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Health Care Supreme

POLICY WORDING

Types of Policy

- Individual Health Care supreme Policy
- Floater Health Care Supreme Policy
- Group Health Care Supreme Policy

Policy period

1year, 2 years or 3 years

Sections under each plan

Medical Expenses Section: Mandatory **Add On Benefits Section**: Optional

Medical Expenses section covers

1. Hospitalisation Expenses
2. Pre Hospitalisation
3. Post Hospitalisation
4. Road Ambulance
5. Air Ambulance
6. Day Care Procedures
7. Out Patient Expenses
8. Organ Donor Expenses
9. Recovery benefit
10. Physiotherapy Expenses
11. Sum Insured Reinstatement Benefit
12. Ayurvedic & Homeopathic treatment Hospitalisation Expenses
13. Maternity Expenses
14. New Born Baby Cover
15. Preventive Health Check Up Annual Free

Add On Benefits section (Optional) covers

1. Ancillary Expenses Benefit
2. Critical Illness cover
3. Personal Accident cover

Preamble

Our agreement to insure You is based on Your Proposal to Us, which is the basis of this agreement, and Your payment of the premium. This Policy records the entire agreement between us and sets out what We insure, how We insure it, and what We expect of You and what You can expect of Us.

Scope of cover

The Company hereby agrees to pay in respect of an admissible claim, any or all of the following expenses subject to the Sum Insured, limits, terms, conditions and definitions, exclusions contained or otherwise expressed in this Policy.

PART I:
Section 1: Medical Expenses Section

A1. Hospitalisation Expenses

If You are Hospitalised on the advice of a Medical Practitioner/Doctor because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then We will pay You In-patient Treatment- Medical Expenses for the below listed items up to the Sum Insured as specified under the policy schedule

In-patient Treatment- Medical Expenses for:

- Room rent, boarding expenses
- Nursing
- Intensive care unit
- Consultation fees
- Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
- Medicines, drugs and consumables,
- Diagnostic procedures,
- The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure. Note:

Our maximum liability collectively for Hospitalization expenses, (section A1), Pre-hospitalization (Section A2), Post hospitalization (Section A3), Road ambulance (Section A4), Day Care expenses (Section A6), Ayurvedic / Homeopathic Hospitalisation Expenses(Section A12) would not exceed the hospitalization Sum Insured as specified in the policy schedule.

The Sum Insured for other sections is as specified under the respective cover in the policy schedule

A2. Pre-Hospitalisation

The Medical Expenses incurred during the 60 days immediately before you were Hospitalised, provided that: Such Medical Expenses were incurred for the same illness/injury for which subsequent Hospitalisation was required, and We have accepted an inpatient Hospitalisation claim under Benefit Hospitalisation expenses (section A1) .

Note:

Our maximum liability collectively for Hospitalization expenses, (section A1), Pre-hospitalization (Section A2), Post hospitalization (Section A3), Road ambulance (Section A4), Day Care expenses (Section A6), Ayurvedic / Homeopathic Hospitalisation Expenses(Section A12) would not exceed the hospitalization Sum Insured as specified in the policy schedule.

A3. Post-Hospitalisation

The Medical Expenses incurred during the 90 days immediately after You were discharged post Hospitalisation provided that: Such costs are incurred in respect of the same illness/injury for which the earlier Hospitalisation was required, and We have accepted an inpatient Hospitalisation claim under Benefit Hospitalisation expenses (section A1).

Note:

Our maximum liability collectively for Hospitalization expenses, (section A1), Pre-hospitalization (Section A2), Post hospitalization (Section A3), Road ambulance (Section A4), Day Care expenses (Section A6), Ayurvedic / Homeopathic Hospitalisation Expenses(Section A12) would not exceed the hospitalization Sum Insured as specified in the policy schedule.

A4. Road Ambulance

We will reimburse the expenses incurred on an ambulance offered by a healthcare or ambulance service provider for transferring You to the nearest Hospital with adequate emergency facilities for the provision of health services following an Emergency, provided that: We have accepted an inpatient Hospitalisation claim under Benefit Hospitalisation expenses (section A1) .

We will also reimburse the expenses incurred on an ambulance offered by a healthcare or ambulance service provider for transferring You from the Hospital where you were admitted initially to another hospital with higher medical facilities provided that: We have accepted an inpatient Hospitalisation claim under Benefit Hospitalisation expenses (section A1).

