POLICY WORDINGS

Smart Super Health Insurance Policy

PREAMBLE:

The insurance cover provided under this Policy to the Insured / Insured Person up to the Sum Insured is and shall be subject to (a) the terms and conditions of this Policy and (b) the receipt of premium and (c) Disclosure to Information Norm (including by way of the Proposal or Information Summary Sheet) and (d) Schedule of Benefits.

SECTION 1 - DEFINITIONS:

Any word or expression to which a specific meaning has been assigned in any part of this Policy or the Schedule shall bear the same meaning wherever it appears. For purposes of this Policy, the terms specified below shall have the meaning set forth:

1.1) **"Accident"** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

1.2) **"Any one Illness"** means continuous period of Illness and it includes a relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

1.3) "**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 themaccessible to the insurance company's authorized representative.

1.4) **"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.

1.5) **"Ayush Treatment"** refers to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

1.6) **"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 approved.

1.7) **"Company"** means Bharti AXA General Insurance Company Limited.

1.8) **"Condition Precedent"** shall mean a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

1.9) **"Congenital Anomaly"** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

1.9.1) **Internal Congenital Anomaly** - Congenital anomaly which is not in the visible and accessible parts of the body.

1.9.2) **External Congenital Anomaly** - Congenital anomaly which is in the visible and accessible parts of the body.

1.10) **"Cumulative Bonus"** shall mean any increase or addition in the Sum Insured granted by the Insurer without an associated increase in the premium**.**

1.11) **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.

1.12) **"Day Care treatment"** means medical treatment, and / or surgical procedure which is:

1.12.1) undertaken under general or local anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and

1.12.2) which would have otherwise required a hospitalization of more than 24 hours.

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

1.13) **"Day care Centre"** means any institution established for day care treatment of Illness and / or injuries or a medical setup within a hospital and which has been registered with the local authorities,

wherever applicable, and is under the supervision of a registered and qualified medical practitioner and must comply with all minimum criteria as under:

i. has qualified nursing staff under its employment
ii. has qualified medical practitioner/s in charge;
iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
iv. maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

1.14) "Dependent Child" means a child (natural or legally adopted), who is unmarried, aged between 91 days and 23 years, financially dependent on the Insured and does not have his / her independent sources of income.

1.15) "Deductible" is a cost-sharing requirement applicable per event/claim under a health insurance Policy that provides, the Insurer will not be liable for a specified rupee amount in case of indemnity policies and/or for a specified number of days/hours in case of hospital cash benefit which will apply before any benefits are payable by the Insurer. A deductible does not reduce the Sum Insured.
1.16) Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
1.17) "Disclosure to information norm" means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

1.18) "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.

1.19) "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:

i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
ii. the patient takes treatment at home on account of non-availability of room in a hospital.

1.20) "Diagnostic Tests" Investigations, such as X-Ray or blood tests, to find the cause of your symptoms and medical condition.

1.21) "Emergency care" means management for a severe 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.

1.22) "Family" means the Insured, his/her lawful spouse and maximum of three dependent children up to the age of 23 years who are specifically covered under the Policy with their name, age, gender etc.

1.23) "Family Floater Policy" means a Policy in terms of which, two or more persons of a Family are named in the Schedule of Insurance Certificate as Insured Persons. In a Family Floater Policy, Family means a unit comprising of up to five members who are related to each other in the following manner:

i) Legally married husband and wife as long as they continues to be married; and/or
ii) Up-to three of their children who are less than 23 years on the date of commencement of the cover under the Policy.

1.24) "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.

1.25) "Hospital" - A 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 the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:

1. 25.1) has qualified nursing staff under its employment round the clock;

1.25.2) 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;

1.25.3) has qualified medical practitioner(s) in charge round the clock;

1.25.4) has a fully equipped operation theatre of its own where surgical procedures are carried out;

1.25.5) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

1.26) "Hospitalization" means admission in a hospital for a minimum period of 24 in-patient care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

1.27) "Illness" means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

1.27.1) **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.

1.27.2) **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 your/Insured person's rehabilitation or for you/Insured member to be specially trained to cope with it;
iv. it continues indefinitely;
v. it recurs or is likely to recur

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

1.29) "Inpatient care" means treatment for which the Insured person has to stay in a hospital for more than 24 hours for a covered event.

1.30) "Insured" 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"**.

1.31) "Insured Person" means the person named in the Schedule to the Policy and for whose benefit the insurance is proposed and appropriate premium paid. Insured Person is other than Insured.

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

1.33) "Intensive Care Unit" means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

1.34) 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.

1.35) "Information Summary Sheet" means the record and confirmation of information provided to Company or Company's representatives over the telephone for the purposes of applying for this Policy.

1.36) "Maternity expense" shall include

I. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).
II. Expenses towards lawful medical termination of pregnancy during the Policy period.

1.37) "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.

1.38) "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.

1.39) "Medically Necessary" treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

1.39.1) is required for the medical management of the Illness or Injury suffered by the Insured;

1.39.2) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

1.39.3) must have been prescribed by a medical practitioner,

1.39.4) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

1.40) "Medical Advise" means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

1.41) "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.

1.42) "**New Born Baby**" means baby born during the Policy Period and is aged upto 90 days. .

1.43) "Network Provider" means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

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

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

1.46) "OPD treatment" means 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.

1.47) "Policy period" means the period between the inception date and the expiry date as specified in the Schedule to this Policy or the cancellation of this insurance, whichever is earlier.

1.48) "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.

1.49) "Policy Year" means the period of one year commencing on the date of commencement specified in the Schedule of Insurance Certificate or any anniversary thereof.

1.50) "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.

