this does not cover

I. Treatment of less than 3 days. In the event of treatment period exceeding 3 continuous days, coverage shall be provided from the first day for expenses incurred for the entire course of treatment.
II. Post-Hospitalization expenses;
III. The following medical conditions:

a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza,
b. Arthritis, Gout and Rheumatism,
c. Chronic Nephritis and Nephritic Syndrome,
d. Diarrhoea and all type of Dysenteries including Gastroenteritis,
e. Diabetes Mellitus and Insupidus,
f. Epilepsy,
g. Hypertension,
h. Psychiatric or Psychosomatic Disorders of all kinds,
i. Pyrexia of unknown origin.

Domiciliary hospitalization also covers expenses on Qualified nurse(s) engaged on the recommendation of the attending Medical Practitioner.

The coverage under this Section is limited to the available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

- **B. Optional Sections**

I. **Day Care Treatment Expenses-** This section covers hospitalization expenses towards medical treatment, and/or procedure incurred by the Insured / Insured Person which is undertaken under General or Local Anesthesia in a Hospital/day care centre (where 24 hours of hospitalization is not required due to technologically advanced treatment) which shall be payable, in respect of listed treatments as given in the Appendix I. The coverage under this Section is limited to the available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy.

II. **Pre- Post Hospitalization Expenses-** Necessary & Reasonable expenses incurred prior to or following an In-patient Care/ Day Care Treatment /Domiciliary Hospitalization if opted to by the insured shall be covered subject to Pre & Post Hospitalization period specified in the Schedule and Exclusions/Conditions under the policy.

Pre Hospitalization	**Post Hospitalization**
1. Doctor's Consultation Charge	1. Doctor's Consultation for Follow-up
2. Cost of Medicine & Drugs	2. Cost of Medicine & Drugs
3. Diagnostic Tests	3. Diagnostic Tests
	4. Physiotherapy treatment in Hospital Premises

The coverage under this Section is limited to the available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

III. **Organ Donor Expenses-** The expenses incurred in organ donor's treatment for the harvesting of the organ donated and Donor's Post Hospitalization expenses upto 180 Days from date of organ donation, provided that:

I. The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs and tissues rules 2014 (amendment) and the organ donated is for the use of the Insured Person, and

II. There shall be an admissible claim under In-patient Care or Day Care Treatment /Domiciliary Hospitalization if opted to by the Insured..

The post hospitalization expenses do not relate to any complication(s) arising due to the harvesting of the organ donated. This Section does not cover costs directly or indirectly associated with the acquisition of the donor's organ.

The coverage under this Section is limited to the available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

IV. Surface Ambulance Charges- Reimbursement against expenses upto sublimit specified in the schedule and incurred on a surface transport ambulance offered by a registered healthcare or ambulance service provider used to transfer the Insured Person(s) to the nearest Hospital requiring Emergency Care or if advised by the medical practitioner.

There shall be an admissible claim under In-patient Care or Day Care Treatment.

The coverage under this Section is limited to the available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

V. AYUSH - This section provides reimbursement to the Insured/ Insured Person of Medical Expenses incurred for In-patient treatment taken under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems provided that the treatment has been undertaken in

a) Central and State Government Hospitals
b) NABH accredited Ayurvedic hospitals
c) Teaching hospitals attached to Ayurvedic colleges recognized by Central Government/Central Council of Indian Medicine
d) Ayurvedic hospitals having registration with a Government Authority under appropriate Act in a State/UT, minimum fifteen beds, minimum five qualified and registered Ayurvedic doctors, adequate number of qualified paramedical staff, dedicated Ayurveda therapy sections and daily maintenance of medical records.

Note:

a) The reimbursement under Ayush will be applicable for inpatient hospitalization claims only;
b) The Insured/ Insured person will not be entitled for Domiciliary Hospitalization;

The coverage under this Section is available upto the Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

VI. Dental Treatment- Reimbursement of medical expenses incurred towards dental treatment following an accident where the Insured Person(s) suffers injuries or damage to his/her natural teeth and/or gums. This section further provides cover for medical expenses incurred for follow up treatment for the same accidental dental injury up to a maximum of 15 days by the same Dentist. This coverage is subject to sublimit as specified in the Schedule.

Dental Treatment can be availed on Out-patient or In-Patient Care/ Day care Treatment Basis.

The coverage under this Section is limited to the sub-limit under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy. Policy deductible shall not apply in case of dental treatment covered under the policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

VII. Home Nursing Coverage

The Company, on a reimbursement basis, shall pay the Reasonable and Customary Charges incurred during the Policy Year towards a Qualified Nurse arranged by the Hospital or by the Company's network of service providers to visit the Insured Person's home to give expert nursing services limited to the available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy, provided that:

1. The Insured Person must have significant difficulty coping with the required activities of daily living and specialist Medical Practitioner who treated the Insured Person must have recommended these services in writing.
2. The claim becomes payable provided that a claim has been admitted under this policy under the In-Patient Care Expenses and is related to the same condition.
3. The Company shall cover visits by a Qualified Nurse for the period as specified in the policy schedule as it is required for a medically necessary treatment which would normally have been provided in a Hospital subject to the limits as specified in the Policy Schedule.
4. The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons).
    a. Eating (being able to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available).

b. Bathing (being able to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene).
c. Dressing (being able to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other Surgical Appliances).
d. Toileting (being able to get on and off the toilet and manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene).
e. Transferring (being able to get in and out of bed or a chair without assistance).
f. Mobility (being able to move indoors from room to room on level surfaces at the normal place of residence).

5. Home nursing coverage is not related to any Domiciliary Hospitalisation.
6. The company is liable to pay for a qualified nursing services, limited for the period for which services have been availed not exceeding 6 weeks during the policy year.
7. All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

VIII. Cumulative Bonus

a. Regular Cumulative Bonus

If no claim has been made in a Policy Year by any Insured / Insured Person, then for each such Policy year, the Company will offer a Cumulative bonus.

Cumulative bonus will be provided on the Initial Policy **In-Patient Care Expenses** Sum Insured, provided that the Policy is renewed continuously.

The sub-limits applicable to various sections will remain the same and shall not increase proportionately with the increase in Cumulative Bonus.

In case of a claim, the Cumulative bonus earned shall be automatically reduced in the same proportion in the following renewal of the Policy. This will not affect the initial **In-Patient Care Expenses** Sum Insured of the Policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

Regular Cumulative Bonus	
Age at the inception of 1st Policy year <45 yrs.	10% of initial Policy **In-Patient Care Expenses** S.I per annum not exceeding Cumulative Bonus of 100% of initial Policy **In-Patient Care**

	Expenses S.I
Age at the inception of 1st Policy year >45 yrs. and <65 yrs.	10% of initial Policy **In-Patient Care Expenses** S.I per annum not exceeding Cumulative Bonus of 50% of initial Policy **In-Patient Care Expenses** S.I

b. Guaranteed Cumulative Bonus:

In case the Insured has opted for Guaranteed Cumulative Bonus at inception of the policy, the Cumulative Bonus shall get accrued in case of a claim free year and will not get reduced on occurrence of a claim. The rate of accrual shall remain the same as that in Regular Cumultive Bonus. Guaranteed Cumulative Bonus, if opted at inception, shall replace the Regular Cumulative Bonus.

Guaranteed Cumulative Bonus	
Age at the inception of 1st Policy year <45 yrs.	10% of initial Policy **In-Patient Care Expenses** S.I per annum not exceeding Cumulative Bonus of 100% of initial Policy **In-Patient Care Expenses** S.I
Age at the inception of 1st Policy year >45 yrs. and <65 yrs.	10% of initial Policy **In-Patient Care Expenses** S.I per annum not exceeding Cumulative Bonus of 50% of initial Policy **In-Patient Care Expenses** S.I

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

IX. Wellness and Value Added Services

a. Wellness Rewards- Insured can accumulate rewards by opting for an array of wellness programs listed below, that will help assess his/her health status and aid in improving the overall well-being. Each specific program can be opted only once by a particular Insured Person in a policy year.

There will be no limitation to the number of programs one can enroll however maximum rewards that all the insured person(s) in a single policy period can earn, will be limited to 5% of the policy premium in the first year and 10% of the policy premium in the subsequent years and multi-year policies subject to continuous utilization of these programs. The Wellness Rewards will get accrued in the following manner:

Program Type	Rewards Scale#	
	Activization Year 1	**Activization Year 2 & above***
Health Awareness – Health risk assessment	Upto 1% of the Policy Premium**	Upto 2% of the Policy Premium
Health Action – Voluntary Health Checkup which includes all the tests listed below and undergone by the Insured/Insured persons in the last 6 months from the date of renewal with us and their readings • CBC • ESR • Urine Routine • General Physical Examination- Pulse, BP, Height, Weight, Eyesight, Chest & abdominal conditions • Blood Sugar- Fasting Blood Sugar & Post Prandial Blood Sugar • Triglycerides • Serum Cholesterol • Chest X Ray • ECG	Upto 2.50% of the Policy Premium	Upto 5% of the Policy Premium
Health Affinity – Active Membership for any programs which keeps you moving like (on Annual membership basis) Gym membership, Yoga, Swimming, Zumba, etc. Also participation in Professional sporting events like Marathon, Walk for a cause, etc.	Upto 1.5% of the Policy Premium	Upto 3% of the Policy Premium
Total Accrual	Upto 5% of the Policy Premium	Upto 10% of the Policy Premium

The reward scale percentages are applicable basis the proposer covered under the policy. While these can be availed by family members also but the accrual shall happen based on activities availed/performed by the proposer covered under the policy.

