Policy wordings – Bharti AXA Smart Super Health Assure

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

OPERATIVE CLAUSE:
The Company hereby agrees subject to the terms and conditions contained herein or endorsed or otherwise expressed hereon, to indemnify, compensate, pay and/or reimburse the Insured / Insured Person, his/her nominee or the legal representatives, as the case may be, in respect of insured events occurring during the period of insurance stated in the Schedule, in the manner and to the extent set forth in this Policy.

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

1.4) **"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 of pre-authorization approved.

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

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

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

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

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

1.8) **Co-payment (Co-pay)** 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.

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

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

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

1.10.2) 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.

1.11) **"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.

1.12) **"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.

1.13) **"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.

1.14) **"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.

1.15) **"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.

1.16) **"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.

Domiciliary hospitalization benefits shall be subject to the limits as specified in the Schedule to this Policy, and shall, in no case, cover expenses incurred for:

a) Pre and post Hospital treatment,
b) Treatment of any of the following Diseases:
   i. Asthma;
   ii. Bronchitis;
   iii. Chronic nephritis and nephritic syndrome;
   iv. Diarrhoea and all types of dysenteries including gastroenteritis;
   v. Diabetes mellitus and insipidus;
   vi. Epilepsy;
   vii. Hypertension;
   viii. Influenza, cough and cold;
   ix. All psychiatric or psychosomatic disorders;
   x. Pyrexia of unknown origin for less than 10 days;
   xi. Tonsillitis and upper respiratory tract infection including aryngitis and pharyngitis;
   xii. Arthritis, gout and rheumatism.

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

1.18) **"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.

1.19) **"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.

1.20) **"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 continue 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.

1.21) **"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.

1.22) **"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. 22.1) has qualified nursing staff under its employment round the clock;

1.22.2) 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;

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

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

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

1.23) **"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.

1.24) **"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.

1.24.1) **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.

1.24.2) **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 comes back or is likely to come back.

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

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

1.27) **"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"**.

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

1.29) **"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.

1.30) **"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**.**

1.31) **"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.

1.32) **"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 license. 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 who includes Father, Mother, Father-in-law, Mother-in-law, Son, Daughter, Son-in-law, Daughter-in-law, Brother or Sister.

1.33) **"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.

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

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

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

1. 34.3) must have been prescribed by a medical practitioner,

1. 34.4) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

1.35) **"Medical Advise"** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

1.36) "**New Born Baby**" means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

1.37) **"Network Provider"** means hospitals or health care providers enlisted by an Insurer or by a TPA and Insurer together to provide medical services to an Insured on payment by a cashless facility.

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

1.39) **"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

1.40) **"OPD treatment"** is 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.

1.41) **"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.

1.42) **"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.

1.43) **"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.

1.44) **"Portability"** means transfer by an individual health insurance Policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one Insurer to another.

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

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

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

1.46) **"Pre-Existing Disease"** means any condition, ailment or Injury or related condition(s) for which you/Insured member had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months prior to the first Policy issued by the Insurer.

1.47) **"Pre-hospitalization Medical Expenses"** means medical expenses incurred immediately before the Insured Person is Hospitalized, provided that:

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

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

1.48) **"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.

1.49) **"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 all waiting periods.

1.50) **"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.

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

1.52) **"Room rent"** means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

1.53) **"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.

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

1.55) **"Subrogation"** means the right of the insurer to assume the rights of the Insured person to recover expenses paid out under the Policy that may be recovered from any other source.

1.56) **"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.

1.57) **"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.

1.58) **"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.

1.59) **"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.

1.60) **"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.

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% of sum insured 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 of Disease, 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 and forms a part of Section 2.1.

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.

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 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 under Section 2.1 while 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 and the Maternity Benefit limit as specified in the Schedule.

Well Baby Charges are not covered under the Maternity and/or New Born Baby cover.

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. This benefit shall be paid over and above the hospitalization benefit if any.

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 under 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;
9. All tumors in the presence of HIV infection.

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 overt ischemic 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 Failure

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. Third Degree Burns

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

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 (Idiopathic) Pulmonary Hypertension

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

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

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

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

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

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.