1.51) "Post-hospitalization Medical Expenses" means Medical Expenses incurred immediately after the Insured Person is discharged from the hospital provided that:

1.51.1) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

1.51.2) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

1.52) "Pre-Existing Disease" Pre-existing Disease means any condition, ailment, injury or disease:
a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its 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.

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

1.54) "Qualified Nurse" is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

1.55) "Renewal" defines 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.

1.56) "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.

1.57) "Restoration of Sum Insured" means re-instatement of hundred percent of the Sum Insured.

1.58) "Room rent" means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

1.59) "Schedule" means Schedule attached to and forming part of this Policy mentioning the details of the Insured/ Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to.

1.60) "Schedule of Benefits" means the Product Benefits Table issued by the Company and accompanying this Policy and annexures thereto.

1.61) "Subrogation" mean 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.

1.62) "Sum Insured" means the sum as specified in the Schedule to this Policy against the name of Insured / each Insured Person at the inception of a Policy Year and in the event of Policy is upgraded or downgraded on any continuous Renewal, then exclusive of Cumulative Bonus, if any, the Sum Insured for which premium is paid at the commencement of the Policy Year for which the prevalent upgrade or downgrade is sought.

1.63) "Surgery" means Surgery or Surgical Procedure" means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

1.64) "Terrorism/Terrorist Incident" means any actual or threatened use of force or violence directed at or causing damage, Injury, harm or disruption, or the commission of an act dangerous to human life or property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not. Robberies or other criminal acts, primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorist

activity. Terrorism shall also include any act, which is verified or recognized by the relevant Government as an act of terrorism.

1.65) "Third Party Administrator (TPA)" means any organization or institution that is licensed by the IRDA as a TPA and is engaged by the Company for a fee or remuneration for providing Policy and claims facilitation services to the Insured/ Insured Person as well as to the Company for an insurable event.

1.66) "Unproven/Experimental treatment" is treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

SECTION 2 - SALIENT FEATURES & BENEFITS:

Basic cover upto the Sum Insured limit applicable to all plans:

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed, to pay cashless and/or reimburse the following benefits in manner, for the period and to the extent of the Sum Insured as specified in the Schedule to this Policy.

The Policy covers Reasonable and Customary Charges incurred towards medical treatment taken during the Policy Period for an Illness, Accident or condition described below if this is contracted or sustained by an Insured Person during the Policy Period and subject always to the Sum Insured, any subsidiary limit specified in the schedule of Benefits, the terms, conditions, limitations and exclusions mentioned in the Policy and eligibility as per the insurance plan opted for in the schedule of Benefits and as shown in the Schedule of Insurance Certificate.

2.1) In-patient Treatment:

This benefit provides cover for reimbursement / payment of cashless hospitalization expenses which are reasonably and necessarily incurred by the Insured / Insured Person for treatment of Disease, Illness contracted or Injury sustained by the Insured / Insured Person during the Policy period as specified in the Schedule to this Policy, in a Hospital in India as in- patient which among other things, includes, Hospital room rent or boarding expenses, nursing, Intensive Care Unit charges, Operation Theatre charges, Medical Practitioner's charges, fees of Surgeon, Anesthetist, Qualified Nurse, Specialists, the cost of diagnostic tests, medicines, drugs, blood, oxygen, the cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure.

The Insured/Insured Person should have been hospitalized as an in-patient for a minimum period of 24 consecutive hours. The benefit under this Section is limited to the Sum Insured specified for this Section in the Schedule of Benefits to this Policy.

2.2) Pre-hospitalization:

This benefit covers relevant medical expenses incurred during a period up to the number of days as specified in the Schedule of benefits forming part of this Policy, prior to hospitalization or day care treatment for treatment of Disease, Illness contracted or Injury sustained for which the Insured / Insured Person was hospitalized, giving rise to an admissible claim under this Policy. This benefit is a

part of benefit available under Section 2.1 above and is limited to the available Sum Insured under Section 2.1. Pre-hospitalization Medical Expenses can be claimed as reimbursement only.

2.3) Post-hospitalization:
This benefit covers relevant medical expenses incurred during a period up to the number of days as specified in the Schedule of benefits forming part of this Policy, after discharge from Hospital / day care treatment for continuous and follow up treatment of the Disease, Illness contracted or Injury sustained for which the Insured/Insured Person was hospitalized, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Section 2.1 above and is limited to the available Sum Insured under Section 2.1. Post-hospitalization Medical Expenses can be claimed as reimbursement only.

2.4) Organ Donor:
Where the Insured/Insured Person contracts any of the Illness or Injury requiring major Organ Transplantation surgery and undergoes surgery and treatment in a Hospital as an in-patient for which a valid claim under this Policy is admissible, the hospitalization expenses incurred for harvesting the organ donated for the Insured / Insured Person for this treatment is covered under this benefit, provided the donation conforms to The Transplantation of Human Organs Act 1994. This benefit is a part of benefit available under Section 2.1 above and is limited to the available Sum Insured under Section 2.1.

This benefit does not cover pre or post hospitalization medical expenses or screening expenses of the donor or any other medical expenses as a result of harvesting from the donor. This benefit also does not cover costs directly or indirectly associated with the acquisition of the donor's organ.

2.5) Day Care Treatment:
This benefit 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 at the end of this document. The benefit under this Section is limited to the available Sum Insured under Section 2.1 of this Policy as mentioned in the Schedule to this Policy.

.

2.6 Ayush Treatment:
This benefit 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:

I. The treatment is undertaken in a government Hospital or in any institute recognized by government and/ or accredited by Quality Council of India/ National Accreditation Board on Health,

Ayush Treatment is also covered provided the treatment has been undergone in

i. Teaching hospitals of AYUSH colleges recognised by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH)

ii. AYUSH Hospitals having registration with a Government authority under appropriate Act in the State/UT and complies with the following as minimum criteria:

a. has at least fifteen in-patient beds;
b. has minimum five qualified and registered AYUSH doctors;
c. has qualified paramedical staff under its employment round the clock;
d. has dedicated AYUSH therapy sections;
e. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel

Note:

a) The reimbursement under Ayush benefit will be applicable for inpatient hospitalization claims only;
b) The Insured/ Insured person will not be entitled for Domiciliary Hospitalization;
c) Cashless facility is not available.