***** Activization year means the policy year in which the insured performs all or any of the activities as mentioned in the above program types. The accrual shall happen on continuous coverage basis and if

the insured fails to continue these activities in subsequent years or fails to redeem these discounts in the subsequent year/subsequent renewals, the accrual shall fall to zero and the insured will have to start the process again to achieve the maximum discount benefit.

** Policy Premium means the premium paid by the proposer to the Company for the period post application of

all discounts & loadings excluding any applicable taxes.

- The Total Accrual rewards earned as reward scale percentage of the premium paid during the activization year shall be converted to and accumulated as reward points.
- In case of Multi-year policies, the insured is required to perform all or any of the activities at least once during the tenure of the insurance.
- The value of each earned rewards point is worth Re.1 and can be redeemed in the following manner

:

1. Adjustment of 1st year premium, when the insured purchases selected health insurance products from Bharti AXA General Insurance Co Ltd. post accrual of the wellness rewards points under this policy. However, the total rewards points that can be utilized shall not exceed 10% of the policy premium for such health policy. The rewards points can be redeemed on selected health insurance products offered by Bharti AXA General Insurance Co. Ltd.

2. This accrued discount can also be adjusted while paying the renewal premium under the same policy.
3. The equivalent value of the accrued total discount can be redeemed against any OPD Benefit (Doctor consultation, Dietician/Nutritionist consultation, purchase of Pharmacy (allopathy/ayurvedic/homeopathy medicines), 2nd Medical Opinion, Diagnostics, etc. services offered by Bharti AXA General Insurance network of service providers.

- Rewards Points earned by an insured cannot be transferred to anyone or rewards points earned under multiple such programs cannot be clubbed together for redemption in any single policy.
- All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

b. Wellness Management Services: The insured will have a choice to avail various wellness benefits/services under this benefit head provided by the Company through the network of specialists/service providers.

1. Health Coach to monitor your day to day well being
2. Chronic Condition Screening – Customized Health Checks including gene screening to understand the potential health risks the insured(s) may encounter in future or to avail regular screenings for chronic conditions to stay abreast about their on-going health and corrective/precautionary measures can be taken.
3. Condition Specific Care
    a. Orthopedics Program (Rehabilitation and mobilization, Nursing attendant, Physiotherapist and medical equipments, etc.)..
    b. Oncology Program (Palliative care support, Stroma care, Colostomy, Tube feeding, Supportive care, etc.).
    c. Pulmonary Program (Services/programs related to Improving breathing ability. Improving overall strength and exercise tolerance, programs to increase participation in daily physical and social activities)..
    a. Diabetes Management Program (Services such as Personal Health Coach, Personal Nutritionist, Hypo/Hyper Alerts Management, etc may be availed on the basis of need or as recommended by the treating medical practitioner).
    b. Internal Medicine Program (Services such as Doctor visits at home, Triage nursing, Medicine delivery, etc. may be availed on the basis of need or as recommended by the treating medical practitioner).

    All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

X. **Switch Benefit-** We will offer the Insured an option to switch into selected Nil Deductible health insurance products offered by Bharti AXA General Insurance Company Limited for same Sum Insured without re-evaluation of health status or any pre policy check provided that:

A. All Insured Persons has been insured under the policy for first time prior to the age of 45 years and has been renewed continuously and without any break in insurance,

B. This option to switch into selected Nil Deductible health insurance Policy shall be exercised by the Insured Person at time of renewals post completion of 4th policy year ; provided that it has been renewed continuously and without any interruption

C. Insured Person will be offered continuity of coverage in terms of waiver of waiting periods to the extent of benefits covered under this Policy. The Switch Benefit can be exercised only once by the Insured Person .All accrued benefits under this policy shall stand extinguished in the event of discontinuation of this Policy at any point of time or shifting to any other health insurance Policy with Bharti AXA General Insurance Company Limited.

D. The Insured can exercise this option at the time of every fourth consecutive claim free year.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule for the switched policy shall apply.

XI. **Deductible Incentive-** If no claim has been made in a Policy Year by any Insured / Insured Person, then for each such Policy year, the Company will reduce the deductible as per the table mentioned below.

Deductible Incentive	
Age at the inception of 1st Policy year upto 45 yrs.	10% reduction in the initial policy deductible each year not exceeding 50% of the policy deductible
Age at the inception of 1st Policy year >45 yrs. and <65 yrs.	5% reduction in the initial policy deductible each year not exceeding 25% of the policy deductible

Deductible incentive will be provided on the deductible at the inception of the 1st Policy year, provided that the Policy is renewed continuously.

The sub-limits applicable to various sections will remain the same and shall not reduce proportionately with the change in deductible.

In case of a claim, the accrued deductible incentive shall automatically reset in the same proportion as the earned deductible incentive in the following renewal of the Policy. However the deductible shall never exceed the deductible at the inception of the 1st Policy year.
Continuity of earned deductible incentive shall not be ported /carried forward in the following condition:-

- If the Insured exercises option to change the Policy Coverages/ Sum insured/ Deductible during currency or at the time of renewal in the same product or any other health insurance product offered by Bharti AXA General Insurance Co. Ltd. except when there is a natural addition of member in the same policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

XII. **Non Payable items -** The company agrees to pay for all the reasonable expenses incurred by the Insured towards the cost of Non Payable items not exceeding the available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy. The list of Non Payable items is mentioned in the Appendix II.

The below exclusion stands modified to the extent covered under this policy

"Non-payable items as per appendix II"

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

XIII. **Sum Insured Enhancement –**The **In-Patient Care Expenses** Sum Insured can be enhanced one grid up subject to no claim have been lodged/ paid under the policy. In case of increase in the Sum Insured, waiting period shall not apply afresh in relation to the amount by which the Sum Insured has been enhanced.

The Insured can exercise this option at the time of every fourth consecutive claim free policy years. No fresh medicals shall be required for such enhancement of the Sum Insured.

The renewal premium shall be subject to change in revised Sum Insured conditional upon.

All other clauses, terms and conditions and exclusions applicable to and specified in the policy schedule shall apply.

XIV. **Hospital Daily Cash -** Daily cash amount will be payable per day up to the specified limits as mentioned in the Schedule to this Policy if the Insured Person is Hospitalized for treatment of any Disease / Illness / Injury for which a valid claim is admissible. In-Patient care expenses is admissible under the Policy for each continuous and completed period of 24 hours and if the Hospitalization exceeds for more than 24 hours. First continuous and completed period of 24 hours will act as deductible.

This benefit shall not be applicable to Domiciliary Hospitalization/Day-Care Treatment if opted to by the Insured. This is paid up to a maximum of 30 days including all the members & all claims for the entire Policy Year.

This benefit is subject to the specified limits as mentioned in Schedule over and above the In-Patient Care Expenses Sum Insured as mentioned in the Schedule.

We will pay the benefit for the particular hospitalization event for which a valid Inpatient Care expenses claim is admissible under the policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

XV. Emergency Hospitalization (Worldwide Basis)–

The Company shall pay or reimburse to the Insured/ Insured Person expenses incurred for availing emergency medical assistance required on account of any disease/ illness/ injury sustained or contracted whilst on a Trip upto the limit of Sum Insured as specified in the Schedule of Policy.

This is an annual multi trip cover and the insured shall have the option to opt for this cover only at the time of policy inception.

The Sum Insured offered under this section shall be equal to 5 Lakh Indian rupees.

- This section intends to cover:-Out-patient treatment, provided, the same is critical and cannot be deferred till the insured/ insured person's return to the Republic of India.
- The proposer covered under the policy shall be employed or having business in India.
- The coverage under this section is applicable for business & leisure trips where the duration of any single trip should not exceed 5 days.
- In-patient treatment in a local hospital at the place the Insured Person is staying at the time of occurrence of an insurable event.
- Medical aid prescribed by a Medical Practitioner as Medically Necessary part of a treatment for broken limbs or injuries (e.g. plaster casts, bandages and walking aids).
- Radiotherapy, heat therapy or photo therapy and other such treatment prescribed by a Medical Practitioner.
- X-ray, diagnostic tests and all reasonable costs towards diagnostic methods and treatment of all disease/illness/injury provided these pertain to the disease/illness/injury due to which hospitalization was deemed Medically Necessary.
- Cost of transportation, including necessary medical care, by recognized medical service providers for medical attention to the nearest hospital or to the nearest Medical Practitioner or to a special clinic if prescribed by a Medical Practitioner.
- Life saving unforeseen emergency measures provided to the Insured Person by the Medical Practitioner for the disease/illness/injury arising out of a Pre-existing condition. The treatment for these emergency measures would be paid till the Insured Person becomes medically stable, as ascertained by the Panel Doctor of the Emergency Assistance Service Provider. All further medical costs to maintain medically stable state would have to be borne by the Insured/Insured Person.