Note:

Our maximum liability collectively for Hospitalization expenses, (section A1), Pre-hospitalization (Section A2), Post hospitalization (Section A3), Road ambulance (Section A4), Day Care expenses (Section A6), Ayurvedic / Homeopathic Hospitalisation Expenses(Section A12) would not exceed the hospitalization Sum Insured as specified in the policy schedule.

A5. Air Ambulance

We will pay for ambulance transportation in an airplane or helicopter for emergency life threatening health conditions which require immediate and rapid ambulance transportation from the site of first occurrence of the illness /accident to the nearest hospital. The claim would be reimbursed up to the actual expenses subject to a maximum limit as specified under the Air Ambulance section in the policy schedule.

Return transportation to the client's home by air ambulance is excluded

A6. Day Care Procedures

We will pay you the medical expenses as listed above under Section A1 for Day care procedures / Surgeries taken as an inpatient in a hospital or day care centre but not in the outpatient department. Indicative list of Day Care Procedures is given in the annexure 1 of Policy wordings

Note:

Our maximum liability collectively for Hospitalization expenses, (section A1), Pre-hospitalization (Section A2), Post hospitalization (Section A3), Road ambulance (Section A4), Day Care expenses (Section A6), Ayurvedic / Homeopathic Hospitalisation Expenses(Section A12) would not exceed the hospitalization Sum Insured as specified in the policy schedule.

A7. Out Patient Expenses

If you consult a specialist consultant / specialist medical Practitioner on Outpatient basis for the illness / injury contracted during the policy period, we will pay you Out Patient expenses for,

- Specialist Consultations
- Investigations related to the illness / injury as prescribed by the specialist
- Medicines related to the illness / injury as prescribed by the specialist
- Dental Procedures – Root Canal Treatment, Extractions
- Consultations for Psychiatric disorders

Our maximum liability for the above expenses shall be limited to the amount specified under **Out Patient Expenses** in the policy schedule

A8. Organ Donor Expenses:

We will pay the lump sum amount as specified under the policy schedule towards organ donor's treatment for harvesting of the donated organ, provided that,

The organ donor is any person whose organ has been made available in accordance and in compliance with THE TRANSPLANTATION OF HUMAN ORGANS (AMENDMENT) BILL, 2011 and the organ donated is for the use of the Insured Person, and

We have accepted an inpatient Hospitalisation claim for the insured member under Hospitalisation expenses (section A1). We will pay one time lump sum benefit amount as specified under Organ donor Expenses in the policy schedule

A9. Recovery benefit:

In the event of insured member hospitalised for a disease/illness/injury for a continuous period exceeding 7 days, We will pay a onetime lump sum amount per policy period, as specified under the Recovery benefit in the policy schedule.
This benefit will be triggered provided that the hospitalization claim is accepted under Part I-Section A1-Hospitalisation expenses.

A10. Physiotherapy Expenses:

We will pay the expenses incurred towards Physiotherapy treatment taken on Out patient Basis for illness/Injury contracted during the policy period, maximum up to the amount specified under the Physiotherapy Expenses in the policy schedule, provided that,

i. The treatment is prescribed by a Specialist consultant for Muskulo- skeletal /Neurological diseases / Injuries or other Systemic diseases
ii. The treatment should be carried out in a hospital as defined under the policy
iii. Total 10 sittings of Physiotherapy sessions would be considered per illness/injury per policy period, maximum up to the specified limit as per the plan opted
iv. During the first year of Health Care Supreme policy with us, 90 days waiting period would be applicable for all the claims, however the waiting period would not be applied during subsequent renewals.

A11. Sum Insured Reinstatement Benefit:

If the Hospitalisation Sum Insured and cumulative benefit (if any) is exhausted due to claims lodged during the Policy period, then it is agreed that 100% of the hospitalization Sum Insured specified under Part I- Hospitalisation expenses (section A1) will be reinstated for the particular Policy period provided that:

i. The reinstated Sum Insured will be triggered only after the Hospitalisation Sum Insured inclusive of the Cumulative Bonus (If applicable) has been completely exhausted during the policy period;
ii. The reinstated Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Hospitalisation Expenses Section A1;
iii. If the claimed amount is higher than the Balance Sum Insured inclusive of the Cumulative Bonus (If applicable) under the policy, then this benefit will not be triggered for such claims
iv. The reinstated Sum Insured would be triggered only for subsequent claims made by the Insured Person and not arising out of any illness/disease (including its complications) for which a claim has been lodged in the current policy year under Hospitalisation Expenses Section A1.
v. This benefit is applicable only once during each policy period & will not be carried forward to the subsequent renewals if the benefit is not utilized.
vi. Additional premium would not be charged for reinstatement of the Sum Insured.