The benefit under this Section is available upto the Sum Insured under Section 2.1 of this Policy as mentioned in the Schedule to this Policy.

2.7) Domiciliary Hospitalization:

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

1. Treatment of less than 3 days. (Coverage will be provided for expenses incurred in first three days however this benefit will be applicable if treatment period is greater than 3 days);

2. Post-Hospitalization expenses;

3. 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 benefits also cover expenses on Qualified nurses engaged on the recommendation of the attending Medical Practitioner.

The benefit under this Section is limited to the available Sum Insured under Section 2.1 of this Policy as mentioned in the Schedule to this Policy.

SECTION 3 – OTHER BENEFITS:

Benefits under this Section are payable as additional benefits / in-built benefits upto the limits specified in the Schedule to this Policy. A valid claim should have been admitted under the Hospitalization Section of the Policy, for admission of liability under this Section. However, the amount under this shall be part of the overall Sum Insured

3.1 Restoration of Sum Insured:

In case of a situation where the Sum Insured and No claim bonus are exhausted due to claims made and paid during the Policy Year, and the Insured/Insured Persons have to subsequently, incur any hospitalization expenses due to any Disease/ Illness / Injury for which a valid claim is admissible under the Policy, then the Sum Insured shall be restored which is equal to 100% for the particular Policy year for all members in the Policy, provided that;

I. The Restored Sum Insured will be enforceable only after the Sum Insured and No claim bonus (if any) have been completely exhausted in that year ; and the Restored Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section 2 and 3.
II. The Restored Sum Insured shall be available only for fresh/ any new Disease / Illness / Injury and not in relation to any Illness/ Injury for which a Claim has already been admitted partially or fully for that Insured person during that Policy Year.
III. The Restored Sum Insured will only be allowed once during a Policy Year;
IV. Restoration of Sum Insured is not applicable for add-on benefits.

If the Restored Sum Insured is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

3.2 Emergency Surface Ambulance Charges:

This benefit provides for cashless / reimbursement to the Insured/Insured Person of expenses incurred for his/her surface transport by ambulance to hospital or between hospitals and/or diagnostic centre for treatment ofDisease, Illness or Injury in a Hospital as an in-patient for which a valid claim under this Policy is admissible.

This benefit is subject to sub limits (per hospitalization claim) as mentioned in Schedule of benefit but within overall limit of the Sum Insured as specified in the Schedule to this Policy.

This benefit is applicable irrespective of the number of occurrences during the Policy period subject to the overall Sum Insured.

3.3 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 allowance as mentioned in the Schedule of benefit attached to this Policy.

This benefit is subject to sub limits as mentioned in Schedule of benefits payable only once during the Policy period but within overall limit of the Sum Insured as specified in the Schedule to this Policy.

3.4 Out-patient Emergency treatment (Accidents only):
This benefit provides for reimbursement of medical expenses incurred towards emergency treatment by a Medical Practitioner for the Insured / Insured Person following an Accidental Injury and only if such Emergency Treatment is administered within 24 hours following the Accident.

It also provides cover for medical expenses incurred for follow-up treatment by the same Medical Practitioner up to 30 days from the date of Accident, including expenses incurred for medication prescribed on a written basis by the attending Medical Practitioner for that same treatment or consultation. This benefit is subject to sub limits as mentioned in Schedule of benefits but within overall limit of the Sum Insured as specified in the Schedule to this Policy.

3.5 Animal Bite (Vaccination)
The Company will cover Medical Expenses of OPD Treatment for vaccinations or immunizations for treatment post an animal bite, up to the limit provided in the Schedule of Benefits. This benefit is available only on reimbursement basis.

3.6 Domestic Air Ambulance:
The Company will 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 benefit 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 the maximum limit as specified in the Schedule of benefit.

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

3.7 Out-patient- Dental Emergency Treatment (arising out of Accident only):
This benefit provides for reimbursement of medical expenses incurred towards emergency treatment given by a Dentist following an Accident where the Insured / Insured Person suffer Injuries or damage to his/her natural teeth and/or gums. This benefit further provides cover for medical expenses incurred for follow up treatment up to a maximum of 15 days. The benefit under this is subject to sub limits as

mentioned in Schedule of benefits but within overall limit of the Sum Insured as specified in the Schedule to this Policy.

SECTION 4 – OPTIONAL ADD-ON BENEFIT:

Benefits under this Section are payable as add-on benefits on payment of additional premium, up to the limits specified in the Schedule to this Policy unless specified otherwise.

4.1 Hospital Cash Allowance:

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 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 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 Sum Insured as mentioned in the Schedule.

4.2 Maternity Benefit:

This benefit covers the medical expenses including (after a waiting period of 9 months with the company) up to limits specified in the schedule (over and above Sum Insured mentioned in the Schedule) for the delivery of a baby and / or expenses related to medically recommended lawful termination of pregnancy but only in life threatening situation under the advice of Medical Practitioner, limited to maximum of two deliveries or terminations as said herein during the lifetime of an Insured/Insured Person between the ages of 18 years to 45 years(being the age of eldest member in the Policy).

This benefit may be opted subject to the following:

(a) This benefit is available only under a Family Floater Policy.

(b) This benefit is available for Insured / Insured's spouse provided both are covered under the same Policy.