  All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

Specific Definition:

"Emergency Assistance Service Provider" means any organization or institution appointed by the Company for providing services to the Insured/Insured Person for an insurable event.

Specific Exclusions:

1. Any pre-existing condition, unless the medical assistance provided abroad involves unforeseen emergency measures to save the Insured/Insured person's life.

2. Where the insured person is travelling against the advise of a physician or receiving or on a waiting list for specified medical treatment; or is travelling for the purpose of obtaining treatment or has received a terminal prognosis for a medical condition; or

3. Treatment of orthopedic, degenerative, oncological diseases, unless the medical assistance provided abroad involves unforeseen emergency measures to save the Insured Person's life.
4. Treatment which could be reasonably delayed until the Insured Person's return to the Republic of India. The question of what can or what cannot be reasonably delayed will be decided jointly by the treating Medical Practitioner, Emergency Assistance Service Provider and the Company and shall be in accordance with accepted standards of medical care.
5. Charges in excess of reasonable and customary charges incurred for emergency treatment on account of an insured event.
6. Treatment relating to the removal of physical flaws or anomalies (cosmetic treatment or plastic surgery in any form or manner unless medically required as part of treatment for cancer, accidents and burns).
7. Expenses incurred in connection with rest or recuperation at a spa, health resort, Sanatorium, convalescence home, rehabilitation measures, private duty nursing, respite care, domiciliary care, long-term nursing care, custodial care and treatment related alcoholism and drug dependency.
8. Maternity, child birth and any consequences, including changes in other chronic conditions as a result of pregnancy. However, this exclusion will not apply in following cases:
   a) Ectopic Pregnancy proved by diagnostic means and certified to be life threatening condition / situation by the attending Medical Practitioner
   b) If the medical assistance provided abroad involves unforeseen emergency measures to save the Insured Person's or the child's life in the event of acute complications, provided that the Insured Person has not completed the age of 38 years and the 30th week of the pregnancy is not yet completed.
9. Rehabilitation and/or physiotherapy or the costs of prostheses/ prosthetics (artificial limbs) etc.

XVI. Convalescence Benefit

In case the Insured / Insured Person is hospitalized for a continuous period of 10 days or more for treatment of any Disease/ Illness /Injury for which a valid claim is admissible under the Policy, this benefit provides for payment to the Insured / Insured Person of a fixed amount as mentioned in the Schedule of benefit attached to this Policy.

This benefit offers additional Sum Insured over and above the **In-Patient Care Expenses** Sum Insured as mentioned in the Policy Schedule. This benefit under any policy shall be payable only once during the policy year.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

XVII. Health Check-up:

The Company will cover the cost of preventive health checkup every year provided that there are no claims made or paid related to any insured person covered under the previous policy year. Insured / Insured Person further understand and agree that this benefit is only available at Renewal for Policies that are renewed without any break.

Preventive health checkup under this section shall any of the following:-

- CBC
- ESR
- Urine Routine
- General Physical Examination- Pulse, BP, Height, Weight, Eyesight, Chest & abdominal conditions
- Blood Sugar- Fasting Blood Sugar & Post Prandial Blood Sugar
- Triglycerides
- Serum Cholesterol
- Chest X Ray
- ECG

The liability of the Company under this Section shall be restricted to 1% of the **In-Patient Care Expenses** Sum Insured on aggregate basis to all Insured Person covered under the previous policy year.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

XVIII. Personal Accident:

Benefits & Definitions Applicable to this section

If at any time during the currency of this Policy, the Insured/ Insured Person shall sustain any bodily injury resulting solely and directly from accident caused by external, violent and visible means, then the Company shall pay to the Insured /insured person, his or her nominee, beneficiary or legal heir, as the case may be, the Sum Insured specified in the Schedule.

Personal Accident Sum Insured shall be the lesser amount of the following:

- 12 times of the gross annual income of the proposer covered under the policy.
- In-Patient Care Expenses Sum Insured
- Sum Insured for dependent spouse & parents/in laws shall be restricted to 50% of the In-Patient Care Expenses sum Insured upto maximum INR. 5,00,000.
- Sum Insured for dependent children shall be restricted to 25% of the In-Patient Care Expenses sum insured upto maximum INR. 2,50,000.

i. Accidental Death:

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of death of the Insured/Insured Person, the Sum Insured stated in the Policy Schedule shall become payable. Once this benefit is paid, the coverage under this policy would cease for the respective member.

ii. Permanent Total Disability:

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of:

A. sight of both eyes, or of the actual loss by physical separation of two entire hands or two entire feet, or of one entire hand and one entire foot, or of such loss of sight of one eye and such loss of one entire hand or one entire foot, the amount stated in the Policy Schedule shall become payable;

B. use of two hands or two feet, or of one hand and one foot, or of such loss of sight of one eye and such loss of use of one hand or one foot, the amount stated in the Policy Schedule shall become payable.

C. Loss of all fingers and both thumbs OR loss of both arm - at shoulder; between shoulder and elbow ; at and below elbow OR Loss of both leg - at hip; between knee and hip ; below knee, , then a lump sum stated in the Policy Schedule shall become payable.

NOTE: For the purpose of Clauses above, 'physical separation' of a hand means separation at or above the wrist and of the foot means at or above the ankle.

Permanent Total Disability can be claimed only once during the lifetime of the Insured. Once this benefit is paid, the personal accident coverage would cease for the respective member.

iii. Permanent Partial Disability:

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of:

A. the sight of one eye, or of the actual loss by physical separation of one entire hand or of one entire foot, fifty percent (50%) of Sum Insured the amount stated in the Policy Schedule shall become payable;

B. use of a hand or a foot without physical separation, fifty percent (50%) the amount stated in the Policy Schedule shall become payable.

NOTE: For the purpose of Clauses above, 'physical separation' of a hand means separation at or above the wrist and of the foot means at or above the ankle.

C. If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and/or partial and irrecoverable loss of use or of the actual loss by physical separation of the following, then the percentage of the Sum Insured as indicated below shall be payable.

Table of Benefits	Percentage of Personal Accident Sum Insured
1. Death (worldwide)	100%
2. PTD – (worldwide) Total and irrecoverable loss of :	
i) Sight of both eyes or of the actual loss by physical separation of two entire hands or two entire feet or one entire hand and one entire foot or of such loss of sight of one eye and such loss of one entire hand or one entire foot.	100%
ii) Use of two hands or of two feet or of one hand and one foot or of such loss of sight of one eye and such loss of use of one hand or one foot.	100%
iii) Loss of all fingers and both thumbs OR loss of both arm - at shoulder; between shoulder and elbow ; at and below elbow OR Loss of both leg - at hip; between knee and hip ; below knee	100%
3. Permanent total and absolute disablement disabling the Insured Person from engaging in any employment or occupation of any description whatsoever.	100%
4. PPD - Total and irrecoverable loss of various parts as given below:	
The sight of one eye or the actual loss by physical separation of	50%

one entire hand or one entire foot.	
Use of a hand or a foot without physical separation	50%
Loss of speech	50%
Loss of toes – all	20%
Loss of toes great - both phalanges	5%
Loss of toes great - one phalanx	2%
Loss of toes other than great, if more than one toe lost: each	2%
Loss of hearing - both ears	75%
Loss of hearing - one ear	30%
Loss of four fingers and thumb of one hand	50%
Loss of four fingers of one hand	40%
Loss of thumb - both phalanges	25%
Loss of thumb – one phalanx	10%
Loss of index finger – three phalanges	15%
Loss of index finger – two phalanges	10%
Loss of index finger - one phalanx	5%
Loss of middle finger or ring finger or little finger – three phalanges	10%
Loss of middle finger or ring finger or little finger – two phalanges	7%
Loss of middle finger or ring finger or little finger - one phalanx	3%
Loss of metacarpals – first or second (additional) or third, fourth or fifth (additional)	3%
Any other permanent partial disablement	Percentage as assessed by a panel doctor of the Company

The Permanent Partial Disability benefit may be paid multiple times for mutually exclusive disablements until the limit of sum insured is exhausted during the lifetime of the customer. In other words, the coverage would continue even after the payment of benefit if the sum insured limit is not exhausted. However, if any claim arises under the Accidental Death and Permanent Total disability post triggering of the Permanent Partial Disability benefit, the respective applicable sum insured would

become payable subject to deduction of the benefit amount already paid under section Permanent Partial Disability.

The maximum liability of the company under this section is restricted to the lifetime SI .In the event of a claim been paid under the policy, SI will not be replenished to the initial sum insured under Personal accident at the time of renewal.