Bacterial Meningitis in the presence of HIV infection is excluded.

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 empaneled service providers. Insured / Insured Person further understands and agrees 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 shall be 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 irrespective of the policy term whether 1 year, 2 years or 3 years, the Company will offer a no claim bonus as specified below.

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. The rate of accrual shall be based on the age at which the policy was bought (age at inception). The same rate shall be applicable in all the policy years as long as the policy is renewed.

No Claim Bonus – Accrual Rate	
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

The rate of accrual or reduction for each applicable policy year shall remain the same even for a policy term of 2 years or 3 years.

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. However, in cases where the insured has availed health checkup, the same shall not be considered as claim and the policy shall be eligible for No Claim Bonus provided there is no claim in the respective policy year. This will not affect the Sum Insured of the Policy.

5.3. Portability:

i. From another company to Bharti AXA Policy

(i) If the proposed Insured Person was insured continuously and without a break under another Indian retail health insurance Policy with any other Indian General Insurance company or stand-alone Health Insurance Company, it is understood and agreed that:

(1) If Insured person wish to exercise the Portability Benefit, The Company should have received the application for portability and the completed Portability Form with complete documentation at least 45 days before the expiry of the existing insurance Policy.

(2) This benefit is available only at the time of renewal of the existing health insurance Policy.

(3) Portability benefit is available only up to the existing cover. If the proposed Sum Insured is higher than the Sum Insured under the expiring policy, waiting periods would be applied on the amount of proposed increase in Sum Insured only, in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.

(4) Waiting period credits would be extended to Pre-existing Diseases and time bound exclusions / waiting periods in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.

(5) The Portability Benefit shall be applied by the Company within 15 days of receiving the completed Application and Portability Form from the proposer subject to the following:
(a) Proposer shall provide the Company all additional documentation and/or information requested;
(b) The proposer shall pay the Company the applicable premium in full;

(c) The Company may, subject to medical underwriting, restrict the terms upon which the Company may offer cover, the decision as to which shall be in the Company sole and absolute discretion; This is subject to Company's Board approved Underwriting policy filed with Authority.

(d) There is no obligation on the Company to insure all Insured Persons or to insure all Insured Persons on the proposed terms, even if the proposer have given all documentation to the Company; This is subject to Company's Board approved Underwriting policy filed with Authority.

(e) The Company shall be received necessary details of medical history and claim history from the previous insurance company for the Insured Person's previous health insurance Policy through the IRDA's web portal.

(ii). No additional loading or charges shall be applied by the Company exclusively for porting the Policy.

ii. From the Company's existing health insurance policies to this Policy

(i) If the proposed Insured Person was insured continuously and without a break under another health insurance Policy with the Company, it is understood and agreed that:

(1) If the Insured wish to exercise the Portability Benefit, the Company should have received the Insured's application and completed Portability Form before the expiry of the existing insurance Policy;

(2) This benefit is available only at the time of renewal of existing health insurance Policy.

(3) Portability benefit is available only up to the existing cover. If the proposed Sum Insured is higher than the Sum Insured under the expiring Policy, waiting periods would be applied on the amount of proposed increase in Sum Insured only, in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.

(4) Waiting period credits would be extended to Pre-existing Diseases and time bound exclusions/waiting periods in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.

(5) The Portability Benefit shall be applied by the Company within 15 days of receiving Insured's completed Application and Portability Form subject to the following:

(a) Insured / Insured Person shall give the Company all additional documentation and/or information request's;

(b) Insured / Insured Person pay the Company the applicable premium in full;

(c) The Company may, subject to medical underwriting, restrict the terms upon which the company may offer cover, the decision as to which shall be in Company's sole and absolute discretion; This is subject to Company's Board approved Underwriting policy filed with Authority.

(d) There is no obligation on Company to insure all Insured Persons or to insure all Insured Persons on the proposed terms, even if Insured/ Insured person have given

all documentation. This is subject to Company's Board approved Underwriting policy filed with Authority.

(e) No additional loading or charges shall be applied by Company exclusively for porting the Policy.