A12. Ayurvedic & Homeopathic treatment Hospitalisation Expenses

If You are Hospitalised for not less than 24 hrs, in an Ayurvedic / Homeopathic Hospital on the advice of a Medical Practitioner/Doctor because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period then We will pay You:
In-patient Treatment- Medical Expenses for Ayurvedic & Homeopathic treatment:

- Room rent, boarding expenses
- Nursing care
- Consultation fees
- Medicines, drugs and consumables,
- Ayurvedic & Homeopathic treatment procedure

The claim will be admissible under the policy provided that,

i. The illness/injury requires inpatient admission & the procedure performed on the insured cannot be carried out on Outpatient basis
ii. the treatment has been undergone in a government hospital Note:

Our maximum liability collectively for Hospitalization expenses, (section A1), Pre-hospitalization (Section A2), Post hospitalization (Section A3), Road ambulance (Section A4), Day Care expenses (Section A6), Ayurvedic / Homeopathic Hospitalisation Expenses(Section A12) would not exceed the hospitalization Sum Insured as specified in the policy schedule.

A13. Maternity Expenses

We will pay the Medical Expenses for the delivery of a baby (including caesarean section) and/or expenses related to medically recommended and lawful termination of pregnancy, limited to maximum 2 deliveries or termination(s) or either, during the lifetime of the insured person, provided that,

i. Our maximum liability per delivery or termination shall be limited to the amount specified in the policy Schedule as per the plan opted.
ii. We will pay the Medical Expenses of pre-natal and post-natal hospitalization per delivery or termination upto the amount stated in the policy Schedule
iii. We will cover the Medical Expenses incurred for the medically necessary treatment of the new born baby upto the amount stated in the Schedule of Benefits
iv. This coverage is limited to Self & a lawfully wedded spouse when both are covered under a single policy for 24 months, either as a family floater or individual Sum Insured policy
v. Waiting period of 24 months from the date of issuance of the first policy with us, provided that the policy has been renewed continuously with us without break for you & your spouse
vi. We will not cover Ectopic pregnancy under this benefit (although it shall be covered under section Hospitalisation A1).
vii. Any complications arising out of or as a consequence of maternity/child birth will be covered within the limit of Sum Insured available under this benefit

A14. New Born Baby Cover

Coverage for new born baby will be considered subject to a valid claim being accepted under maternity expenses section A13.
We will pay the following expenses within the limit of the Sum Insured available under the maternity cover

i. Medical Expenses towards treatment of your new born baby while you are hospitalised as an inpatient for delivery for the hospitalization,
ii. Hospitalisation charges incurred on the new born baby during post birth including any complications shall be covered up to a period of 90 days from the date of birth and within limit of the Sum Insured under Maternity Cover without payment of any additional premium
iii. Mandatory Vaccinations of the new born baby up to 90 days, as recommended by the Indian Pediatric Association will be covered under the Maternity Sum Insured

A15. Free Annual Preventive Health Check Up

After each renewal of Health Care Supreme policy with us you will be entitled for a Free Annual Preventive Health Check up at Our empanelled Diagnostic centers Or empanelled Hospitals, list of tests as specified below. You would have to approach us for the arrangement of the Health Check up. For the avoidance of doubt, We shall not be liable for any other ancillary or peripheral costs or expenses (including but not limited to those for transportation, accommodation or sustenance).
This benefit can be availed by all members covered under Individual Sum Insured Policies. This benefit can be availed by proposer & spouse only under Floater Sum Insured Policies

Eligible List of tests for Males above 25 years	Eligible List of tests for Females above 25 years	Eligible List of tests for age 5 years – 25 years
Full Medical Report CBC (Complete Blood Count) FBS (Fasting Blood Sugar) Serum Creatinine ECG Serum Cholesterol Ultra Sonography of Abdomen & Pelvis	Full Medical Report CBC FBS Serum Creatinine ECG PAP smear Serum Cholesterol Ultra Sonography of Abdomen & Pelvis	Full Medical Report CBC Chest X ray Blood Group Urine Routine

Note:

The hospitalization Sum Insured under Medical Expenses Section covers the below listed expenses
The claim payout under the below headings should not exceed the Hospitalisation Sum Insured.