If due to any single accident, any Insured person sustains injury and there are admissible claims under multiple sections of Personal Accident, the liability of the Company shall be restricted to the highest Sum Insured specified under any one section of Personal accident.

(i) Specific Exclusions applicable to this Section

The Company shall not be liable under this Policy for;

a. Death or disablement resulting directly or indirectly caused by, contributed to or aggravated or prolonged by child birth or from pregnancy or in consequence thereof.
b. Any payment in case of more than one claim under the policy during any one period of insurance by which the maximum liability of the Company in that period would exceed the Sum Insured as indicated in the Policy Schedule.
c. Any pre-existing disability / accidental injury.
d. Accidental death or permanent disability due to mental disorders or disturbances of consciousness, strokes, fits or convulsions which affect the entire body and pathological disturbances caused by the mental reaction to the same.
e. Accidental death or permanent disability caused by curative measures, radiation, infection, poisoning except where these arise from an accident.
f. Any claim in respect of accidental death or permanent disablement of the Insured/Insured Person.
    - from intentional self-injury, suicide or attempted suicide
    - due to willful or deliberate exposure to danger except in an attempt to save human life
    - whilst under the influence of liquor or drugs or other intoxicants
    - whilst engaging in aviation, flying or taking part in aerial activities (including cabin crew) whilst mounting into, dismounting from or traveling in any aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world
    - arising or resulting from the Insured committing any breach of law or participating in an actual or attempted felony, riot, crime, misdemeanour or civil commotion
    - whilst engaging in racing, hunting, mountaineering, ice hockey, winter sports.
g. Any consequential loss or damage cost or expense of whatsoever nature.

h. Death or permanent disablement due to accidental injury arising out of or directly or indirectly connected with or traceable to war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and detainments of all Kings, Princes and people of whatsoever nation, condition or quality.

i. Death or permanent disablement due to accidental injury, directly or indirectly, caused by or contributed to by or arising from -

   A. ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel and for the purposes hereof, combustion shall include any self-sustaining process of nuclear fission;
   B. nuclear weapons material.

j. Any accident to an Insured/Insured Person which arises in the course of his/her occupation if his/her occupation falls within the following categories or involves the following activities: Air crew, ship crew, professional sportsman, diving, oil-rig platform and/or off-shore work, fire fighting, police, naval, military, air force service or operations and any hazardous occupation.

k. Whilst engaging in Adventure Sports. The list of adventurous sports are Water Rafting, Wildlife/Jeep Safaris, Trekking, Camping, Boat safaris, Parasailing, Paragliding, Elephant/Camel/Horse/Yak Safaris, Cycling, House Boat stays, Motor Bike tours, Kayaking, Rock Climbing, Artificial Wall Climbing, Bungee Jumping, Paintball, Suba Diving, Hot Air Ballooning, Canoeing, Mountain Biking, Rappelling, Snorkeling, Zip wires & high Rope course, Abseiling, Surfing, Water Skiing, Skiing, Caving, Self-Drive tours, Mountaineering/Hiking, All Terrain Vehicle, Hang Gliding, Snowboarding, Ultra-Light flying, Heli-skiing, Sky Diving.

All other clauses, terms and conditions, and exclusions applicable to and specified in the policy schedule shall apply.

XIX. Critical Illness Benefit- If, 60 days after the inception of this Policy, the Insured / Insured Person is at any time during the Policy period (after the above waiting period of 60 days), being diagnosed as contracting any Critical Illness as specified below, the specified limits as mentioned in Schedule (over and above the In-Patient Care Expenses Sum Insured mentioned in the Schedule) for this benefit shall be payable to the Insured/Insured Person as Lump Sum benefit.

However, in case of diagnosis of multiple illnesses qualified as Critical Illness under the Policy, the payment of compensation shall be limited to the limit specified in the schedule and shall be payable

only once in the lifetime of Insured/Insured person. Critical Illness benefit will lapse after reporting of and payment of one claim for the claiming Insured/Insured person.

After availing the Critical Illness Benefit, if the Insured / Insured Person takes treatment for the Critical Illness in a Hospital in India, the hospitalization expenses incurred for the same would be payable/reimbursed, subject to the deductible & terms and conditions of the Policy, out of the Sum Insured available for Hospitalization Expenses under this Policy.

Critical Illness limit opted cannot be more than Sum Insured opted for In-Patient Care Expenses. The illnesses qualified as Critical Illnesses and covered in this section are as follows:

1. Cancer
2. End Stage Renal Failure
3. Multiple Sclerosis
4. Major Organ Transplant
5. Heart Valve Replacement
6. Coronary Artery Bypass Graft
7. Stroke
8. Paralysis
9. Myocardial Infarction
10. Coma
11. Parkinson's Disease
12. Benign Brain Tumour
13. Alzheimer's Disease
14. End Stage Liver Disease
15. Surgery of aorta
16. Deafness
17. Loss of speech
18. Major Burns
19. Motor Neurone Disease with Permanent Symptoms;
20. Primary Pulmonary Hypertension;
21. Pulmonary Artery Graft Surgery;
22. Muscular Dystrophy;
23. Systemic Lupus Erythematosis with Lupus Nephritis;
24. Pneumonectomy;
25. Medullary Cystic Disease

Specific Critical Illness Definition (Applicable to Critical Illness Benefit Section & Restricted Critical Illness Endorsement)

1. Cancer of Specified Severity:

A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Kidney Failure Requiring Regular Dialysis:

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

3. Multiple Sclerosis with persisting symptoms:

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

4. Major Organ / Bone Marrow Transplant:

I. The actual undergoing of a transplant of –

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

II. The following are excluded:

a. Other stem-cell transplants
b. Where only islets of langerhans are transplanted

5. Open Heart Replacement or Repair of Heart Valves:

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

6. Open Chest – CABG (Coronary Artery By-pass Graft) surgery:

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

II. The following are excluded:

1) Angioplasty and/or any other intra-arterial procedures

7. Stroke Resulting In Permanent Symptoms:

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

II. The following are excluded:

1. Transient ischemic attacks (TIA)
2. Traumatic injury of the brain
3. Vascular disease affecting only the eye or optic nerve or vestibular functions.

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

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

i. A History of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers

II. The following are excluded:

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

10. Coma of specified severity:
I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;

(ii) life support measures are necessary to sustain life; and

(iii) permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

11. Parkinson's Disease:
A definite diagnosis of Parkinson's disease by a consultant neurologist. There must be permanent clinical impairment of motor function with associated tremor, muscle rigidity and postural instability. For the above definition the following are not covered:

- Other Parkinsonian syndromes.
- Parkinson"s disease secondary to drug abuse

12. Benign Brain Tumour:

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

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded:

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

13. Alzheimer's Disease:

The Unequivocal diagnosis of Alzheimer's disease (presenile dementia) before age 60 that has to be confirmed by a specialist Medical Practitioner (Neurologist) and evidenced by typical findings in cognitive and neuroradiological tests (e.g. CT scan, MRI, PET of the brain). The disease must also result in a permanent inability to perform independently three or more Activities of Daily Living or must result in need of supervision and the permanent presence of care staff due to the disease. These conditions must be medically documented for at least 90 days.

Alzheimer's disease is a condition which affects the brain Symptoms include memory loss, confusion, communication problems and general impairment of mental function. The condition gradually worsens, which can lead to changes in personality and makes routine tasks difficult. Eventually, 24 hour care may be needed.

14. End Stage Liver Failure:

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

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy.

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

15. Surgery to Aorta

The actual undergoing of major surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches. Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures are excluded.

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

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

18. Third Degree Burns:
There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.19. Motor Neurone Disease with Permanent Symptoms;

19. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

20. Primary (IDIOPATHIC) Pulmonary Hypertension:
I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

21. Pulmonary Artery Graft Surgery;

The undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

22. Muscular Dystrophy;
A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist acceptable to us, with confirmation of at least 3 of the following 4 conditions:

a. Family history of muscular dystrophy;
b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
c. Characteristic electromygrom; or
d. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Insured person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

23. Systemic Lupus Erythematosus (SLE):
A definite diagnosis of systemic lupus erythematosus by a consultant rheumatologist resulting in either of
the following:

1. Permanent neurological deficit with persisting clinical symptoms*; or

2. The permanent impairment of kidney function tests as follows; Glomerular Filtration Rate (GFR) below 30 ml/min.

   * Permanent neurological deficit with persisting clinical symptoms.

3. Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

4. Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localized weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, lethargy, dementia, delirium and coma

24. Pneumonectomy:
The undergoing of surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic injury suffered by the life assured.

The following conditions are excluded:

• Removal of a lobe of the lungs (lobectomy)
• Lung resection or incision

25. Medullary Cystic Disease:
A progressive hereditary disease of the kidneys characterised by the presence of cysts in the medulla, tubular atrophy and intestitial fibrosis with the clinical manifestations of anaemia, polyuria and renal loss of sodium, progressing to chronic renal failure. The diagnosis must be supported by renal biopsy.

All other clauses, terms and conditions and exclusions applicable to and specified in the policy schedule shall apply.