The Company reserves the right to modify or amend the terms and the applicability of the Portability Benefit in accordance with the provisions of the regulations and guidance issued by the Insurance Regulatory and Development Authority as amended from time to time.

SECTION 6 - EXCLUSIONS:

6.1 Waiting Period:

1. 30 days waiting period:

Expenses incurred for treatment undertaken for Disease or Illness within 30 days of the inception date of first / initial Policy. This exclusion, however, doesn't apply in case of

- Subsequent renewals with the Company without a break.
- Expenses due to Accident occurring after the Policy inception date.
- Portability to the extent of waiting period and Sum Insured waived off in the Schedule of the Policy.

2. Specific waiting period:

Hospitalization Expenses incurred on treatment of following Diseases or Illness or procedures/surgeries within the first two years (continuously renewed without any break) from the inception of initial / first Policy:

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

This exclusion, however, doesn't apply in case of

- Subsequent renewals with the Company without a break post the first 2 years of the Policy

- Portability to the extent of waiting period and Sum Insured waived off in the Schedule of the Policy.

In the event that the above listed Illness/diseases arise on account of a pre-existing condition, they shall be covered under this policy only upon completion of 48 months of continuous coverage

3. Pre-existing Diseases / Illness / Injury / conditions:
The benefits will not be available for any condition(s) as defined in the Policy, until 48 months of continuous coverage have elapsed, since inception of the first Policy with the Company.

Disclosure of any Pre-existing Diseases with details must be done at the time of application for this Policy/ addition of member in existing Policy, in the Proposal Form and shall be classified as pre-existing Disease post acceptance of such application by the company.

4. 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.

6. Internal Congenital Anomalies are covered after a waiting period of 48 months.

7. Genetic disorders are covered after a waiting period of 48 months.

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

1. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
2. Any Illness or Injury directly or indirectly resulting or arising from or occurring during commission of any breach of any law by the Insured Person with criminal intent.
3. Disease/ Illness/ Injury whilst performing duties as a serving member of a military or a police force.
4. Any loss, Injury/Illness, directly or indirectly caused due to an act of terrorism or terrorist incident, regardless of any contributory causes (if the Company alleges that by reason of this exclusion any loss is not covered by this insurance, the burden of proving the contrary shall be upon the Insured / Insured Person).
5. Expenses following Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any

nuclear waste from the combustion of nuclear fuel.

6. Medical Treatment in respect of the Illness / Injury / Disease caused whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing, potholing, abseiling, deep sea diving, polo, snow and ice sports.
7. Medical treatment in respect of the Injury caused whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular Scheduled commercial airline
8. Circumcision unless necessary for treatment of Disease, Illness or Injury not excluded hereunder, or, as may be necessitated due to an Accident.
9. Dental treatment or surgery of any kind unless requiring hospitalization or in case of out-patient Dental Emergency Treatment (unless arising out of Accident only as specified under the scope of the Policy).
10. Birth control procedures, hormone replacement therapy, contraceptive supplies or services including complications arising due to supplying services or Assisted Reproductive Technology, treatment arising from or traceable to pregnancy, childbirth including caesarean section and voluntary medical termination of pregnancy during the first 12 weeks from the date of conception. However, this exclusion will not apply to Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.
11. Any treatment arising from or traceable to any fertility, infertility, sub-fertility or assisted conception procedure or sterilization.
12. Charges incurred in connection with cost of spectacles and/or contact lenses, hearing aids, routine eye and ear examinations, laser surgery for correction of refractory errors, dentures, artificial teeth and or all other similar external appliances and/or devices whether for diagnosis or treatment, Issue of medical certificates and examinations as to suitability for employment or travel.
13. Any condition directly or indirectly caused by or associated with venereal Disease, sexually transmitted Disease, including Genital Warts, Syphilis, Gonorrhea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, whether or not arising out of HIV, Human T-Cell Lymphtropic Virus Type III (HTLV–III or IITLB-III) or Lymphadenopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind
14. Vitamins and tonics unless forming part of treatment for Disease, Illness or Injury as certified by the Medical Practitioner.
15. Weight management services and or treatment, services and supplies including treatment of obesity(including morbid obesity),
16. Any treatments related to sleep disorder, sleep apnea syndrome, general debility, treatment received in convalescent homes, cure, rundown condition or rest cure, congenital external Diseases / Illness or defects or anomalies, sterility, venereal Disease or intentional self-Injury
17. Any treatment received in convalescent homes, convalescent Hospitals, health hydros, nature cure clinics or similar establishments.
18. Medical Treatment following use/abuse of intoxicating drugs or alcohol or drug abuse, solvent abuse or any addiction or medical condition resulting from or relating to such abuse or addiction.
19. Sex change or treatment, which results from, or is in any way related to, sex change.
20. All preventive care vaccination including inoculation or immunization of any kind unless forming a part of post animal bite treatment.
21. Treatment by a family member (Father, Mother, Father-in-law, Mother-in-law, Son, Daughter, Son-in-law, Daughter-in-law, Brother or Sister) and or self-medication or any treatment except AYUSH that is not scientifically recognized.
22. Medical treatment required following involvement in any criminal act of the Insured / Insured Person.
23. Prostheses, corrective devices and medical appliances, which are not, required intra-operatively.