- Hospitalization expenses
- Pre-hospitalization
- Posthospitalization
- Road ambulance
- Day Care expenses
- Ayurvedic / Homeopathic Treatment Hospitalisation Expenses

Separate Sum Insured has been Specified for the below mentioned sections

- Air Ambulance
- Out Patient Expenses
- Organ Donor Expenses
- Recovery benefit
- Physiotherapy Expenses
- Sum Insured Reinstatement Benefit
- Maternity Expenses (and New Born Baby Cover)

A16. Modern Treatment:

Modern Treatment Methods and Advancement in Technologies (as per below list) shall be restricted to 50% of Sum Insured or 10 Lacs, whichever is lower.

A. Uterine Artery Embolization and HIFU
B. Balloon Sinuplasty
C. Deep Brain stimulation D. Oral chemotherapy
E. Immunotherapy- Monoclonal Antibody to be given as injection
F. Intra vitreal injections
G. Robotic surgeries
H. Stereotactic radio surgeries
I. Bronchical Thermoplasty
J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
K. IONM -(Intra Operative Neuro Monitoring)
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

Section 2: Definitions Applicable for All Covers of this Policy

Words or terms in Italic have the meaning ascribed to them wherever they appear in this Policy, and references to the singular or to the masculine include references to the plural or to the feminine wherever the context permits:

1. **Accident, Accidental**
An accident is a sudden, unforeseen and involuntary event caused by external, visible and violent means

2. **Alternative treatments**
Alternative treatments are forms of treatments other than treatment "Allopathy" or "Modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context

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

4. **AYUSH Hospital:**
An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a. Central or State Government AYUSH Hospital; or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i. Having at least 5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

5. **AYUSH Day Care Centre:**
AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

6. **Bodily Injury/ 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..

7. **Bajaj Allianz Network Hospitals / Network Hospitals/Network Provider** means the Hospitals which have been empanelled by Us as per the latest version of the schedule of Hospitals maintained by Us, which is available to You on request.

8. **Bajaj Allianz Diagnostic Centre** means the diagnostic centres which have been empanelled by Us as per the latest version of the schedule of diagnostic centres maintained by Us, which is available to You on request.

9. **Congenital Anomaly**
Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
   a. **Internal Congenital Anomaly**
   Congenital anomaly which is not in the visible and accessible parts of the body
   b. **External Congenital Anomaly**
   Congenital anomaly which is in the visible and accessible parts of the body

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

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

12. **Contribution**

Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion.

13. **Critical Illness** means an illness, sickness or a disease or a corrective measure as specified in Part II Section 2 of this Policy.

14. **Critical Illness Benefit** means the amount specified in the Schedule, which is the maximum amount for which the Company may be liable to make payment for any Critical Illness.

15. **Cumulative Bonus**
Cumulative Bonus shall mean any increase in the Sum Insured granted by the insurer without an associated increase in premium.

16. **Day care centre** means any institution established for day care treatment of sickness and / or injuries or a medical set-up 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:-
- has qualified nursing staff under its employment;
- has qualified medical practitioner/s in charge;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

17. **Day Care Treatment**
Day care treatment refers to medical treatment, and/or surgical procedure which is:
I. Undertaken under General or Local Anaesthesia in a hospital/day care centre in
II. Less than 24 hrs because of technological advancement, and 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 cover

18. **Dental Treatment**
means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

19. **Dependent child** A child is considered a dependent for insurance purposes until his 35th birthday (even if not enrolled in an educational institution) provided he is unmarried, financially dependent, on the proposer.

20. **Disclosure to information norm**
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.

21. **Doctor / medical practioner**
A Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence.

22. **Doctor for alternative treatment** means a person who holds a recognized qualification in Ayurvedic /Homeopathic medicine and is registered by the medical council of any State of India in which he operates and is practicing within the scope of such license

23. **Ectopic Pregnancy** means pregnancy in which the embryo is located or the foetus develops, outside the uterus, which is proved by diagnostic means & certified by a Specialist consultant in writing

24. **Emergency Care**
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.

25. **Family or Family Members**
For the purpose of Individual Sum Insured Policy- includes the Insured; his/her lawfully wedded spouse and dependent children, parents, Sister, Brother, In laws, Aunt, Uncle, Grandchildren.
For the purpose of Family Floater- includes the Insured; his/her lawfully wedded spouse and dependent children. For Parents separate floater Policy can be taken.

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

27. **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:
--has qualified nursing staff under its employment round the clock;

--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;
--has qualified medical practitioner(s) in charge round the clock;
--has a fully equipped operation theatre of its own where surgical procedures are carried out;
--maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

28. Hospitalisation
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 24consecutive hours.

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

30. Intensive Care Unit
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.

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

a. **Acute condition -** Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.

b. **Chronic condition -** A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:— it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests—it needs ongoing or long-term control or relief of symptoms— it requires your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it comes back or is likely to come back

32. Insured/Insured Person means the person(s) named in the policy schedule, who are covered under this policy, for whom the insurance is proposed, appropriate premium is paid.

