Policy wordings - Smart Health High Deductible Insurance Policy

I. Preamble

WHEREAS the Insured designated in the Schedule to this Policy having by a proposal and declaration together with any statement, report or other document which shall be the basis of this contract and shall be deemed to be incorporated herein, has applied to Bharti AXA General Insurance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth and paid appropriate premium for the period as specified in the Schedule.

Now this Policy witnesseth: That subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon the Company, undertakes, that if during the period as specified in the Schedule to this Policy, the Insured/Insured Person shall contract any disease, illness or sustain any injury and if such disease, illness or injury shall upon the advice of a duly qualified Medical Practitioner require such Insured/Insured Person, to incur hospitalisation and/or other related expenses towards treatment of such disease, illness or injury at any Hospital/Nursing Home in India as an inpatient expenses in any of the circumstances mentioned hereunder, then the Company will pay to the Insured/Insured Person, his/her nominee, or legal representatives, as the case may be, the amount of such hospitalisation or related expenses/charges as would fall under the different heads mentioned below and as are reasonably and necessarily incurred by or on behalf of such Insured/Insured Person for

1. Hospital (Room & Boarding and Operation theatre) charges
2. Fees of Surgeon, Anesthetist, Nurse, Specialists etc.
3. Cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.
4. Pre and post hospitalization expenses
5. Ambulance charges in manner, for the period and to the extent of the Sum Insured as specified in this Policy.

This policy is offered for the person having age between 5 years to 65 years. Children below 5 years can be covered if any of the parents is covered under the policy.

The Policy can also be offered to group of individuals, association of persons, other groups, employers to cover their employees etc wherein the premium rating structure for group insurance needs to be followed

Residents in India shall include all Citizens of India and permanent residents of India as well as expatriates or foreigners who are holding an employment pass, dependant pass or work permit and residing in India.
Expatriates or foreigners must provide a copy of either a valid employment pass or work permit, and a bona-fide residential address in India.
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II. Definitions

Policy Wordings – Smart Health High Deductible Insurance Policy
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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. **“Accident"** means a sudden, unforeseen, and involuntary event caused by external, visible and violent means.

2. **“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.

3. **"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.

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

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

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

6. **"Contribution"** is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

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

8. **"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.

9. **"Any One Illness"** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

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

11. **"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.

12. **"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.

13. **"Family"** means the Insured, his/her lawful spouse and maximum of two dependant children up to the age of 23 years.

14. **"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:
    i. has qualified nursing staff under its employment round the clock;
    ii. 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;
    iii. has qualified medical practitioner(s) in charge round the clock;
    iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel

15. **"Hospitalisation"** Means admission in a Hospital for a minimum period of 24 Inpatient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

16. **"Hospitalisation expenses"** mean expenses on hospitalisation for minimum period of 24 hours incurred in India, which are admissible under this Policy.

17. **"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.

    a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
    b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
    I) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
    ii) it needs ongoing or long-term control or relief of symptoms

iii) it requires your rehabilitation or for you to be specially trained to cope with it
iv) it continues indefinitely
v) it comes back or is likely to come back

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

19. **"Insured"** means the individual who has a permanent place of residence in India and on whose name the Policy is issued.

20. **"Insured Person"** means the person named in the Schedule to the Policy, who has a permanent place of residence in India and for whose benefit the insurance is proposed and appropriate premium paid.

21. **"Medical Advice"** mean any consultation or advice from a Medical Practitioner including the issue of any prescription or follow - up prescription.

22. **"Medical Practitioner"** is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence. The term Medical Practitioner includes a physician, specialist and surgeon, provided that this person is not a member of the Insured/Insured Person's family.

23. **"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.
24. 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

25. **"Notification of claim"** is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

26. **"Period of Insurance"** means the Policy period defined hereunder.

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

28. **"Policy"** means this document of Policy describing the terms and conditions of this contract of insurance including the Company's covering letter to the Insured, if any,, the Schedule attached to and forming part of this Policy, the Insured's Proposal Form 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.