XX. Air Ambulance

The Company shall pay for transportation in an airplane or helicopter, which is certified to use as an ambulance for Emergency Care which require immediate and rapid transportation from the site of first occurrence of the Illness / Accident to the nearest Hospital within a reasonable timeframe. This cover is available only where the medical treatment required and as advised by medical practitioner is not available in any Hospital of the city of first occurrence. The claim would be reimbursed up to the actual expenses subject to available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy.

The Company shall not pay for air ambulance for the transfer of Insured / Insured Person within the same city of first occurrence. Return transportation is excluded.

Claim under this section is payable on per hospitalization event basis and admissibility of claim under this section shall be determined basis an admissible hospitalization claim under the policy that requires admission in the hospital as In-Patient.

The coverage is available on worldwide basis including geographical limits within India.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

General Exclusions

A Exclusion Name: Pre-Existing Diseases - Code- Excl01

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48/36/24 months of continuous coverage after the date of inception of the first policy with insurer as selected by the Insurer.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If the Insured Person is continuously covered without any break as defined under the portability / migration norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

B. Exclusion Name: Specified disease/procedure waiting period- Code- Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) 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.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures

1. Any types of gastric or duodenal ulcers

2. Benign prostatic hypertrophy

3. All types of sinuses

4. Hemorrhoids

5. Dysfunctional uterine bleeding

6. Endometriosis

7. Stones in the urinary and biliary systems

8. Surgery on ears/tonsils/adenoids/ paranasal sinuses

9. Cataracts,

10. Hernia of all types and Hydrocele

11. Fistulae in anus

12. Fissure in anus

13. Fibromyoma

14. Hysterectomy

15. Surgery for any skin ailment

16. Surgery on all internal or external tumours/ cysts/ nodules/polyps of any kind including breast lumps with exception of Malignancy

17. Dialysis required for Chronic Renal Failure.

18. Joint Replacement Surgeries unless necessitated by Accident happening after the Policy risk inception date.

19. Dilatation and curettage

20. Varicose Veins and Varicose Ulcers

21. Non Infective Arthritis and other form arthritis

22) Gout and Rheumatism

23) Prolapse inter Vertebral Disc and Spinal Diseases including spondylitis/spondylosis unless arising from Accident

C. 30-day waiting period- Code- Excl03

a) 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.

b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

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

D. Investigation & Evaluation- Code- Excl04

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

E. Exclusion Name: Rest Cure, rehabilitation and respite care- Code- Excl05

a) 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.

F. Obesity/ Weight Control: Code- Excl06

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

G. Change-of-Gender treatments: Code- Excl07

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

H. Cosmetic or plastic Surgery: Code- Excl08

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.

I. Hazardous or Adventure sports: Code- Excl09

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.

J. Breach of law: Code- Excl10

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

K. 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 policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

L. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and

consequences thereof. Code- Excl 12

M. Treatments received in heath 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- Excl13

N. 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- Excl14

O. Refractive Error: Code- Excl15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7. 5 dioptres.

P. Unproven Treatments: Code- Exel 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.

Q. Sterility and Infertility: Code- Excl 17

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

R. Maternity: Code Excl18

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.

S. 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.

T. 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.

U. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

V. Treatment taken outside the geographical limits of India

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

General Conditions

- **Entry Age –** The minimum entry age for the Primary insured person & Spouse shall be 18 Years. Maximum Entry age shall be 65 Years.
  Dependent Children can be covered from the 91st day after birth till 23 Years.

- **Category of Room –** The Company shall pay Room Rent Charges on actuals incurred expenses. There is no restriction on the category of room availed for treatment of disease/illness/ injury.

- **Pre-Policy Checkup**

- **–** Insured Person(s) proposed to be covered under the Insurance policy may be required to undergo Pre-Policy Checkup at our network based on Age, Sum insured & any declared health condition as stated in the Company's underwriting guidelines. Based on the findings of the medical reports, we may accept/reject the proposal or send a counter offer letter with restrictive terms/permanent exclusions/Loadings.

  Proposer shall within 7 days from the date of receipt of the communication; give us consent on the counter offer. In the event of no confirmation from the proposer within the timelines, we will consider non-acceptability of counter offer and process the refund.

  The Company shall bear minimum 50% of the expenses related to Pre-Policy Checkup upon acceptance of the proposal, successful issuance of the policy and subsequent non-cancellation during the free look period.

  In the event of rejection of the proposal or Proposer not keen to accept the counter offer made by us, we will process the refund of premium after deduction of entire Pre-Policy Checkup Charges.

- **Deductible -** Admissibility of claim arises only when the aggregate of expenses covered under hospitalization (Single or Multiple) exceeds the defined aggregate policy deductible opted. Amount payable is only in excess of the defined aggregate policy deductible specified in the Schedule.

  Deductible shall apply afresh for each Policy Year in case of Multiyear policies.

- **Geographical Limits & Currency -** This Policy only covers medical treatment taken within India. The following sections if opted shall be covered on worldwide basis:
  a. Hospital Daily Cash
  b. Convalescence Benefit
  c. Emergency Hospitalization (Worldwide basis)
  d. Personal Accident
  e. Critical Illness Benefit
  f. Air Ambulance

All payments under this Policy will only be made in Indian Rupees within India.

- **Free Look Period**
- The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.
- The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document 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 person, 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.

Disclosure of 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 by the policyholder. Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk

Cancellation by Insured – i. The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Period on Risk	Rate of Premium to be retained by Company for 1 year Policy	Rate of Premium to be retained by Company for 2 years Policy	Rate of Premium to be retained by Company for 3 years Policy
Up to 1 month	25%	15%	10%
Exceeding 1 month Up to 3 months	50%	25%	15%
Exceeding 3 months Up to 6 months	75%	50%	25%
Exceeding 6 months Up to 12 months	100%	75%	50%
Exceeding 12 months Up to 18 months	N.A	85%	75%

Exceeding 18 months Up to 24 months	N.A	100%	85%
Exceeding 24 months Up to 30 months	N.A	N.A	90%
Beyond 30 months	N.A	N.A	100%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

- **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 at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

- **Premium Payment in Installments**

1) Modes of premium payment:

(i)All the modes (Yly, Hly, Qly, Mly) shall be allowed.

(ii) ECS (Auto Debit facility) is also allowed in respect of the above mentioned modes.

If the insured person has opted for Payment of Premium on an installment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i) For Yearly payment of mode, a fixed period of 30 days is to be allowed as Grace Period and for all other modes of payment a fixed period of 15 days be allowed as grace period.

ii) During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii) The insured person will get the accrued continuity benefit in respect of the ' Waiting Periods' , ' Specific Waiting Periods' in the event of payment of premium within the stipulated grace Period.iv) No interest will be charged If the installment premium is not paid on due date.

v) In case of installment premium due not received within the grace Period, the Policy will get cancelled.

vi) In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii) If any claim occurs prior to policy ceases to exist and is reported after policy ceases to exist on grounds of non-payment of the instalment premium, as provided in V above, then such claim shall be admitted subject to policy terms & conditions and payment of entire balance unpaid premium. However, policy shall not be revived and stand terminated as mentioned in point V above.

viii) The company has the right to recoVer and deduct all the pending installments from the claim amount due under the policy.

Renewal of Policy:

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days (Note to insurers: Insurer to specify grace period as per product design) to maintain continuity of benefits withoutbreak in policy. Coverage is not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

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.

Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

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 effected.

Nomination

The policyholder 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 policyholder. 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. In the event of death of the policyholder. 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 policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

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 and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shal! be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not belieVe to be true;

b) the actiVe concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceiVe; and

d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

Condition Precedent to Admission of Liability:

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

Grace Period:

All applications for renewal of the Policy must be received by us before the end of the Policy. A Grace Period of 30 days for annual premium and 15 days for other than annual mode for renewing the Policy is provided under this Policy.

Multiple policies

i. In case of multiple policies taken by an insured person during a period from 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 chosen by the insured person 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.

ii. 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 shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

- **Notice -** Any notice, direction or instruction under the Policy shall be in writing and if it is to:
  a) Insured Person, it would be sent at the address specified in Schedule / endorsement.
  b) Company, shall be delivered to the address specified in the Schedule.
  c) No insurance agents, brokers, other person or entity is authorized to receive any notice on behalf of the Company unless explicitly stated in writing by the Company.

Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently co\vered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

I. Claim Notification - Multi Model Intimation:

In case of any grie\lance the insured person may contact the company through via:

- Toll Free call Centre of the TPA (24x7) - **1800-103-2292**
- Toll Free call Centre of the Insurance Company(24x7) - **1800-103-2292**
- Login to the website of the Insurance Company and intimate the claim – http://www.bharti-axagi.co.in/contact-us
- Send an email to the TPA/Company- customer.service@bhartiaxa,.com

- Post/courier to TPA/Company - Claims, Bharti AXA General Insurance Company Limited spectrum Tower, 3rd flr, Chincholi Bunder Rd, Rajan Pada, Mindspace, Malad West, Mumbai, Maharashtra 400064
- Directly Contacting our Company office but in writing. - Bharti AXA General Insurance Company Limited, 19th Floor, Parinee Crescenzo, G-Block, Bandra Kurla Complex, Opposite MCA Club, Bandra (E), Mumbai - 400051
- Grievance may also be lodged at IRDAI Integrated Grievance Management System
- - https://iqms. irda.qov. in/
- Email: complaints@irda.gov.in
- Toll Free Number 155255 (or) 1800 4254 732

In all the above, the intimations are directed to a central team for prompt and immediate action.