This benefit is applicable only for the Insured person who has opted for 3 years Policy term. This benefit can be opted only on renewals for female Insured/ Insured Person.

In case, insured has taken three year policy without maternity add-on and would like to opt for maternity add-on, then this can be availed on at the time of renewal

Ectopic Pregnancy is not covered under Section 4.2. However the same is covered under Section 2.1.

New Born Baby Cover:
Medical Expenses for any medically necessary treatment described at 2.1 while the Insured Person (the Newborn baby) is hospitalized during the Policy Period within first 90 days of birth, as an inpatient under this benefit. The coverage is subject to the Policy exclusions, terms and conditions. This Benefit is applicable if Maternity benefit is opted and the Company has accepted a maternity claim under this Policy.

This benefit is subject to the specified limits as mentioned in Schedule however over and above the Sum Insured mentioned in the Schedule.

4.3 Lump sum benefit for critical Illnesses (over and above S.I)
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 and surviving for more than 30 days post such diagnosis, the specified limits as mentioned in Schedule (over and above the Sum Insured mentioned in the Schedule) for this benefit shall be payable to the Insured/Insured Person as Lump Sum benefit.

After availing the benefit under Para 4.3 Section 4, if the Insured / Insured Person takes treatment for the Critical Illness in a Hospital, the hospitalization expenses incurred for the same would be payable/reimbursed, subject to the terms and conditions of the Policy, out of the Sum Insured available for Hospitalization Benefit cover under Para Section 2.1 of this Policy. 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. Critical Illness limit opted cannot be more than Sum Insured opted for Section 2.1. The illnesses qualified as Critical Illnesses and covered in this section are as follows:

1. Cancer of Specified Severity
2. First Heart Attack of Specified Severity
3. Coronary Artery Disease
4. Open Chest CABG
5. Open Heart Replacement or Repair of Heart Valves
6. Surgery to Aorta
7. Stroke resulting in Permanent Symptoms
8. Kidney Failure requiring Regular Dialysis
9. Aplastic Anaemia
10. End Stage Lung Disease
11. End Stage Liver Failure
12. Coma of Specified Severity
13. Major Burns
14. Major organ /bone marrow transplant
15. Multiple Sclerosis with Persisting Symptoms
16. Fulminant Hepatitis
17. Motor Neurone Disease with Permanent Symptoms

18. Primary Pulmonary Hypertension
19. Terminal Illness
20. Bacterial Meningitis

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 -

1. 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
2. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
3. Malignant melanoma that has not caused invasion beyond the epidermis;
4. 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
5. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
6. Chronic lymphocytic leukaemia less than RAI stage 3
7. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
8. 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. 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

3. Coronary Artery Disease

The narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, as proven by coronary arteriography, regardless of whether or not any form of coronary artery surgery has been performed. Coronary arteries herein refer to left main stem, left anterior descending circumflex and right coronary artery.

4. 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

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. 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.

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. 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.

9. Aplastic Anaemia

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

I. Blood product transfusion;
II. Marrow stimulating agents;
III. Immunosuppressive agents; or
IV. Bone marrow transplantation

The diagnosis must be confirmed by a haematologist.

10. End Stage Lung Disease

End Stage Lung Disease, causing chronic respiratory failure. This diagnosis must be supported by evidence of all of the following:

I. FEVI test results which are consistently less than one litre;
II. Permanent supplementary oxygen therapy for hypoxemia;
III. Arterial blood gas analyses with partial oxygen pressures of 55mm Hg or less (PaO2 <- 55 mm Hg); and
IV. Dyspnea at rest.

The diagnosis must be confirmed by a respiratory physician

11. 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.

12. 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.

13. Major 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;

14. 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

15. Multiple Sclerosis with persistent symptoms

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

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

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

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

16. Fulminant Hepatitis

A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure.

This diagnosis must be supported by all of the following:

I. Rapid decreasing of liver size;
II. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
III. Rapid deterioration of liver function tests;
IV. Deepening jaundice; and
V. Hepatic encephalopathy.

17. Motor Neurone Disease with permanent symptoms

Motor neurone 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

18. Primary Pulmonary Hypertension

Primary Pulmonary Hypertension with substantial right ventricular enlargement confirmed by investigations including cardiac catheterization resulting in permanent physical impairment of Class IV of the New York Heart Association (NYHA) Classification of Cardiac Impairment.

The NYHA Classification of Cardiac Impairment (Source "Current Medical Diagnosis & Treatment-39th edition"): Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

19. Terminal Illness

The conclusive diagnosis of an Illness that is expected to result in the death of the insured person within 12 months. This diagnosis must be supported by a specialist and confirmed by the Company's appointed Doctor.
Terminal Illness in the presence of HIV infection is excluded.

20. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:

I. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
II. A consultant neurologist.

SECTION 5 - RENEWAL INCENTIVE:

5.1. Health Check-up:

The Company will cover the cost of a health checkup as per plan eligibility as defined in the Schedule of Benefits provided that Insured / Insured Person has applied for the same. Only that Insured / Insured Person who has attained minimum age of 18 years at the time of Renewal shall be eligible for a health check-up. The Company will only cover health checkups arranged by the Company through their empanelled service providers. Insured / Insured Person further understand and agree that this benefit is only available at Renewal for Policies that are renewed without any break.

The list of tests conducted for the plan opted is as per Appendix II.

5.2. No Claim 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 no claim bonus as mentioned in the Appendix III.

No claim bonus will be provided on the expiring Policy Sum Insured, provided that the Policy is renewed continuously.

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

No Claim Bonus will be calculated on the basis of Sum Insured of the last completed Policy Year.

In case of a claim, the no claim bonus earned shall be automatically reduced in the same proportion in the following renewal of the Policy. This will not affect the Sum Insured of the Policy.