33. Limit of Indemnity means Our maximum liability for each Insured Person for any and all benefits claimed for during each Policy Year, and in relation to a Family Floater represents Our maximum liability for any and all claims made by You and all of Your Dependents during each Policy Year.

34. Medical Advice
Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

35. Medical expenses
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.

36. Medically Necessary
Medically necessary treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

I. is required for the medical management of the illness or injury suffered by the insured;
II. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
III. must have been prescribed by a medical practitioner,
IV. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

37. Maternity expense / treatment shall include the following Medical treatment
Expenses:

I. Medical Expenses for a delivery (including complicated deliveries and Caesarean sections) incurred during Hospitalization;
II. The lawful medical termination of pregnancy during the Policy Period limited to 2 deliveries or terminations or either during the lifetime of the Insured Person;
III. Pre-natal and post-natal Medical Expenses for delivery or termination.

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

39. New Born Baby
Newborn baby means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

40. Nominee means a person designated by You to receive the proceeds of this Policy upon Your death.

41. Non- Network
Any hospital, day care centre or other provider that is not part of the network

42. Notification of Claim
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.

43. **Occupational Diseases :** A disease resulting from exposure during employment to conditions or substances that are detrimental to health

44. **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.

45. **Obesity** means abnormal or excessive fat accumulation that may impair health. Obesity is measured in Body Mass Index.
Body mass index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m2).
The WHO definition is:

- BMI greater than or equal to 25 is overweight
- BMI greater than or equal to 30 is obesity

46. **Permanent Total Disability**
Medical Practitioner/Doctor certified total, continuous and permanent:

- Loss of the sight of both eyes
- Physical separation of or the loss of ability to use both hands or both feet
- Physical separation of or the loss of ability to use one hand and one foot
- Loss of sight of one eye and physical separation of or the loss of ability to use either one hand or one foot.

47. **Permanent Partial Disability**
Medical Practitioner/Doctor certified total and permanent loss or impairment of body part or sensory organ

48. **Physiotherapy**
A branch of rehabilitative treatment that uses specially designed exercises and equipment to help patients regain or improve their physical abilities

49. **Policy** means the proposal, the Schedule (and any endorsements attaching to or forming part thereof) and the policy document.

50. **Policy Period** means the period between the commencement date and the expiry date specified in the Schedule and includes both the commencement date as well as the expiry date.

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

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

53. **Post-hospitalization Medical Expenses**
Medical Expenses incurred immediately after the Insured Person is Hospitalised, provided that:
I. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
II. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

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

56. **Qualified Nurse**
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.

57. **Reasonable and customary charges** means the charges for services or supplies, which are the standard charge 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.

58. **Renewal**
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.

59. **Room rent:** Room Rent shall mean the amount charged by a hospital for the deductibles occupying of a bed and associated medical expenses

60. **Schedule** means the schedule and any annexure to it.

61. **Surgery or Surgical Procedure** means a manual and/or operative procedure(s) required for the 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 by a Medical Practitioner

62. **Specialist Consultant** means a person who holds a medical post graduate or higher degree in the specific line of treatment under Allopathic medicine

63. **Sum Insured** means the amount stated in the Schedule against the Cover for each insured person separately for Individual Sum Insured policy and aggregately for all insured members for a Floater policy.

64. **Unproven/Experimental treatment / Non-standard treatment**
Unproven/Experimental treatment/ Non-standard is treatment, including drug Experimental therapy, which is not based on established medical practice in India.

65. **We, Our, Ours, Us** means the Bajaj Allianz General Insurance Company Limited.

66. **You, Your, Yourself** means the person or persons that We insure as set out in the Schedule.