- **Claim Procedure -** Procedures for Cashless and Reimbursement Service have been laid down under the policy.

  a) Cashless Claims Service – Insured Person(s) can avail the Cashless services in any of our network providers. In Order to avail Cashless Claims Service, the following procedure must be followed:-

  The duly filled claim form and Health Card with all supporting documents shall be furnished to the TPA/Company through the TPA desk at the provider's premises where the Insured person(s) shall undertake treatment. Notification of claim should be done at least 48 hours prior to the Insured Person(s) hospitalization for planned treatment and within 24 hours of the start of the Insured Person(s) hospitalization for Emergency Treatment.

  The TPA will check the policy coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent to TPA for cashless authorization, the same shall be communicated to the network provider by TPA within 6 hours of receipt of the documents.

  Cashless Service may not be available to claim requests where conclusive information/complete document are not available to establish the admissibility of claim under the policy. The Policyholder/Insured Person(s) shall pay such expenses to the hospital and may register a Reimbursement claim under the policy. A panel of doctors representing the Company shall review the merits of such cases. However there is no obligation to pay if such claims do not qualify in lieu of the scope of cover, exclusions and policy terms and conditions.

If the cashless is approved, the original bills and evidence of treatment in respect of the same shall be left with the Network Provider. Pre-authorization does not guarantee that all costs and expenses will be covered. The Company reserves the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy. If the claim is admissible under the policy, the Company will make the payment to the extent of the liability directly to the network provider subject to policy Scope of cover, Exclusions, Terms & Conditions, and Endorsement.

Those cases where initial covered Medical expenses were not expected to exceed the deductible but subsequently found to be exceeding the opted deductible, notification must be done immediately along with the copy of intimation made to other Insurer (if covered under any other Health Insurance Policy).
The list of network providers is available in the TPA/Company's website.

b) Reimbursement Claims Service – The Policyholder/Insured person(s) or any one acting on behalf shall register a claim through our toll- free number specified in the Policy/Health Card to the Company/ TPA with the particulars mentioned below:-

i. Policy Number/Health Card No.
ii. Name of the Policyholder & Details of the Insured Person(s) availing treatment
iii. Details of the disease/illness/injury
iv. Name and address of the hospital
v. Any other supporting information

Within 15 Days from the date of discharge from the hospital, the policyholder/Insured Person(s) shall further furnish the documents mentioned in the **Claim Documentation Section** to the TPA at his own expense. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the policy.

If there is any deficiency in the documents/ information submitted by you, the Company will send the deficiency letter within 7 days of receipt of the claim documents.

- **Claim Documentation**
  i. Duly filled Claim form
  ii. Photocopy of Government ID Proof, PAN Card and Health Card.

iii. Original Hospital Bills with bill no. along with break-up of each item and Discharge/Daycare - summary/certificate/card from the Hospital.
iv. Original Hospital payment Receipt of the hospital bill with receipt number. (Reimbursement Claim)
v. Original Cash Memos from Hospital Pharmacy/Chemist, supported by proper prescriptions.
vi. Original Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner /Surgeon demanding such Pathological tests.
vii. First Consultation letter and subsequent Prescriptions.
viii. Surgeon's certificate stating nature of operation performed and Surgeons' original bill and receipt.
ix. Attending Doctor's/Consultant's/Specialist's/Anesthetist's original bill and receipt, and certificate regarding diagnosis.
x. Medical Case History/Summary.
xi. Original bills & receipts for claiming Ambulance Charges.
xii. Original invoice/bills for Implants (viz. Stent / PHS Mesh / IOL etc.) with original payment receipts.
xiii. Hospital Registration Number and PAN details from the hospital.
xiv. Doctor's registration Number and Qualification from the doctor.
xv. Treating Doctor's certificate giving details of Injury (How, when & where injury sustained).
xvi. First Information Report from Police Department/ Copy of Medico Legal Certificate for Medico Legal Cases.
xvii. Original Death Summary from hospital, copy of Death certificate from treating doctor or hospital authority, copy of legal heir certificate (if nomination is not available) and port-mortem report (if conducted) to be furnished in an event of death of the Insured person.

Pre-Post hospitalization Claims to be submitted along with a self-attested copy of Point iii) and originals of Point no. i), ii), v), vi), ix) mentioned in the Claim Documentation Section.

In the case of a covered Hospitalization, the costs of which were not initially estimated to exceed the Deductible but were subsequently found likely to exceed the Deductible, the intimation should be submitted along with a copy of intimation made to the other insurer immediately on knowing that the Deductible is likely to be exceeded.

In the event of the original documents being provided to any other Insurance Company, The Company shall accept verified photocopies of such documents attested by such other Insurance Company along with the Settlement letter.

If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming from other organization/provider, then on request from the Insured

Person, We will provide attested copies of the bills and other documents submitted by the Insured Person.

- **Dishonest or Fraudulent Claims -** If any claim 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 Policy holder/Insured Person or anyone acting on his/her behalf to obtain any benefits under the Policy, the policy shall be cancelled ab-initio and all benefits under this Policy shall be forfeited. There will be no refund of premium. If there is any claim already paid under the policy, Company shall have the right to reclaim the amount already paid from the Policyholder/Insured Person(s).

- **Right to Investigate -** The Insured Person(s) shall at any time as may be required authorize and permit the TPA and/or Company to obtain any further information or records from the Hospital, Medical Practitioner, Lab or other agency, in connection with the treatment relating to the claim. The Company may call for additional documents/information and/or carry out verification on a case to case basis to ascertain the facts/collect additional information/documents of the case to determine the extent of loss. Verification carried out will be done by professional Investigators or a member of the Service Provider and costs for such investigations shall be borne by the Company.

- **Policy Disputes -** Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law.

- **Arbitration -** If any dispute or difference shall arise as to the quantum to be paid under this 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 to the dispute/difference, or if they cannot agree upon a single Arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 Arbitrators, comprising of 2 Arbitrators and 1 to be appointed by each of the parties to the dispute/difference and the third Arbitrator to be appointed by such 2 Arbitrators.

Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996.

It is agreed and understood that no dispute or difference shall be referred to arbitration; the Company has disputed or not accepted liability under the policy.

It is expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that the award by such Arbitrator/Arbitrators of the amount of the loss shall be first obtained.

Claim Settlement

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

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

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

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

Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due

Complete Discharge

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

GRIEVANCES REDRESSAL PROCEDURE:

The Company is committed to extend the best possible services to its customers. However, If Policyholder/Insured Person have a grievance that he/she wish us to redress, he/she may contact the Company with the details of their grievance via:

•Website: www.bharti-axagi.co.in

•Email: customer.service@bhartiaxa.com

•Phone: 022-61188888080

•Courier: Any of the Company's Branch office or corporate office

Policyholder/Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday.

Escalation Level 1

In case the Policyholder/Insured/Insured Person has not got his/her grievances redressed through one of the above methods (After 5 days of intimating of your complaint), Policyholder/ Insured/ Insured Person may contact the National Grievance Redressal Officer at :

Write to: Bharti AXA General Insurance, Spectrum Towers, 3rd floor, Malad Link Road, Malad (west), Mumbai- 400064

Call: 022-48815939

Email: NGRO@bhartiaxa.com

3rd floor, Spectrum Tower, Rajan Pada

Mindspace, Malad (W), Mumbai - 400 064

Escalation Level 2

In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed through any of the above methods (After 5 days of approaching National Grievance Redressal Officer), Policyholder/ Insured/ Insured Person may contact the Chief Grievance Redressal Officer at:

Email : CGRO@bhartiaxa.com

Escalation Level 3

In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed by the Company within 14 days, or, If Policyholder/ Insured/Insured Person is not satisfied with Company's redressal of the grievance through one of the above methods, Policyholder/ Insured/ Insured Person may approach the nearest Insurance Ombudsman for resolution of their grievance. The contact details of Ombudsman offices are mentioned below. Policy holder may also obtain copy of IRDAI circular Ref No. F. No. IRDAI/Reg/8/145/2017, notification on Insurance Regulatory and Development Authority (Protection of Policy holders' interests) Regulations, 2017 from any of our offices.

Grievance of Senior Citizens:

In respect of Senior Citizens, the Company has established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen's channel of the Company for faster attention or speedy disposal of grievance, if any.

•Website: www.bharti-axagi.co.in

•Email: customer.service@bhartiaxa.com

•Phone: 1800-103- 2292

•Courier: Any of the Company's Branch office or corporate office

Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday.