SECTION 6 - 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 months of continuous coverage after the date of inception of the first policy with 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 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 byInsurer.

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 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-Gendertreatments: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- Excl11 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. (Explanation: Details of
excluded providers shall be provided with the policy document. Insurers to use various means of communication to notify the policyholders, such as email, SMS about the updated list being uploaded in the website.)

L. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.**Code- Excl12**

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- Excl16

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- Excl17

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:
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.
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.
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 OPD treatment unless covered under the policy.

V. Treatment taken outside the geographical limits of India

X. Maternity expenses where maternity cover is opted:The benefits will not be available for any condition(s) as defined in the Policy, until 9 months since inception of the first Policy with the Company. In all other cases where maternity benefit cover is not opted, all claims directly or indirectly related to maternity stands excluded always.
Y. Critical Illness: 60 days waiting period for fresh policy and 30 days survival period
Z. Internal Congenital Anomalies are covered after a waiting period of 48 months.
AA. Genetic disorders are covered after a waiting period of 48 months.

SECTION 7 - GENERAL CONDITIONS:

7.1) Disclosure of Information:

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.

7.2) Floater Policy:

Where the Policy is obtained on floater basis covering the family members, the Sum Insured as specified in the Schedule to this Policy, shall be available to the Insured and all other Insured members. However, the Sum Insured shall be the overall limit including add-on Sum Insured unless otherwise specified, if opted and no claim bonus, if any for the entire period of Insurance/Policy period including all members/Insured persons and all claims.

7.3) 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.

7.4) Material Change:

The Insured / Insured Person shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business, partial disclosure of the medical history at Insured / Insured person own expense. The Company may, adjust the scope of cover and / or the premium,if necessary, accordingly.

7.5) 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.

7.6) No Constructive Notice:
The Company shall not take notice of any information relating to the Insured person unless such information is submitted in writing by the Insured, even if such information was available with the Company.

7.7) Notice of Charge:
The Company is not under obligation to take note of any trust, assignment, lien or similar charge on or relating to thePolicy. However, any payment by the Company to Insured or legal representative or bank shall be binding on all concerned and shall be considered as complete discharge by the Company.

7.8) Special Provisions:
Any special provisions subject to which this Policy has been entered into and endorsed on the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

7.9) Electronic Transaction:
The Insured / Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time and hereby agrees and confirm that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centres, tele service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication established by or on behalf of the Company for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDA regulations for protection of Policy holder's interests.

7.10) Duty of the Insured on occurrence of loss/event leading to claim
On the occurrence of loss/event/claim within the scope of cover under the Policy resulting in a claim, the Insured / Insured Person shall:

a) Forthwith file/submit a claim form in accordance with "Claim Procedure" clause.
b) Allow the Medical Practitioner or any agent of the Company to inspect the medical and hospitalization records and to examine the Insured / Insured Person
c) Assist and not hinder or prevent the Company or any of its agents in pursuance of their duties

In case the Insured / Insured Person does not comply with the provisions of this clause or other obligations cast upon the Insured / Insured Person under this Policy or in any of the Policy documents, all benefit under the Policy shall be forfeited, at the option of the Company.

7.11) Right to Inspect:
If required by the Company, an agent/representative of the Company including a physician appointed in that behalf in case of any loss/event/claim or any circumstances that have given rise to a claim to the Insured / Insured Person, be permitted at all reasonable times to examine into the circumstances

of such loss/event leading to claim. The Insured / Insured Person shall on being required so to do by the Company produce all relevant documents relating to or containing reference relating to the loss/event or such circumstance in his/her possession including presenting himself/herself for examination and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or shall assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy.

The Company shall bear all cost of examination required under this section.

7.12) Position after a claim:

As from the day of receipt of the claim amount by the Insured / Insured Person, the Sum Insured for the remainder of the Policy year of insurance shall stand reduced by a corresponding amount.

.

7.13) 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.

7.14) Forfeiture of claims:

If any claim is made and rejected and no court action or suit is commenced within 12 months after such rejection or, in case of arbitration taking place as provided therein, within 12 calendar months after the arbitrator or arbitrators have made their award, all benefits under this Policy shall be forfeited and will not have any rights whatsoever.

7.15) 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;

7.16) 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 for renewing the Policy is provided under this Policy.

However, there is no coverage provided during the break period.

7.17) Cancellation:

i. The policyholder may cancel this policy by giving l5days' 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.

7.18) Cause of action/Currency of payment:
No claim shall be payable under this Policy unless the cause of action arises in India. All claims shall be payable in India in Indian Rupees only.

7.19) Policy Disputes:
The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian law. All matters arising hereunder shall be determined in accordance with the law and practice of such court with in Indian Territory.

7.20) 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 - 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 hereby agreed and understood that no dispute or difference shall be referred to arbitration, as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.
It is expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/arbitrators of the amount of the loss shall be first obtained.

7.21)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.

7.22) Sum Insured Enhancement:

i. The Insured member can apply for enhancement of Sum Insured at the time of renewal by submitting a duly filled fresh Proposal Form to the Company.
ii. The acceptance of enhancement of Sum Insured would be at the discretion of the Company, based on the health condition of the Insured members, claim history and subject to acceptance by the Company post underwriting.
All waiting periods as defined in the Policy shall apply afresh for this enhanced Sum Insured from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy in respect of such increased Sum Insured.

7.23) Inclusion of Dependent members under the Policy:

New Person can be added to this Policy, either by way of endorsement in case of mid-term inclusion or at the time of renewal. Mid-term inclusion is available only in case of such new person i.e. spouse and or new born child post 90 days of birth subject to acceptance by underwriters.
The pre-existing Disease clause, exclusions and waiting periods will be applicable afresh in respect of such newly added person,

7.24) Renewal:

The Company shall allow renewal of the Policy and accept renewal premium in all cases except in case of noncooperation of the Insured/Insured Person in implementing the terms and conditions of this Policy..