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

30. **"Post-hospitalization Medical Expenses"** means Medical Expenses incurred immediately after the insured person is discharged from the hospital provided that:
    i. Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required and
    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company

31. "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.

32. "Pre-hospitalization Medical Expenses" means Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

33. "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.

34. "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.

35. "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

36. "Third Party Administrator (TPA)" means any organisation 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.

37. "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.

38. "Sum Insured" means the sum as specified in the Schedule to this Policy against the name of Insured / each Insured Person, which sum represents the Company's maximum liability for any or all claims under this Policy during the Policy period for the respective benefit(s) against which the sum is mentioned in the Schedule to this Policy.

39. "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.

40. "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, against any individual, property or government, with the stated or un stated 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.

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

III. Scope of cover

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed, to pay 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.

Section I

a. Hospitalisation Expenses

Hospitalisation expenses benefit provides cover for payment/reimbursement of hospitalisation 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 & Boarding and Operation theatre) charges,

fees of Surgeon, Anesthetist, Nurses, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.

b. Pre-hospitalisation

This benefit covers relevant medical expenses incurred during a period up to 30 days prior to hospitalisation for treatment of disease, illness contracted or injury sustained for which the Insured / Insured Person was hospitalised, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a.

c. Post Hospitalisation

This benefit covers relevant medical expenses incurred during a period up to 60 days after discharge from Hospital for continuous and follow up treatment of the disease, illness contracted or injury sustained for which the Insured /Insured Person was hospitalised, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a.

d. Pre-existing Diseases

This benefit covers relevant hospitalisation expenses incurred for treatment of pre-existing disease, illness or injury, in a Hospital as an in-patient, after specific waiting period as mentioned in the Schedule to this Policy. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a.

e. Transplantation of Organs

Where the Insured/Insured Person undergoes major Organ Transplantation surgery and treatment in a Hospital as an in-patient for which a valid claim under this Policy is admissible under Section 1a, then this policy covers expenses incurred towards hospitalization expenses of donor for major organ transplantation. This benefit is a available over and above the original sum insured and restricted to 5% of original sum insured.

f. Ambulance Charges

This benefit provides for reimbursement to the Insured/Insured Person of expenses incurred for his/her transportation by ambulance to and from the Hospital for treatment of disease / illness / injury in a Hospital as an in-patient for which a valid claim under this Policy is admissible. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a.

g. In-patient Physiotherapy Charges

This benefit provides for reimbursement of charges incurred towards physiotherapy in the Hospital that is confirmed as being necessary by the attending Medical Practitioner and the same relates directly to the disease / illness / injury for which the Insured/Insured Person has undertaken treatment in the Hospital for which a valid claim is admissible under this Policy. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a.

h. Accompanying Person's Expenses

This benefit provides for payment of an allowance to the Insured/Insured Person towards expenses incurred on the accompanying person at the Hospital/Nursing Home during hospitalisation treatment of the Insured/Insured Person for the disease/illness/injury necessitating hospitalization for which a valid claim is admissible under this Policy. This benefit will be paid over and above limit of sum insured of section I a.

The deductible in respect of this Section I will be applicable for each and every claim separately and shall be of an amount as specified in the Schedule to this Policy.

Section II - Day Care Treatment

Payment or reimbursement of hospitalisation expenses incurred in case of day care treatment (where 24 hours of hospitalisation is not required) such as dialysis, chemotherapy, radiotherapy, eye surgery, lithotripsy (kidney stone removal), D & C, tonsillectomy taken in a Hospital / Nursing Home.

The deductible with respect to respect of Section I & II will be applicable for each and every claim separately and shall be of an amount as specified in the Schedule to the Policy.

For detailed and updated list of non payable items, kindly visit our website www.bharti-axagi.co.in

IV. Exclusions

The Company shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

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.

V. Additional Features

1. Income Tax Relief

Premium paid under the Policy shall be eligible for income tax deduction benefit under Sec 80 D as per the Income Tax Act.