Grievance Redressal Cell of the Consumer Affairs Department of IRDAI

The insurance company should resolve the complaint within a reasonable time. In case if it is not resolved within 15 days or if the Insured/Insured Person is unhappy with their resolution you can approach the Grievance Redressal Cell of the Consumer Affairs Department of IRDAI.

•Website: igms.irda.gov.in

•Email: complaints@irda.gov.in

•Toll Free Number 155255 (or) 1800 4254 732

Fill and send the Complaint Registration Form along with any letter or enclosures, if felt necessary, by post or courier to:

General Manager
Consumer Affairs Department- Grievance Redressal Cell,
Insurance Regulatory and Development Authority of India(IRDAI),
Sy.No.115/1,Financial District, Nanakramguda,
Gachibowli, Hyderabad-500032

The Compliant Registration Form is available for download at http://www.policyholder.gov.in/uploads/CEDocuments/complaintform.pdf

LIST OF INSURANCE OMBUDSMEN

If Insured person is not satisfied with the redressal of grie\lance 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.
Refer Link for updated list- http://ecoi.co.in/ombudsman.html

Location	Office Details	Jurisdiction of Office, Union Territory, District
Ahmedabad	Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
Bengaluru	Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka
Bhopal	Shri Guru Saran Shrivastava 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@ecoi.co.in	Madhya Pradesh Chattisgarh

Bhubaneshwar	Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Odisa
Chandigarh	Dr. Dinesh Kumar Verma 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@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh
Chennai	Shri M. Vasantha Krishna 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@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
Delhi	Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi
Guwahati	Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura

Hyderabad	Shri I. Suresh Babu 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 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry
Jaipur	Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan
Ernakulam	Ms Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry
Kolkata	Shri P.K. Rath 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@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands

Lucknow	Shri Justice Anil Kumar Srivastava 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@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
Mumbai	Shri Milind A. Kharat 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@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
Noida	Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur

Patna	Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand
Pune	Shri Vinay Sah 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@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

POLICY WORDINGS

Bharti AXA Smart Super Top Up Policy

List I – Optional Items

Sl 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	LEGGINGS
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	PHOTOCOPIES 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

List II – Items that are to be subsumed into Room Charges

Sl 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

List III – Items that are to be subsumed into Procedure Charges

Sl 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

List IV – Items that are to be subsumed into costs of treatment

Sl 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

POLICY WORDINGS

Bharti AXA Smart Super Top Up Policy

List of Day Care Treatments

(Admissibility will be determined as per the policy terms, conditions and exclusions)

ENT

1. Stapedotomy
2. Myringoplasty(Type I Tympanoplasty)
3. Revision stapedectomy
4. Labyrinthectomy for severe Vertigo
5. Stapedectomy under GA
6. Ossiculoplasty
7. Myringotomy with Grommet Insertion
8. Tympanoplasty (Type III)
9. Stapedectomy under LA
10. Revision of the fenestration of the inner ear.
11. Tympanoplasty (Type IV)
12. Endolymphatic Sac Surgery for Meniere's Disease
13. Turbinectomy
14. Removal of Tympanic Drain under LA
15. Endoscopic Stapedectomy
16. Fenestration of the inner ear
17. Incision and drainage of perichondritis
18. Septoplasty
19. Vestibular Nerve section
20. Thyroplasty Type I
21. Pseudocyst of the Pinna - Excision
22. Incision and drainage - Haematoma Auricle
23. Tympanoplasty (Type II)
24. Keratosis removal under GA
25. Reduction of fracture of Nasal Bone
26. Excision and destruction of lingual tonsils
27. Conchoplasty
28. Thyroplasty Type II
29. Tracheostomy
30. Excision of Angioma Septum
31. Turbinoplasty
32. Incision & Drainage of Retro Pharyngeal Abscess
33. Uvulo Palato Pharyngo Plasty

34. Palatoplasty
35. Tonsillectomy without adenoidectomy
36. Adenoidectomy with Grommet insertion
37. Adenoidectomy without Grommet insertion
38. Vocal Cord lateralisation Procedure
39. Incision & Drainage of Para Pharyngeal Abscess
40. Transoral incision and drainage of a pharyngeal abscess
41. Tonsillectomy with adenoidectomy
42. Tracheoplasty

OPHTHALMOLOGY

43. Incision of tear glands
44. Other operation on the tear ducts
45. Incision of diseased eyelids
46. Excision and destruction of the diseased tissue of the eyelid
47. Removal of foreign body from the lens of the eye.
48. Corrective surgery of the entropion and ectropion
49. Operations for pterygium
50. Corrective surgery of blepharoptosis
51. Removal of foreign body from conjunctiva
52. Biopsy of tear gland
53. Removal of Foreign body from cornea
54. Incision of the cornea
55. Other operations on the cornea
56. Operation on the canthus and epicanthus
57. Removal of foreign body from the orbit and the eye ball.
58. Surgery for cataract
59. Treatment of retinal lesion
60. Removal of foreign body from the posterior chamber of the eye

ONCOLOGY

61. IV Push Chemotherapy
62. HBI-Hemibody Radiotherapy
63. Infusional Targeted therapy
64. SRT-Stereotactic Arc Therapy
65. SC administration of Growth Factors
66. Continuous Infusional Chemotherapy
67. Infusional Chemotherapy
68. CCRT-Concurrent Chemo + RT
69. 2D Radiotherapy

70. 3D Conformal Radiotherapy
71. IGRT- Image Guided Radiotherapy
72. IMRT- Step & Shoot
73. Infusional Bisphosphonates
74. IMRT- DMLC
75. Rotational Arc Therapy
76. Tele gamma therapy
77. FSRT-Fractionated SRT
78. VMAT-Volumetric Modulated Arc Therapy
79. SBRT-Stereotactic Body Radiotherapy
80. Helical Tomotherapy
81. SRS-Stereotactic Radiosurgery
82. X-Knife SRS
83. Gammaknife SRS
84. TBI- Total Body Radiotherapy
85. intraluminal Brachytherapy
86. Electron Therapy
87. TSET-Total Electron Skin Therapy
88. Extracorporeal Irradiation of Blood Products
89. Telecobalt Therapy
90. Telecesium Therapy
91. External mould Brachytherapy
92. Interstitial Brachytherapy
93. Intracavity Brachytherapy
94. 3D Brachytherapy
95. Implant Brachytherapy
96. Intravesical Brachytherapy
97. Adjuvant Radiotherapy
98. Afterloading Catheter Brachytherapy
99. Conditioning Radiothearpy for BMT
100. Extracorporeal Irradiation to the Homologous Bone grafts
101. Radical chemotherapy
102. Neoadjuvant radiotherapy
103. LDR Brachytherapy
104. Palliative Radiotherapy
105. Radical Radiotherapy
106. Palliative chemotherapy
107. Template Brachytherapy

108. Neoadjuvant chemotherapy
109. Adjuvant chemotherapy
110. Induction chemotherapy
111. Consolidation chemotherapy
112. Maintenance chemotherapy
113. HDR Brachytherapy

PLASTIC SURGERY

114. Construction skin pedicle flap
115. Gluteal pressure ulcer-Excision
116. Muscle-skin graft, leg
117. Removal of bone for graft
118. Muscle-skin graft duct fistula
119. Removal cartilage graft
120. Myocutaneous flap
121. Fibro myocutaneous flap
122. Breast reconstruction surgery after mastectomy
123. Sling operation for facial palsy
124. Split Skin Grafting under RA
125. Wolfe skin graft
126. Plastic surgery to the floor of the mouth under GA

UROLOGY

127. AV fistula - wrist
128. URSL with stenting
129. URSL with lithotripsy
130. Cystoscopic Litholapaxy
131. ESWL
132. Haemodialysis
133. Bladder Neck Incision
134. Cystoscopy & Biopsy
135. Cystoscopy and removal of polyp
136. Suprapubic cystostomy
137. percutaneous nephrostomy
138. Cystoscopy and "SLING" procedure.
139. TUNA- prostate
140. Excision of urethral diverticulum
141. Removal of urethral Stone
142. Excision of urethral prolapse
143. Mega-ureter reconstruction

144. Kidney renoscopy and biopsy
145. Ureter endoscopy and treatment
146. Vesico ureteric reflux correction
147. Surgery for pelvi ureteric junction obstruction
148. Anderson hynes operation
149. Kidney endoscopy and biopsy
150. Paraphimosis surgery
151. injury prepuce- circumcision
152. Frenular tear repair
153. Meatotomy for meatal stenosis
154. surgery for fournier's gangrene scrotum
155. surgery filarial scrotum
156. surgery for watering can perineum
157. Repair of penile torsion
158. Drainage of prostate abscess
159. Orchiectomy
160. Cystoscopy and removal of FB