Section 3: Exclusions:

A. **The below exclusions will be applicable for** Hospitalization expenses (section A1), Pre-hospitalization (Section A2), Post hospitalization (Section A3), Road ambulance (Section A4), Air Ambulance (Section A5), Day Care Procedures (Section A6),Recovery benefit (Section A9), Physiotherapy Expenses (Section A10), Sum insured reinstatement benefit (Section A11) and Ayurvedic / Homeopathic treatment Hospitalisation Expenses (Section A12)
We shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or attributable to any of the following:

I. Waiting Period

1. **Pre-existing Diseases waiting period (Excl01)**

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Health Care Supreme Policy with us.
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If the Insured is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the Policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

2. **Specified disease/procedure waiting period (Excl02)**

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first Health Care Supreme Policy with Us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
e. If the Insured is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedures is as below:

1. Any type gastrointestinal ulcers	2. Cataracts,
3. Any type of fistula	4. Macular Degeneration
5. Benign prostatic hypertrophy	6. Hernia of all types
7. All types of sinuses	8. Fissure in ano
9. Haemorrhoids, piles	10. Hydrocele
11. Dysfunctional uterine bleeding	12. Fibromyoma
13. Endometriosis	14. Hysterectomy

15. Uterine Prolapse	16. Stones in the urinary and biliary systems
17. Surgery on ears/tonsils/ adenoids/ paranasal sinuses	18. Surgery on all internal or external tumours/cysts/ nodules/polyps of any kind including breast lumps.
19. Mental Illness	20. Diseases of gall bladder including cholecystitis
21. Pancreatitis	22. All forms of Cirrhosis
23. Gout and rheumatism	24. Tonsilitis
25. Surgery for varicose veins and varicose ulcers	26. Chronic Kidney Disease
27. Alzheimer's Disease	

3. A waiting period of 24 months from the first Health Care Supreme Policy inception date will be applicable to the medical and surgical treatment of illness surgical procedures mentioned below.
   - Joint replacement surgery,
   - Surgery for prolapsed inter vertebral disc (unless necessitated due to an accident)
   - Surgery to correct Deviated Nasal Septum and Hypertrophied Turbinates
   - Congenital internal diseases or anomalies
   - Laser treatment for correction of eye sight due to refractive error.
   - Parkinson's Disease
   - Genetic disorders

4. 30-day waiting period (Excl03)

a. Expenses related to the treatment of any illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured has Continuous Coverage for more than twelve months.
The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

5. Any treatment arising from or traceable to pregnancy, child birth including cesarean section until 24 months continuous period has elapsed since the inception of the first Health Care Supreme Policy with US. However this exclusion will not apply to Ectopic pregnancy proved by diagnostic means

II. General exclusions

1. Any dental treatment that comprises of cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization..
2. Medical expenses where Inpatient care is not warranted and does not require supervision of qualified nursing staff and qualified medical practitioner round the clock. This exclusion is however not applicable for any day care treatment taken for the accidental bodily injury in a day care centre/ hospital

B. Exclusions applicable for Out Patient Expenses (Section A7)

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

I. Waiting Period

30-day waiting period (Excl03)

a. Expenses related to the treatment of any illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured has Continuous Coverage for more than twelve months.
The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

II. Specific exclusions

1. Any expenses for investigations/ treatment taken without existence of any disease/ illness, signs /symptoms
2. Any expenses for diagnostic tests, investigations / treatment taken without the Specialist Consultant advising the same and which is not duly supported by his prescriptions
3. Cost of Annual Health Check up
4. Any expenses in excess of the maximum payable amount under the Outpatient medical expenses limit.
5. Any expense for Treatments which is not specified under Section A7 (out patient expenses).

C. Specific Exclusions applicable for Ayurvedic / Homeopathic Treatment Cover (section A12),

The below exclusions would be in addition to the exclusions stated under section 3, part A,
We shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or attributable to any of the following

1. Treatment taken at a hospital which does not fulfill the criteria as per the policy definition
2. Treatment exceeding the limit as specified under the Plan opted
3. Any expenses incurred for treatment taken for other Ayurvedic / Homeopathic therapy which is not defined & covered

under the policy

4. Treatment taken for Unani, naturopathy or any other stream of Medicine except as specified under the policy
5. Treatment taken in Wellness Centre/Spa/Naturopathy centers/Panchakarma centers or any other treatment centres which do not qualify as per the policy definition of AYUSH Hospital.

D. Common Exclusions applicable to all the covers under Part 1 Section A (Medical expenses) :

Hospitalisation expenses, Pre- Hospitalisation, Post-Hospitalisation Expenses, Road Ambulance, Air Ambulance, Day Care Procedures, Out Patient Expense, Organ Donor Expenses, Recovery benefit, Physiotherapy Expenses, Sum Insured Reinstatement Benefit, Ayurvedic / Homeopathic treatment Hospitalisation Expenses, Maternity Expenses, New Born Baby Cover

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

I. General exclusions

1. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not) [except for compelling the Government or any other person to do or abstain from doing any act as defined under the definition of Terrorist act], civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority.
   Any Medical expenses incurred due to Acts of Terrorism will be covered under the policy.