7.25) Notices:

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post or facsimile to
a) In case of the Insured, at the address given in the Schedule to the Policy.
b) In case of the Company, to the Policy issuing office/nearest office of the Company.

7.27 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

7.28 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 coVered 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

7.29 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.

7.30 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.

7.31 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.

7.32 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.

SECTION 8 – GRIEVANCES REDRESSAL PROCEDURE:

In case of any grie\lance the insured person may contact the company through via:
•Website: www.bharti-axagi.co.in
•Email: customer.service@bhartiaxa.com
•Phone: 18001032292
•Courier: Any of the Company's Branch office or corporate office
Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at company branches.
For updated details of grievance officer, kindly refer the link www.bharti-axagi.co.in

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: 18001032292

•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.
Grievance may also be lodged at lRDAl Integrated Grievance Management System
- https://iqms. irda.qov. in/
•Website: igms.irda.gov.in
•Email: complaints@irda.gov.in
•Toll Free Number 155255 (or) 1800 4254 732

LIST OF INSURANCE OMBUDSMEN

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

SECTION 9: CLAIM SERVICING:

9.1 Claim Notification - Multi Model Intimation:

It is the endeavor of Company to give multiple options to the Insured Person/Insured Person's representative to intimate the claim to the Company. The intimation can be given in following ways:
• 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 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 contact 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

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

9.2 Information Details

When the Insured/covered person/patient's care taker intimate the claim as mentioned above the following information should be given for prompt services.

- Policy number
- Name of the Insured
- Name of Covered person/Insured member making the claim

- Contact details
- Nature of the Disease, Illness or Injury
- Name and address, phone number of the attending medical practitioner/hospital.
- Date of hospitalization
- The Insured / Insured Person must provide notification of claim within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier. The Notification of Claim should be ideally provided by the Insured/Insured Person. In the event Insured / Insured Person is unwell, then the Notification of Claim should be provided by any immediate adult member of the family.

9.3 Claim Form

Upon the notification of the claim, the TPA/Company will dispatch the claim form to the Insured/Covered person. Claim forms will also be available with the network hospitals and Company offices and on its website.

9.4 Claim Procedure

9.4.1 Cashless hospitalization:

- Company will work with one or more TPAs for providing cashless facility to the Insured/Covered person.
- List of network hospitals will be available in the the website of the TPA/Company too.
- Insured/covered person on admission (emergency) or willing to admit (planned admission) in the network hospitals, a preauthorization request form has to be filled in by the treating doctor/hospital and the same has to be sent through fax/e-mail to the TPA by the Insured/hospital. The TPA after verifying the same will decide on the issuance of authorization after necessary discussion- (approval) with insurance company. The action of pre-authorization will be done within 6 hours post receiving all the documents and formalities for emergency admission and 48 hours for planned admission.
- The preauthorization request form will be available in the hospitals or can be downloaded from the website of the TPA/Company or can request for the same to the TPA/Company via email or fax or can be collected in person from the branches of the TPA/Company.
- Denial of the cashless may not necessarily mean the claim has been rejected. Such claims may be examined on merits and will be paid on reimbursement basis later if admissible.
- The Insured/covered person can send the requisite claim documents to the TPA/Company seeking reimbursement.
- The Insured/covered person need not pay any amount to the hospital if he/she has received the authorization letter except;
  - If the bill amount is in excess of the Sum Insured.
  - Non-medical expenses
  - Unrelated treatments
  - Excess/deductible, if any which has to be borne by Insured

- The Insured/covered person may have to pay the difference amount to the network provider, in case the authorized amount is less than estimated/actual bill amount.

9.4.2 Reimbursement claims

- All reimbursement claims should be intimated to TPA/Insurance Company within 7 days from date of discharge.

- Insured/covered person admitted in a non-network hospital can send the claim documents the TPA/Company for the reimbursement within 30 days from the date of discharge. However Pre and post hospitalization bills can be sent within 15 days from the end of post hospitalization period as specified in the Policy.

9.5 Claim Settlement (provision for Penal Interest)

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

Cashless Claim:

In the event of delay in approval / rejection of cashless claim, a penalty of Rs.500/- for every delay of 6 hours beyond 6 hours in case of emergency hospitalization. For planned hospitalization, the Company shall pay the penalty for every 6 hours beyond 48 hours. This penalty shall apply after receipt of all information / documents and will be subject to a maximum amount of Rs.5000/-.

Checklist of documents for settling Claims

SL. NO	CHECKLIST	TICK THE BOXES
1	Claim form duly signed along with attending physician	
2	Pre auth form-in case of cashless claim	
3	Discharge summary	
4	Hospital final bill	
5	Attending Surgeon's/Physician's Prescription advising hospitalization	
6	Surgery/consultation bills and receipts	
7	Operation theatre and pharmacy bills	
8	Medicines bill with doctor's prescription	
9	Pre hospitalization bills with receipts, prescriptions etc	
10	Post hospitalization bills with prescriptions and receipts, Hospital payment receipt in case of reimbursements	
11	Diagnostic reports with doctor's prescription	
12	MLC Report & Police FIR	

9.6 Documents

It is the Policy of the Company to seek documents in a single shot/request. Based on documents submitted, if any further documentation is required then it will be sought promptly, at the earliest.

In cases where investigation is deemed necessary, the same will be conducted in all promptitude. Every attempt will be made to keep the process transparent.

9.7 Repudiations

The power to repudiate claims is vested in the corporate office to ensure transparency and standardization across the country.

9.8 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.