NEUROLOGY

161. Facial nerve physiotherapy
162. Nerve biopsy
163. Muscle biopsy
164. Epidural steroid injection
165. Glycerol rhizotomy
166. Spinal cord stimulation
167. Motor cortex stimulation
168. Stereotactic Radiosurgery
169. Percutaneous Cordotomy
170. Intrathecal Baclofen therapy
171. Entrapment neuropathy Release
172. Diagnostic cerebral angiography
173. VP shunt
174. Ventriculoatrial shunt

THORACIC SURGERY

175. Thoracoscopy and Lung Biopsy
176. Excision of cervical sympathetic Chain Thoracoscopic
177. Laser Ablation of Barrett's oesophagus
178. Pleurodesis
179. Thoracoscopy and pleural biopsy

180. EBUS + Biopsy
181. Thoracoscopy ligation thoracic duct
182. Thoracoscopy assisted empyaema drainage

GASTROENTEROLOGY

183. Pancreatic pseudocyst EUS & drainage
184. RF ablation for barrett's Oesophagus
185. ERCP and papillotomy
186. Esophagoscope and sclerosant injection
187. EUS + submucosal resection
188. Construction of gastrostomy tube
189. EUS + aspiration pancreatic cyst
190. Small bowel endoscopy (therapeutic)
191. Colonoscopy ,lesion removal
192. ERCP
193. Colonscopy stenting of stricture
194. Percutaneous Endoscopic Gastrostomy
195. EUS and pancreatic pseudo cyst drainage
196. ERCP and choledochoscopy
197. Proctosigmoidoscopy volvulus detorsion
198. ERCP and sphincterotomy
199. Esophageal stent placement
200. ERCP + placement of biliary stents
201. Sigmoidoscopy w / stent
202. EUS + coeliac node biopsy

GENERAL SURGERY

203. infected keloid excision
204. Incision of a pilonidal sinus / abscess
205. Axillary lymphadenectomy
206. Wound debridement and Cover
207. Abscess-Decompression
208. Cervical lymphadenectomy
209. infected sebaceous cyst
210. Inguinal lymphadenectomy
211. Incision and drainage of Abscess
212. Suturing of lacerations
213. Scalp Suturing
214. infected lipoma excision
215. Maximal anal dilatation

216. Piles
    A) Injection Sclerotherapy
    B) Piles banding
217. liver Abscess- catheter drainage
218. Fissure in Ano- fissurectomy
219. Fibroadenoma breast excision
220. Oesophageal varices Sclerotherapy
221. ERCP - pancreatic duct stone removal
222. Perianal abscess I&D
223. Perianal hematoma Evacuation
224. Fissure in ano sphincterotomy
225. UGI scopy and Polypectomy oesophagus
226. Breast abscess I& D
227. Feeding Gastrostomy
228. Oesophagoscopy and biopsy of growth oesophagus
229. UGI scopy and injection of adrenaline, sclerosants
230. - bleeding ulcers
231. ERCP - Bile duct stone removal
232. Ileostomy closure
233. Colonoscopy
234. Polypectomy colon
235. Splenic abscesses Laparoscopic Drainage
236. UGI SCOPY and Polypectomy stomach
237. Rigid Oesophagoscopy for FB removal
238. Feeding Jejunostomy
239. Colostomy
240. Ileostomy
241. colostomy closure
242. Submandibular salivary duct stone removal
243. Pneumatic reduction of intussusception
244. Varicose veins legs - Injection sclerotherapy
245. Rigid Oesophagoscopy for Plummer vinson syndrome
246. Pancreatic Pseudocysts Endoscopic Drainage
247. ZADEK's Nail bed excision
248. Subcutaneous mastectomy
249. Excision of Ranula under GA
250. Rigid Oesophagoscopy for dilation of benign Strictures
251. Eversion of Sac a) Unilateral b)Bilateral

252. Lord's plication
253. Jaboulay's Procedure
254. Scrotoplasty
255. Surgical treatment of varicocele
256. Epididymectomy
257. Circumcision for Trauma
258. Meatoplasty
259. Intersphincteric abscess incision and drainage
260. Psoas Abscess Incision and Drainage
261. Thyroid abscess Incision and Drainage
262. TIPS procedure for portal hypertension
263. Esophageal Growth stent
264. PAIR Procedure of Hydatid Cyst liver
265. Tru cut liver biopsy
266. Photodynamic therapy or esophageal tumour and Lung tumour
267. Excision of Cervical RIB
268. laparoscopic reduction of intussusception
269. Microdochectomy breast
270. Surgery for fracture Penis
271. Sentinel node biopsy
272. Parastomal hernia
273. Revision colostomy
274. Prolapsed colostomy- Correction
275. Testicular biopsy
276. laparoscopic cardiomyotomy(Hellers)
277. Sentinel node biopsy malignant melanoma
278. laparoscopic pyloromyotomy(Ramstedt)

ORTHOPEDICS

279. Arthroscopic Repair of ACL tear knee
280. Closed reduction of minor Fractures
281. Arthroscopic repair of PCL tear knee
282. Tendon shortening
283. Arthroscopic Meniscectomy - Knee
284. Treatment of clavicle dislocation
285. Arthroscopic meniscus repair
286. Haemarthrosis knee- lavage
287. Abscess knee joint drainage
288. Carpal tunnel release

289. Closed reduction of minor dislocation
290. Repair of knee cap tendon
291. ORIF with K wire fixation- small bones
292. Release of midfoot joint
293. ORIF with plating- Small long bones
294. Implant removal minor
295. K wire removal
296. POP application
297. Closed reduction and external fixation
298. Arthrotomy Hip joint
299. Syme's amputation
300. Arthroplasty
301. Partial removal of rib
302. Treatment of sesamoid bone fracture
303. Shoulder arthroscopy / surgery
304. Elbow arthroscopy
305. Amputation of metacarpal bone
306. Release of thumb contracture
307. Incision of foot fascia
308. calcaneum spur hydrocort injection
309. Ganglion wrist hyalase injection
310. Partial removal of metatarsal
311. Repair / graft of foot tendon
312. Revision/Removal of Knee cap
313. Amputation follow-up surgery
314. Exploration of ankle joint
315. Remove/graft leg bone lesion
316. Repair/graft achilles tendon
317. Remove of tissue expander
318. Biopsy elbow joint lining
319. Removal of wrist prosthesis
320. Biopsy finger joint lining
321. Tendon lengthening
322. Treatment of shoulder dislocation
323. Lengthening of hand tendon
324. Removal of elbow bursa
325. Fixation of knee joint
326. Treatment of foot dislocation

327. Surgery of bunion
328. intra articular steroid injection
329. Tendon transfer procedure
330. Removal of knee cap bursa
331. Treatment of fracture of ulna
332. Treatment of scapula fracture
333. Removal of tumor of arm/ elbow under RA/GA
334. Repair of ruptured tendon
335. Decompress forearm space
336. Revision of neck muscle (Torticollis release)
337. Lengthening of thigh tendons
338. Treatment fracture of radius & ulna
339. Repair of knee joint

PAEDIATRIC SURGERY

340. Excision Juvenile polyps rectum
341. Vaginoplasty
342. Dilatation of accidental caustic stricture oesophageal
343. Presacral Teratomas Excision
344. Removal of vesical stone
345. Excision Sigmoid Polyp
346. Sternomastoid Tenotomy
347. Infantile Hypertrophic Pyloric Stenosis pyloromyotomy
348. Excision of soft tissue rhabdomyosarcoma
349. Mediastinal lymph node biopsy
350. High Orchidectomy for testis tumours
351. Excision of cervical teratoma
352. Rectal-Myomectomy
353. Rectal prolapse (Delorme's procedure)
354. Orchidopexy for undescended testis
355. Detorsion of torsion Testis
356. lap.Abdominal exploration in cryptorchidism
357. EUA + biopsy multiple fistula in ano
358. Cystic hygroma - Injection treatment
359. Excision of fistula-in-ano

GYNAECOLOGY

360. Hysteroscopic removal of myoma

361. D&C
362. Hysteroscopic resection of septum
363. thermal Cauterisation of Cervix
364. MIRENA insertion
365. Hysteroscopic adhesiolysis
366. LEEP
367. Cryocauterisation of Cervix
368. Polypectomy Endometrium
369. Hysteroscopic resection of fibroid
370. LLETZ
371. Conization
372. polypectomy cervix
373. Hysteroscopic resection of endometrial polyp
374. Vulval wart excision
375. Laparoscopic paraovarian cyst excision
376. uterine artery embolization
377. Bartholin Cyst excision
378. Laparoscopic cystectomy
379. Hymenectomy(imperforate Hymen)
380. Endometrial ablation
381. vaginal wall cyst excision
382. Vulval cyst Excision
383. Laparoscopic paratubal cyst excision
384. Repair of vagina (vaginal atresia)
385. Hysteroscopy, removal of myoma
386. TURBT
387. Ureterocoele repair - congenital internal
388. Vaginal mesh For POP
389. Laparoscopic Myomectomy
390. Surgery for SUI
391. Repair recto- vagina fistula
392. Pelvic floor repair(excluding Fistula repair)
393. URS + LL
394. Laparoscopic oophorectomy