2. Renewal Discount

The Policy shall provide for a discount, equivalent to 5% of renewal premium every year on a progressive scale, as Renewal Discount at the time of renewal, provided that the Policy being renewed is claim free in the expiring year. This renewal discount on a progressive scale will be allowed up to a maximum of 25%. In case of renewal of a Policy where there is a loss, the Insured will lose the entire Renewal Discount accumulated.

This additional benefit is available only on renewal of the policies taken and renewed with our Company. Further the policy for renewal should have been taken in the insured's name.

VI. Portability and Migration

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 lRDAl 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 lRDAl guidelines on portability.

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

Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast30 days before the policy renewal date as per lRDAl guidelines on Migration. If such person is presently co\/ered 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

VII. General Conditions

1. Duty of Disclosure

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.

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 and any one of the Insured Persons for one or more claims during the Policy period.

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.

4. Material Change

The Insured / Insured Person shall immediately notify the Company by fax or In writing of any material change in the risk and cause at his own expense such additional precaution to be taken as circumstances may require to ensure safety thereby containing the circumstances that may give rise to a claim and the Company may adjust the scope of the cover and/or the premium, if necessary, accordingly.

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.

6. No Constructive Notice

Any knowledge or information of any circumstances or condition in connection with the Insured / Insured Person, in possession of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of the premium.

7. Notice of Charge

The Company shall not be bound to take notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy; but the payment by the Company to the Insured / Insured Person, his/her nominee or legal representatives, as the case may be, of any compensation or benefit under the Policy shall in all cases be an effectual discharge to the Company.

8. 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 confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, Electronic data interchange, call centres, teleservice 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 or the Company's other products and services, 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 policyholder's interests.

9. Duty of the Insured/Insured Person on Occurrence of Loss

On the occurrence of loss within the scope of cover under the Policy, 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 hospitalisation records and to examine the Insured/Insued 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.

10. Right to Inspect

If required by the Company, representative of the Company including a Physician appointed in that behalf shall in case of any loss or any circumstances that have given rise to a claim to the Insured/Insured Person be permitted at all reasonable times to examine into the circumstances of such loss. 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 or such circumstance in his/her possession including presenting himself for examination and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or will in any way assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy. Further to this it has been clarified that such examination will be conducted at the companies cost.

11. 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 period of insurance shall stand reduced by a corresponding amount.

12. Multiple policies and Contribution:

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.

13. Forfeiture of Claims

If any claim is made and rejected and no court action or suit commenced within 12 months after such rejection or, in case of arbitration taking place as provided herein, within 12 calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

14. 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;

15. 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 renewing the Policy is provided under this Policy.

However, there is no coverage for injury sustained or disease contacted during this period.

16. Cancellation/Termination

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
Up to 1 month	25% of annual rate
Up to 3 months	50% of annual rate

Up to 6 months	75% of annual rate
Exceeding six months	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.

17. 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.

18. 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.

19. 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 two Arbitrators, one to be appointed by each of the parties to the dispute/difference and the third Arbitrator to be appointed by such two Arbitrators and the 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 referable to arbitration, as hereinbefore 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.

20. Renewal of Policy:

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days (Note to insurers: Insurer to specify grace period as per product design) to maintain continuity of benefits withoutbreak in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience.

Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

Moratorium Period

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

Possibility of Revision of Terms of the Policy Including the Premium Rates

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

Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder. the Company will pay the nominee (as named in the Policy Schedule/Policy Certificate/Endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

21. Renewal Notice

The Company shall give notice for renewal of the Policy and accept renewal premium in all cases except in case of non-cooperation of the Insured/Insured Person in implementing the terms and conditions of this Policy. Every renewal premium (which shall be paid and accepted in respect of this policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein before mentioned and that nothing is known to the insured that may result to enhance the risk of the Company under the guarantee hereby given. No renewal receipt shall be valid unless it is on the printed form of the Company and signed by an authorized official of the Company.