Policy Wordings – **Bharti AXA Smart Super Health Assure Policy**
UIN: BHAHLIP20108V011920
Bharti AXA General Insurance Company Limited, "HOSTO CENTER" 1st Floor No.43,Millers Road. Vasanth Nagar, Bangalore -560052 Ph: 1800-103-2292, CIN : U66030KA2007PLC043362., IRDAI Reg No:- 139
Wesbite:www.bharti-axagi.co.in, Email: customer.service@bhartiaxa.com

24. Any stay in Hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner.
25. Aesthetic treatment, cosmetic surgery or plastic surgery unless necessitated due to Accident
26. Experimental and unproven treatment.
27. Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Disease, Illness or Injury.
28. Cost incurred for medicines which are not under the advice of the Medical Practitioner.
29. Any treatment which is taken as an out-patient without any admission as an in-patient at the Hospital except those that are specifically mentioned as covered specifically in the this Policy.
30. Costs of donor screening or treatment, unless specifically covered and specified in this Policy.
31. Any treatment received outside India.
32. Treatment taken from persons not registered as Medical Practitioners under respective medical councils.
33. Stem cell implantation / Surgery or Growth Hormone Therapy.
34. Acupressure, acupuncture, magnetic therapies.
35. Treatment for Age Related Macular Degeneration (ARMD) , treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy and Robotic surgery.
36. Any kind of Service charges, Surcharges, Luxury Tax and similar charges levied by the Hospital. (other than government taxes).
37. External medical equipment of any kind used at home as post hospitalization care including cost of instrument used in the treatment of Sleep Apnea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition.

SECTION 7 - GENERAL CONDITIONS:

7.1) Duty of Disclosure:

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material facts in the Proposal Form, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent` means or device being used by the Insured/Insured Person or any one acting on their behalf to obtain a benefit under this Policy.

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.

7.4) Observance of terms and conditions:

The due observance and fulfillment of the terms, conditions and endorsements of this Policy in so far as they relate to anything to be done or complied with by the Insured / Insured Person, shall be a condition precedent to any liability of the Company to make any payment under this Policy.

7.5) 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.

7.6) Fraudulent Claims:

If any claim is in any respect fraudulent, or if any false statement or declaration is made or used in support thereof or if any fraudulent means or devices are used by the Insured / Insured Person or anyone acting on his/her behalf to obtain any benefits under the Policy, all benefits under this Policy shall be forfeited. The Company will have the right to reclaim all benefits paid in respect of a claim which is fraudulent as mentioned above under this condition as well as condition No. 7.1 of this Policy.

7.7) 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.

7.8) Notice of Charge:

The Company is not under obligation to take note of any trust, assignment, lien or similar charge on or relating to the Policy. 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.

7.9) 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.

7.11) 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.

7.12) 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.

7.13) 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.

7.14) 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.