POLICY WORDINGS

Smart Super Health Insurance Policy

Schedule of Benefits													
SALIENT FEATURES & BENEFITS	Value		Classic			Uber							
	5L	7.5L	10L	15L	20L	20L	30L	50L	60L	70L	80L	90L	100L
Basic cover (upto the Sum Insured limit applicable to all plans)	Up to S.I		Up to S.I			Up to S.I		Up to S.I					
In-patient Treatment													
Pre-hospitalization - 60 Days													
Post-hospitalization- 90 Days													
Organ Donor													
Day care Treatment (As per Appendix I)													
Ayush Treatment													
Domiciliary Hospitalization													
Other Benefits (Per Policy Period including all members)													
No Claim Bonus	As per Appendix - II		As per Appendix – II			As per Appendix - II							
Health Check-up	Annual – Basic As per Appendix – III		Annual – extended As per Appendix – III			Annual – comprehensive As per Appendix – III							
Restoration of Sum Insured	Up to 100% of S.I		Up to 100% of S.I			Up to 100% of S.I							
Emergency Surface Ambulance charges	Rs.3000/event		Rs.3000/event			Rs.3000/event							
Convalescence Benefit (on continuous 10 days hospitalization or more)	Not Available		Rs.10,000			Rs.15,000		Rs.20,000					
Outpatient emergency treatment (Accident only)	Not Available		Rs.2,500			Rs.10,000		Rs.10,000					
Animal bite (Vaccination)	Not Available		Rs.2,500			Rs.5,000		Rs.5,000					
Domestic Air Ambulance (max once in a Policy year / per life)	Not Available		Not Available			Up to Rs. 1,00,000		Up to Rs. 2,00,000					
Outpatient Dental emergency (arising out of Accident only)	Not Available		Not Available			Rs.5,000		Rs.7,500					
Optional Add-on Benefit (on payment of additional premium): Covered only if specified in Policy schedule													
Hospital cash allowance (Up to Maximum up to 30 days with one day deductible)#	Option of Rs.500 , 1000 / day		Option of Rs.500,1000,2000 / day			Option of Rs.500, 1000,2000,3000 / day							

Maternity Benefit: -Maternity Benefit with 9 month waiting period, up to first 2 deliveries/MTP in lifetime (available only with 3 yr. Policy term) -New Born Baby for first 90 days	Rs.35,000 - Maternity Rs. 25000 -New Born	Rs.50,000 - Maternity Rs.50,000 - New Born	Rs.75,000 - Maternity Rs. 75,000 - New Born	Rs.1,00,000 - Maternity Rs.1,00,000- New Born
Lump sum benefit for critical illnesses (over and above the S.I)*	Option of Rs.2L, 3L, 5L, 7.5L, 10L,15L, 20L, 25L, 30L			

***Critical Illness Sum Insured opted should not be more than the Sum Insured under section 2.1 , Critical Illness cover is available for Insured/Insured person(s) selected, with each member having Individual limit of coverage, however limits for Insured/Insured person(s) cannot be different from each other.**

 # Hospital Cash allowance if opted has to be opted for all Insured/Insured person(s) in a Policy with common limit for Insured/Insured person(s)

Appendix I: Day Care Treatment

1. Suturing - CLW -under LA or GA
2. Surgical debridement of wound
3. Therapeutic Ascitic Tapping
4. Therapeutic Pleural Tapping
5. Therapeutic Joint Aspiration
6. Aspiration of an internal abscess under ultrasound guidance
7. Aspiration of hematoma
8. Incision and Drainage
9. Endoscopic Foreign Body Removal - Trachea /- pharynx-larynx/ bronchus
10. Endoscopic Foreign Body Removal -Oesophagus/stomach /rectum.
11. True cut Biopsy - breast/- liver/- kidney-Lymph Node/-Pleura/-lung/-Muscle biopsy/-Nerve biopsy/-Synovial biopsy/-Bone trephine
biopsy/-Pericardial biopsy
12. Endoscopic ligation/banding

13. Sclerotherapy
14. Dilatation of digestive tract strictures
15. Endoscopic ultrasonography and biopsy
16. Nissen fundoplication for Hiatus Hernia /Gastro esophageal reflux disease
17. Endoscopic placement/removal of stents
18. Endoscopic Gastrostomy
19. Replacement of Gastrostomy tube
20. Endoscopic polypectomy
21. Endoscopic decompression of colon
22. Therapeutic ERCP
23. Brochoscopic treatment of bleeding lesion
24. Brochoscopic treatment of fistula /stenting
25. Bronchoalveolar lavage & biopsy
26. Tonsillectomy without Adenoidectomy
27. Tonsillectomy with Adenoidectomy
28. Excision and destruction of lingual tonsil
29. Foreign body removal from nose
30. Myringotomy
31. Myringotomy with Grommet insertion
32. Myringoplasty /Tympanoplasty
33. Antral wash under LA
34. Quinsy drainage
35. Direct Laryngoscopy with or w/o biopsy
36. Reduction of nasal fracture

37. Mastoidectomy
38. Removal of tympanic drain
39. Reconstruction of middle ear
40. Incision of mastoid process & middle ear
41. Excision of nose granuloma
42. Blood transfusion for recipient
43. Therapeutic Phlebotomy
44. Haemodialysis/Peritoneal Dialysis
45. Chemotherapy
46. Radiotherapy
47. Coronary Angioplasty (PTCA)
48. Pericardiocentesis
49. Insertion of filter in inferior vena cava
50. Insertion of gel foam in artery or vein
51. Carotid angioplasty
52. Renal angioplasty
53. Tumor embolisation
54. TIPS procedure for portal hypertension
55. Endoscopic Drainage of Pseudopancreatic cyst
56. Lithotripsy
57. PCNS (Percutaneous nephrostomy)
58. PCNL (percutaneous nephrolithotomy)
59. Suprapubic cytostomy
60. Tran urethral resection of bladder tumor