2. Investigation & Evaluation (Excl04)
   a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded even if the same requires confinement at a Hospital.
   Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

3. Rest Cure, rehabilitation and respite care (Excl05)
   a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
      i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
      ii. Any services for people who are terminally ill to address medical, physical, social, emotional and spiritual needs.

4. Obesity/Weight Control (Excl06)
   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   1) Surgery to be conducted is upon the advice of the Medical Practitioner/Doctor
   2) The surgery/Procedure conducted should be supported by clinical protocols
   3) The member has to be 18 years of age or older and
   4) Body Mass Index (BMI);
      a) greater than or equal to 40 or
      b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         i. Obesity-related cardiomyopathy
         ii. Coronary heart disease
         iii. Severe Sleep Apnea
         iv. Uncontrolled Type2 Diabetes

5. Change-of-gender treatments (Excl07)
   Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

6. Cosmetic or plastic Surgery (Excl08)
   Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

7. Breach of law (Excl10)
   Expenses for treatment directly arising from or consequent upon any Insured committing or attempting to commit a breach of law with criminal intent.

8. Excluded Providers (Excl11)
   Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

9. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Excl12)

10. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Excl13)

11. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. (Excl14)

12. Expenses related to donor screening, treatment, including surgery to remove organs from a donor in the case of transplant surgery. This exclusion is not applicable for Donor Expenses under Part I Section A8 (Organ Donor Expenses)

13. Refractive Error (Excl15)
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

14. Unproven Treatments (Excl16)
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

15. Sterility and Infertility (Excl17)
Expenses related to sterility and infertility. This includes:
    a) Any type of contraception, sterilization
    b) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    c) Gestational Surrogacy
    d) Reversal of sterilization

16. Circumcision unless required for the treatment of Illness or Accidental bodily injury,

17. The cost of spectacles, contact lenses, hearing aids, crutches, dentures, artificial teeth and all other external appliances and/or devices whether for diagnosis or treatment except for Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like Pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents etc.

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

19. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol)

20. Vaccination or inoculation unless forming a part of post bite treatment or if medically necessary and forming a part of treatment recommended by the treating Medical Practitioner/doctor. This exclusion is not applicable for Part I section A14 (New Born Baby Cover).

21. Treatment for any other system other than modern medicine (also known as Allopathy). This exclusion is not applicable for Ayurvedic / Homeopathic Medicine Expenses under Part I section A12 (Ayurvedic / Homeopathic treatment Hospitalisation Expenses).

22. All non-medical Items as per Annexure II provided in Policy Wordings

23. Any treatment received outside India is not covered under this policy.

24. Any claim directly or indirectly caused by or contributed to by nuclear weapons and/or materials.

PART II: Health Care Supreme: Add On covers:

Note: These benefits are optional and applicable only if opted for and issued accordingly in the Schedule of Benefits

Section1: Ancillary Expenses Benefit

If You are Hospitalised on the advice of a Medical Practitioner/Doctor because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then We will pay You:

i. The Daily Allowance as specified under the policy, for each continuous and completed period of 24 hours of Hospitalization necessitated solely by reason of the said Accidental Bodily Injury or Illness, subject to a maximum of 30 days during the Policy Period for Individual SI policy & 60 days during the Policy Period for Floater SI policy

ii. Two times the Daily Allowance for each continuous and completed period of 24 hours hospitalisation in the Intensive Care Unit during any period of Hospitalization necessitated solely by reason of the said Accidental Bodily Injury or Illness, subject to a maximum of 15 days during the Policy Period for Individual SI policy & 30 days during the Policy Period for Floater SI policy

Note:

a. The claim under i & ii would be admissible provided that we have accepted the claim under Hospitalisation cover under policy section A1 (Hospitalisation expenses)

b. Our maximum liability collectively for Hospitalization & ICU hospitalization for Individual & Floater policies would not exceed the Total Sum Insured as specified in the policy schedule

Definitions & Exclusions:

All definitions & Exclusions of Part I as specified under Section 2 (Definitions), Section 3 (Exclusions) would be applicable to Ancillary Expenses Benefit section.

Section2. Critical Illness Benefit

A. Coverage

If you are diagnosed as suffering from any of the Critical Illness, as listed under the policy, which first occurs or manifests itself during the Policy Period, and fulfills the criteria as defined under the policy, we will pay you the lump sum amount as specified under Critical Illness section in the policy Schedule.