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7.15) Multiple policies

If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

1. In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

2. Claims under other policy/ies may be made after exhaustion of Sum Insured in the earlier chosen policy / policies.
3. If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

7.16) 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.

7.17) Free Look Period:

Insured has a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If the Insured has any objections to any of the terms and conditions, he / she have the option of cancelling the Policy stating the reasons for cancellation and in such a case, the Company will refund premium subject to

- A deduction of the expenses incurred on any medical check-up, stamp duty charges, if the risk has not commenced.
- A deduction of the expenses incurred on any medical check-up, stamp duty charges and proportionate risk premium for period on cover, if the risk has commenced.
- A deduction of such proportionate risk premium commensurating with the risk covered during such period, where only a part of risk has commenced.

The Policy can be cancelled only if Insured has not made any claims under the Policy.

Free look provision is not applicable and/or available at the time of renewal of the Policy.

7.18) 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 provided during the break period.

7.19) Cancellation/Termination:

The Company may cancel this Policy, by giving 15 days' notice in writing by registered post acknowledgment due to the Insured at his / their last known address. The Company shall exercise its right to cancel only on grounds of mis-representation, fraud, non-disclosure of material facts or non-cooperation of the Insured / Insured Person in implementing the terms and conditions of this Policy, in which case the Company shall be liable to repay on demand a ratable proportion of the premium for the unexpired term from the date of the cancellation. The Insured may also give 15 days' notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of notice, cancel the Policy and retain the premium for the period this Policy has been in force at the Company's short period scales given below. Provided that, refund on cancellation of Policy by the Insured shall be made only if no claim has/is occurred/reported up to the date of cancellation of this Policy / Policy riders.

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%

7.20) 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.

7.21) 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.

7.22) 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.

7.23) Terms of renewal:
- The Company offers life-long renewal unless the Insured/ Insured Person or any one acting on behalf of an Insured/ Insured Person has acted in an improper, dishonest or fraudulent manner or has made misrepresentation in relation to this Policy or the Policy poses a moral hazard.

- The premium for renewal will be applicable as per the premium chart based on age; Sum Insured; geography.

- Company will not load the premium for any adverse claims experience of particular Insured/Insured Person at the time of renewal if there is no change in the coverage of continuing Policy.

- The Company may change the renewal premium and/or benefits payable subject to approval from regulator (IRDA) and inform the same to the Insured at least 3 months prior to the effective date of revision and/ or modification or renewal

- In the likelihood of this Policy being withdrawn in future, the Company will inform the same to the Insured at least 3 months prior to expiry of the Policy. Insured will have the option to migrate to other plan under similar health insurance Policy at the time of renewal, provided the Policy is maintained without a break.

All applications for renewal of the Policy must be received by us before the expiry of current 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 grace period/break period.

7.24) 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.

7.25) 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,

7.26) 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..

7.27) 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.

SECTION 8 – GRIEVANCES REDRESSAL PROCEDURE:

The Company is committed to extend the best possible services to its customers. However, If Policyholder/Insured Person have a grievance that he/she wish us to redress, he/she may contact the Company with the details of their grievance via:
•Website: www.bharti-axagi.co.in
•Email: customer.service@bhartiaxa.com
•Phone: 18001032292
•Courier: Any of the Company's Branch office or corporate office
Policyholder/Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday.

Escalation Level 1
In case the Policyholder/Insured/Insured Person has not got his/her grievances redressed through one of the above methods (After 5 days of intimating of your complaint), Policyholder/ Insured/ Insured Person may contact the National Grievance Redressal Officer at :
Write to: Bharti AXA General Insurance, Spectrum Towers, 3rd floor, Malad Link Road, Malad (west), Mumbai- 400064
Call: 022-48815939
Email: NGRO@bhartiaxa.com
3rd floor, Spectrum Tower, Rajan Pada
Mindspace, Malad (W), Mumbai - 400 064

Escalation Level 2
In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed through any of the above methods (After 5 days of approaching National Grievance Redressal Officer), Policyholder/ Insured/ Insured Person may contact the Chief Grievance Redressal Officer at:
Email : CGRO@bhartiaxa.com

Escalation Level 3
In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed by the Company within 14 days, or, If Policyholder/ Insured/Insured Person is not satisfied with Company's redressal of the grievance through one of the above methods, Policyholder/ Insured/ Insured Person may approach the nearest Insurance Ombudsman for resolution of their grievance. The contact details of Ombudsman offices are mentioned below. Policy holder may also obtain copy of IRDAI circular Ref No. F. No. IRDAI/Reg/8/145/2017, notification on Insurance Regulatory and Development Authority (Protection of Policy holders' interests) Regulations, 2017 from any of our offices.