22. 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 / Insured Person, 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.

23. 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 lRDAI 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 grie\lance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

Refer Link for updated list- http://ecoi.co.in/ombudsman.html

Location	Office Details	Jurisdiction of Office, Union Territory, District

Ahmedabad	Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
Bengaluru	Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka
Bhopal	Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh Chattisgarh
Bhubaneshwar	Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Odisa

Chandigarh	Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh
Chennai	Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
Delhi	Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi
Guwahati	Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura

Hyderabad	Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry
Jaipur	Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan
Ernakulam	Ms Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry
Kolkata	Shri P.K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands

Lucknow	Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
Mumbai	Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
Noida	Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj,

		Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
Patna	Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand
Pune	Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

VIII. 1 Claim Notification Multi Model Intimation:

It is the endeavor of Company to give multiple options to the Insured/covered person/patient's care taker to intimate the claim to the Third party administrator (TPA)/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 TPA/Company- customer.service@bhartiaxa,.com
- Post/courier to TPA/Company - Claims, Bharti AXA General Insurance Company Limited spectrum Tower, 3rd flr, Chincholi Bunder Rd, Rajan Pada, Mindspace, Malad West, Mumbai, Maharashtra 400064
- Directly Contacting our Company office but in writing. - Bharti AXA General Insurance Company Limited, 19th Floor, Parinee Crescenzo, G-Block, Bandra Kurla Complex, Opposite MCA Club, Bandra (E), Mumbai - 400051

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

Information Details

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

- Policy number
- Name of the Insured/Covered person
- Contact details
- Nature of the disease, illness or injury
- Name and address, phone number of the attending medical practitioner/hospital

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

VIII.2 Claim Procedure

1. **Cashless hospitalisation:**

- Company will work with one or more TPAs for providing cashless facility to the Insured/Covered person.
- List of network hospitals will be provided to the Insured/Covered person along with the policy and it will be regularly updated and informed to them. Insured/Covered person can view the updated hospital list from 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 faxed to the TPA by the insured/hospital. The TPA after verifying the same will decide on the issuance of authorization. The action of pre-authorization will be done within 6 hours for emergency admission and 48 hours for planned admission.
- The preauthorization request form will be available in the benefit guide issued along with the policy, available in the hospitals, can be downloaded from the website of the

TPA/Company, 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 does not mean the claim has been rejected.
- 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 has received the authorization letter except
  - If the bill amount is in excess of the sum insured
  - Non-medical expenses
  - Unrelated treatments
  - Excess, if any
- The hospital will receive the payment from TPA/Company within 21 days from the date of receipt of complete claim documents

. 2. **Reimbursement claims**

- Insured/covered person unwilling to utilize the cashless facility in the network hospital can send the claim documents along with the pre/post hospitalization documents for the period specified in the policy to the TPA/Company for the reimbursement within 15 days of end of the post hospitalization period or the medical fitness certificate issued by the attending physician, whichever is earlier.

- Insured/covered person admitted in a non-network hospital can send the claim documents along with the pre/post hospitalization documents for the period specified in the policy to the TPA/Company for the reimbursement within 15 days of end of the post hospitalization period or the medical fitness certificate issued by the attending physician, whichever is earlier.

- Insured/covered person should intimate the claim to the TPA/Company within reasonable period of hospitalization.

After receiving the complete documents, the TPA/Company will reimburse the claim amount within 14 days to the insured normally.

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

Checklist of documents for settling Claims

SL. NO	CHECKLIST	TICK THE BOXES
1	Claim form duly signed along with attending physician statement	
2	Pre auth form-if 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	
10	Post hospitalization bills with receipts Hospital payment receipt in case of reimbursements	
11	Diagnostic reports with doctor's prescription	
12	Others if any	

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.

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.

Repudiations

The power to repudiate claims is vested in the corporate office to ensure transparency and standardization across the country. This is also with a view to keep the guidelines of regulator in

mind. In the unfortunate event of repudiation, the customers will be informed of the existence of forums for grievance redressal.