61. Hydrocele surgery
62. Epididymectomy
63. Orchidectomy
64. Herniorrhaphy
65. Hernioplasty
66. Incision and excision of tissue in the perianal region
67. Surgical treatment of anal fistula
68. Surgical treatment of hemorrhoids
69. Sphincterotomy/Fissurectomy
70. Laparoscopic appendicectomy
71. Laparoscopic cholecystectomy
72. TURP (Resection prostate)
73. Varicose vein stripping or ligation
74. Excision of dupuytren's contractureHG/V004/wef 1st Oct 2013 16
75. Carpal tunnel decompression
76. Excision of granuloma
77. Arthroscopic therapy
78. Surgery for ligament tear
79. Surgery for meniscus tear
80. Surgery for hemoarthrosis/pyoarthrosis
81. Removal of fracture pins/nails
82. Removal of metal wire
83. Incision of bone, septic and aseptic
84. Closed reduction on fracture, luxation or epiphyseolysis with osetosynthesis

85. Suture and other operations on tendons and tendon sheath
86. Reduction of dislocation under GA
87. Cataract surgery
88. Excision of lachrymal cyst
89. Excision of pterigium
90. Glaucoma Surgery
91. Surgery for retinal detachment
92. Chalazion removal (Eye)
93. Incision of lachrymal glands
94. Incision of diseased eye lids
95. Excision of eye lid granuloma
96. Operation on canthus & epicanthus
97. Corrective surgery for entropion & ectropion
98. Corrective surgery for blepharoptosis
99. Foreign body removal from conjunctiva
100. Foreign body removal from cornea
101. Incision of cornea
102. Foreign body removal from lens of the eye
103. Foreign body removal from posterior chamber of eye
104. Foreign body removal from orbit and eye ball
105. Excision of breast lump /Fibro adenoma
106. Operations on the nipple
107. Incision/Drainage of breast abscess
108. Incision of pilonidal sinus

109. Local excision of diseased tissue of skin and subcutaneous tissue
110. Simple restoration of surface continuity of the skin and subcutaneous tissue
111. Free skin transportation, donor site
112. Free skin transportation recipient site
113. Revision of skin plasty
114. Destruction of the diseases tissue of the skin and subcutaneous tissue
115. Incision, excision, destruction of the diseased tissue of the tongue
116. Glossectomy
117. Reconstruction of the tongue
118. Incision and lancing of the salivary gland and a salivary duct
119. Resection of a salivary duct
120. Reconstruction of a salivary gland and a salivary duct
121. External incision and drainage in the region of the mouth, jaw and face
122. Incision of hard and soft palate
123. Excision and destruction of the diseased hard and soft palate
124. Incision, excision and destruction in the mouth
125. Surgery to the floor of mouth
126. Palatoplasty
127. Transoral incision and drainage of pharyngeal abscess
128. Dilatation and curettage
129. Myomectomies
130. Simple Oophorectomies

Note: The standard exclusions and waiting periods are applicable to all of the above procedures depending on the medical condition/disease under treatment. Only 24 hours hospitalization is not mandatory.

.

Appendix II - Health Check-up tests on Policy renewal

Value		Classic		Uber
Age band <35 years				
Complete Blood Count and ESR Tests		Complete Blood Count and ESR Tests		Complete Blood Count and ESR Tests
Urine Routine Analysis		Urine Routine Analysis		Urine Routine Analysis
Pre and Post Fasting Blood Sugar Test		Pre and Post Fasting Blood Sugar Test		Pre and Post Fasting Blood Sugar Test
Age band 36-50 years				
Complete Blood Count and ESR Tests		Complete Blood Count and ESR Tests		Complete Blood Count and ESR Tests
Urine Routine Analysis		Urine Routine Analysis		Urine Routine Analysis
Pre and Post Fasting Blood Sugar Test		Pre and Post Fasting Blood Sugar Test		Pre and Post Fasting Blood Sugar Test
Serum Cholesterol & Triglycerides		Chest X-Ray		Chest X-Ray

ECG		ECG		ECG
		Blood test for blood sugar levels status in past 90 days		Blood test for blood sugar levels status in past 90 days
		Serum Cholesterol and Triglycerides		Serum Cholesterol and Triglycerides
				Kidney Function Test
				PSA (males only)
				Prostate Exams (males only)
				Mammography (females only)
				Cervical Smear (females only)
Age band > 50 years				
Complete Blood Count and ESR Tests		Complete Blood Count and ESR Tests		Complete Blood Count and ESR Tests
Urine Routine Analysis		Urine Routine Analysis		Urine Routine Analysis
Pre and Post Fasting Blood Sugar Test		Pre and Post Fasting Blood Sugar Test		Pre and Post Fasting Blood Sugar Test
Lipid Profile		Chest X-Ray		Chest X-Ray
ECG		ECG		ECG
		Blood test for average plasma sugar concentration in past 90 days		Blood test for average plasma sugar concentration in past 90 days
		Serum Cholesterol and Triglycerides		Serum Cholesterol and Triglycerides
		Liver Function Test		Liver Function Test

		Kidney Function Test		Kidney Function Test
				Hepatitis B surface Antigen
				Tread Mill Test or Stress Test
				Abdominal Ultrasound
				Prostate Exams (males only)
				Mammography (females only)

Appendix III - No Claim Bonus

No Claim Bonus	
Age at the inception of 1st Policy year <45 yrs.	50% of expiring Policy S.I per annum not exceeding Cumulative Bonus of 100% of current Policy S.I
Age at the inception of 1st Policy year >45 yrs. and <65 yrs.	20% of expiring Policy S.I per annum not exceeding Cumulative Bonus of 100% of current Policy S.I

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