Grievance of Senior Citizens:
In respect of Senior Citizens, the Company has established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen's channel of the Company for faster attention or speedy disposal of grievance, if any.
•Website: www.bharti-axagi.co.in
•Email: customer.service@bhartiaxa.com
•Phone: 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.

•Website: igms.irda.gov.in
•Email: complaints@irda.gov.in
•Toll Free Number 155255 (or) 1800 4254 732

LIST OF INSURANCE OMBUDSMEN

1. Office Details
AHMEDABAD - Shri/Smt..... 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
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
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
BHUBANESHWAR - Shri/Smt..... Office of the Insurance Ombudsman, 62, Forest park,

Policy Wordings – **Bharti AXA Smart Super Health Assure Policy**
UIN: BHAHLIP20108V011920
Bharti AXA General Insurance Company Limited, "HOSTO CENTER" 1st Floor No.43,Millers Road. Vasanth Nagar, Bangalore -560052 Ph: 1800-103-2292, CIN : U66030KA2007PLC043362., IRDAI Reg No:- 139
Wesbite:www.bharti-axagi.co.in, Email: customer.service@bhartiaxa.com

1. Office Details
Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
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
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
DELHI - Shri/Smt..... 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

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Wesbite:www.bharti-axagi.co.in, Email: customer.service@bhartiaxa.com

suraksha ka naya nazariya

1. Office Details

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

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

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

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

KOLKATA - Shri/Smt.....

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Wesbite:www.bharti-axagi.co.in, Email: customer.service@bhartiaxa.com

suraksha ka naya nazariya

1. Office Details
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
LUCKNOW -Shri/Smt..... 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
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
NOIDA - Shri/Smt..... 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
PATNA - Shri/Smt..... Office of the Insurance Ombudsman,

1. Office Details
1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in
PUNE - Shri/Smt..... 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

SECTION 9: CLAIM SERVICING:

9.1 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.

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 Service Guarantee

9.5.1 Re-imbursement Claims

Notwithstanding the above, upon the receipt of all required documents and processing of the claim, the claim will be settled within 30 days from the date of submission of the said documents. Settlement (payment) of claim will be made within 7 days of receipt of acceptance in response to offer of settlement, failing which penal interest (in compliance with applicable regulations) at a rate of 2% higher than bank rate (prevailing as on the date of beginning of financial year in which the claim is reviewed) will be paid.

9.5.2 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.

Annexure 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 embolization
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 pterygium
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

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Bharti AXA General Insurance Company Limited, "HOSTO CENTER" 1st Floor No.43,Millers Road. Vasanth Nagar, Bangalore -560052 Ph: 1800-103-2292, CIN : U66030KA2007PLC043362., IRDAI Reg No:- 139
Wesbite:www.bharti-axagi.co.in, Email: customer.service@bhartiaxa.com

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..

Annexure II - Health Check-up tests on Renewal	
Age band <35 years	
Complete Blood Count and ESR Tests	Pre and Post Fasting Blood Sugar Test
Urine Routine Analysis	
Age band 36-50 years	
Complete Blood Count and ESR Tests	Serum Cholesterol & Triglycerides
Urine Routine Analysis	ECG
Pre and Post Fasting Blood Sugar Test	
Age band > 50 years	
Complete Blood Count and ESR Tests	Lipid Profile
Urine Routine Analysis	ECG
Pre and Post Fasting Blood Sugar Test	