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.

Schedule of Benefit - Smart*Health High Deductiable Policy*

Section		Particulars	Benefit							
			SUM INSURED (in Rs.)	300000	400000	500000	700000	600000	800000	1000000
I	a	Hospitalisation:	1. Hospital (Room & Boarding and Operation theatre) charges, Admission charges, Registration charges	100% of Sum Insured	100% of Sum Insured	100% of Sum Insured	100% of Sum Insured	100% of Sum Insured	100% of Sum Insured	100% of Sum Insured
			2. Fees of Surgeon, Anesthetist, Nurse, Specialists etc.							
			3. Cost of diagnostic tests, medicine							

			s, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.							
			4. Second Opinion Charges							
	b	Pre-Hospitalisation:	Provides for payment of relevant medical expenses incurred during a period up to 30 days prior to hospitalisation in respect of the disease/ illness or injury sustained which is considered a part of a claim admissible under							

			this Policy.								
	c	Post-Hospitalisation	Provides for payment of relevant medical expenses incurred during a period up to 60 days follwoing discharge from hospitalisation in respect of the disease/ illness or injury sustained which is considered a part of a claim admissible under this Policy.								
	d	Coverage of pre-existing diseases	Provides for payment of hospitalisation								

			expenses for medical treatment relating to pre-existing diseases, illness, injury from the 5th year of the Policy after four continuous renewals							
	e	Transplantation of Organs:	Where the Insured contracts any of the Critical illnesses requiring major organ transplant and undertakes hospitalisation treatment for the same which is covered under the Policy, the hospitali	5% of SI over and above the Original SI	5% of SI over and above the Original SI	5% of SI over and above the Original SI	5% of SI over and above the Original SI	5% of SI over and above the Original SI	5% of SI over and above the Original SI	5% of SI over and above the Original SI

			sation expenses incurred towards donor is covered							
	f	Ambulance Charges:	Provides for reimbursement of ambulance charges incurred for transport of the Insured either to Hospital at the time of admission or to residence post discharge	Rs 1500	Rs 1500	Rs 1500	Rs 1500	Rs 1500	Rs 1500	Rs 1500
	g	Inpatient Physiotherapy:	Provides for reimbursement of charges incurred for Physiotheraphy that are medically necessary and related to the	1% of SI	1% of SI	1% of SI	1% of SI	1% of SI	1% of SI	1% of SI

			treatment taken at the hospital							
	h	Accompanying Person Expenses	Provides for payment of fixed allowance towards meeting the expenses for a person who is accompanying the Insured at the Hospital / Nursing Home.	Rs 250 for 5 days after first three days	Rs 250 for 5 days after first three days	Rs 250 for 5 days after first three days	Rs 250 for 5 days after first three days	Rs 250 for 5 days after first three days	Rs 250 for 5 days after first three days	Rs 250 for 5 days after first three days
II		Day Care Treatment:	Provides for payment of hospitalisation expenses in case of day care treatment (where 24 hours of hospitalisation is not required) in case of procedur	Included under 1a	Included under 1a	Included under 1a	Included under 1a	Included under 1a	Included under 1a	Included under 1a

		es like dialysis, chemotherapy, radiotherapy, eye surgery, lithotripsy (kidney stone removal), D & C, tonsillectomy taken in a Hospital / Nursing Home. A complete list of such procedure where cover is available will be enclosed to the Policy							
	DEDUCTIBLE		Rs.10 0,000	Rs.20 0,000	Rs.20 0,000	Rs.20 0,000	Rs.30 0,000	Rs.30 0,000	Rs.30 0,000

List of Generally excluded in Hospitalization Policy

List I – Optional Items

Sl No	Item
1	BABY FOOD

2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES

25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT

48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS

20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

Sl No.	**Item**

1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET

23	ORTHOBUNDLE, GYNAEC BUNDLE

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

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

17	Glucometer& Strips
18	URINE BAG