Annexure 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

Appendix IV - List of Generally excluded in Hospitalization Policy

List of Generally excluded in Hospitalization Policy		
SNO	**List of Expenses Generally Excluded ("Non-Medical")in Hospital Indemnity Policy -**	**SUGGESTIONS**
TOILETRIES/COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS		
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	MOISTUR1SER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine.
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable

26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable/ Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable

58	SLINGS	Reasonable costs for one sling in case of upper arm fractures should be considered
ITEMS SPECIFIC ALL Y EXCLUDED IN THE POLICIES		
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in Policy unless otherwise specified
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Exclusion in Policy unless otherwise specified
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALIZATION	Exclusion in Policy unless otherwise specified
62	HORMONE REPLACEMENT THERAPY	Exclusion in Policy unless otherwise specified
63	HOME VISIT CHARGES	Exclusion in Policy unless otherwise specified
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in Policy unless otherwise specified
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Exclusion in Policy unless otherwise specified
66	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in Policy unless otherwise specified
67	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in Policy unless otherwise specified
68	DONOR SCREENING CHARGES	Exclusion in Policy unless otherwise specified
69	ADMISSION/REGISTRATION CHARGES	Exclusion in Policy unless otherwise specified
70	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in Policy unless otherwise specified
71	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not payable - Exclusion in Policy unless otherwise specified
72	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not payable as per HIV/AIDS exclusion
73	STEM CELL IMPLANTATION/ SURGERY and storage	Not Payable except Bone Marrow Transplantation where covered by Policy
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS		
74	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately

75	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
76	MICROSCOPE COVER	Payable under OT Charges, not payable separately
77	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not payable separately
78	SURGICAL DRILL	Payable under OT Charges, not payable separately
79	EYE KIT	Payable under OT Charges, not payable separately
80	EYE DRAPE	Payable under OT Charges, not payable separately
81	X-RAY FILM	Payable under Radiology Charges, not as consumable
82	SPUTUM CUP	Payable under Investigation Charges, not as consumable
83	BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
84	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
85	Antiseptic or disinfectant lotions	Not Payable -Part of Dressing Charges
86	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES,SYRINGES	Not Payable -Part of Dressing Charges
87	COTTON	Not Payable -Part of Dressing Charges
88	COTTON BANDAGE	Not Payable -Part of Dressing Charges
89	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed , otherwise included as Dressing Charges
90	BLADE	Not Payable
91	APRON	Not Payable -Part of Hospital Services/Disposable linen to be part of OT/ICU charges
92	TORNIQUET	Not Payable (service is charged by hospitals,consumables can not be separately charged)
93	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
94	URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE		

95	LUXURY TAX	Actual tax levied by government is payable .Part of room charge for sub limits
96	HVAC	Part of room charge not payable separately
97	HOUSE KEEPING CHARGES	Part of room charge not payable separately
98	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
99	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
100	SURCHARGES	Part of room charge not payable separately
101	ATTENDANT CHARGES	Not Payable - Part of Room Charges
102	IM IV INJECTION CHARGES	Part of nursing charges, not payable
103	CLEAN SHEET ^	Part of Laundry/Housekeeping not payable separately
104	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
105	BLANKET/WARMER BLANKET ADMINISTRATIVE OR NON-MEDICAL CHARGES	Not Payable- part of room charges
106	ADMISSION KIT	Not Payable
107	BIRTH CERTIFICATE	Not Payable
108	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
109	CERTIFICATE CHARGES	Not Payable
110	COURIER CHARGES	Not Payable
111	CONVENYANCE CHARGES	Not Payable
112	DIABETIC CHART CHARGES	Not Payable
113	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
114	DISCHARGE PROCEDURE CHARGES	Not Payable
115	DAILY CHART CHARGES	Not Payable
116	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
117	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
118	FILE OPENING CHARGES	Not Payable

119	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
120	MEDICAL CERTIFICATE	Not Payable
121	MAINTENANCE CHARGES	Not Payable
122	MEDICAL RECORDS	Not Payable
123	PREPARATION CHARGES	Not Payable
124	PHOTOCOPIES CHARGES	Not Payable
125	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
126	WASHING CHARGES	Not Payable
127	MEDICINE BOX	Not Payable
128	MORTUARY CHARGES	Payable up to 24 hrs,shifting charges not payable
129	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES		
130	WALKING AIDS CHARGES	Not Payable
131	BIPAP MACHINE	Not Payable
132	COMMODE	Not Payable
133	CPAP/ CAPD EQUIPMENTS Device	Not Payable
134	INFUSION PUMP - COST Device	Not Payable
135	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
136	PULSEOXYMETER CHARGES Device	Not Payable
137	SPACER	Not Payable
138	SPIROMETRE Device	Not Payable
139	SP0 2PROB E	Not Payable
140	NEBULIZER KIT	Not Payable
141	STEAM INHALER	Not Payable
142	ARMSLING	Not Payable
143	THERMOMETER	Not Payable (paid by patient)
144	CERVICAL COLLAR	Not Payable
145	SPLINT	Not Payable
146	DIABETIC FOOT WEAR	Not Payable
147	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable

148	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
149	LUMBOSACRAL BELT	Essential and should be paid specifically for cases who have undergone surgery of lumbar spine.
150	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia /quadripiegia for any reason and at reasonable cost of approximately Rs 200/ day
151	AMBULANCE COLLAR	Not Payable
152	AMBULANCE EQUIPMENT	Not Payable
153	MICROSHEILD	Not Payable
154	ABDOMINAL BINDER	Essential and should be paid in post surgery patients of major abdominal surgery including TAH, LSCS,incisional hernia repair, exploratory laparotomy for intestinal liver transplant etc.obstruction,
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION		
155	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\DISINFECTANTS ETC	May be payable when prescribed for patient , not payable for hospital use in OT or ward or for dressings in hospital
156	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post hospitalization nursing charges not Payable
157	NUTRITION PLANNING CHARGES - DIETICIAN CHARGESDIET CHARGES	Patient Diet provided by hospital is payable
158	SUGAR FREE Tablets	Payable -Sugar free variants of admissible medicines are not excluded
159	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
160	Digestion gels	Payable when prescribed
161	ECG ELECTRODES	Up to 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
162	GLOVES Sterilized Gloves	payable /unsterilized gloves not payable
163	HIV KIT	Payable - payable Pre operative screening

164	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
165	LOZENGES	Payable when prescribed
166	MOUTH PAINT	Payable when prescribed
167	NEBULISATION KIT	If used during hospitalization is payable reasonably
168	NOVARAPID	Payable when prescribed
169	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
170	ZYTEE GEL	Payable when prescribed
171	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
PART OF HOSPITAL'S OWN COSTS AND NOT PA YA BLE		
172	AHD	Not Payable - Part of Hospital's internal Cost
173	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
174	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
OTHERS		
175	VACCINE CHARGES FOR BABY	Payable as per Plan
176	AESTHETIC TREATMENT / SURGERY	Not Payable
177	TPA CHARGES	Not Payable
178	VISCO BELT CHARGES	Not Payable
179	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT,ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
180	EXAMINATION GLOVES	Not Payable
181	KIDNEY TRAY	Not Payable
182	MASK	Not Payable
183	OUNCE GLASS	Not Payable
184	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable, except for telemedicine consultations w here covered by Policy
185	186 OXYGEN MASK	Not Payable
186	PAPER GLOVES	Not Payable
187	PELVIC TRACTION BELT	Should be payable in case of PIVI) requiring traction as this is generally not reused
188	REFERAL DOCTOR'S FEES	Not Payable
189	ACCU CHECK (Glucometery/ Strips)	Not payable pre-hospitilazation o r post hospitalization / Reports and Charts required / Device not payable

190	PAN CAN	Not Payable
191	SOFNET	Not Payable
192	TROLLY COVER	Not Payable
193	UROMETER, URINE JUG	Not Payable
194	AMBULANCE	Payable as per Plan
195	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs an d then 1 in 24 hrs
196	URINE BAG P	Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs
197	SOFTOVAC	Not Payable
198	STOCKINGS	Essential for case like CABG etc. where it should be paid.