B. List & Definitions of Critical Illness covered under the policy

All the common definitions of Part I (Medical Expenses) specified under Section 2 would be applicable to Critical Illness Benefit List & definition of Critical Illness covered under the policy given below

1. CANCER OF SPECIFIED SEVERITY

I. 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.

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix. All tumors in the presence of HIV infection.

2. 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:
a. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
b. New characteristic electrocardiogram changes
c. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:
a. Other acute Coronary Syndromes
b. Any type of angina pectoris
c. 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. COMA OF SPECIFIED SEVERITY

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:

a. No response to external stimuli continuously for at least 96 hours;
b. Life support measures are necessary to sustain life; and
c. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma
d. The condition has to be confirmed by a specialist medical practitioner.

Exclusion:
Coma resulting directly from alcohol or drug abuse is excluded.

4. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

5. STROKE RESULTING IN PERMANENT NEUROLOGICAL SEQUELAE

Any cerebrovascular incident producing permanent neurological sequelae, this includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and Embolisation from an extra-cranial 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.

The following are excluded:

i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions

6. MAJOR ORGAN /BONE MARROW TRANSPLANT

The actual undergoing of a transplant of:

a. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

b. Human bone marrow using haematopoietic stem cells

The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

7. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

The definite occurrence of multiple sclerosis:

The diagnosis must be supported by all of the following:

a. Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;

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

Exclusion:

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

8. APLASTIC ANEMIA

Chronic persistent bone marrow failure which results in anemia, 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.

9. END STAGE LUNG DISEASE

End stage lung disease, causing chronic respiratory failure. This diagnosis must be supported by evidence of all of the following:

a. FEV1 test results which are consistently less than 1 litre;

b. Permanent supplementary oxygen therapy for hypoxemia;

c. Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less (PaO2≤55mmHg); and

d. Dyspnea at rest.

The diagnosis must be confirmed by a Respiratory Physician

10. END STAGE LIVER FAILURE

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

a. Permanent jaundice;

b. Ascites;

c. Hepatic encephalopathy.

II. Exclusion:

Liver disease secondary to alcohol or drug abuse is excluded.

11. PARKINSON'S DISEASE

The unequivocal diagnosis of idiopathic Parkinson's disease by a consultant neurologist This diagnosis must be supported by all of the following conditions:

a. The disease cannot be controlled with medication;

b. Signs of progressive impairment; and

c. Inability to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living" for a continuous period of at least 6 month

Activities of Daily Living:

i. Washing- the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii. Dressing- the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring- the ability to move from a bed to an upright chair or wheelchair and vice versa;

iv. Mobility- the ability to move indoors from room to room on level surfaces;

v. Toileting- the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

vi. Feeding- the ability to feed oneself once food has been prepared and made available.

Exclusion:

Drug-induced or toxic causes of Parkinsonism are excluded.

12. SURGERY OF AORTA

The actual undergoing of major surgery, to repair or correct an 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.
Exclusion:
Surgery performed using only minimally invasive or intra arterial techniques are excluded.

13. ALZHEIMER'S DISEASE

Deterioration or loss of intellectual capacity as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease or irreversible organic disorders, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. This diagnosis must be supported by the clinical confirmation of an Specialist Consultant and supported by the Company's appointed Medical Practitioner/doctor (If required).
The following are excluded:

- Non-organic diseases such as neurosis and psychiatric illnesses; and
- Alcohol related brain damage.

14. PRIMARY 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:
   a. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
   b. 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.

15. MAJOR BURNS

Burns involving 40% or more of the body surface area (as calculated on rule of 9 for each area of body affected) OR Second or third degree burns caused by accidental thermal, electric, chemical burn injury.
Exclusion:
Radiation induced burns are specifically excluded.

C: Exclusions applicable for Critical Illness Cover:
We shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or attributable to any of the following:

I. Waiting Period

1. Any Critical Illness diagnosed within the first 90 days of the date of commencement of the Policy is excluded. This exclusion shall not apply to an Insured for whom coverage has been renewed by the Named Insured, without a break, for subsequent years.

II. General exclusions

1. Any Critical Illness for which care, treatment, or advice was recommended by or received from a Physician, or which first manifested itself or was contracted before the start of the Policy Period, or for which a claim has or could have been made under any earlier policy.

2. Any sexually transmitted diseases or any condition directly or indirectly caused by or associated with Human T-Cell Lymphotropic Virus type III (III LB III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS.

3. Treatment arising from or traceable to pregnancy, childbirth postpartum complications including but not limited to caesarian section, birth defects and congenital anomalies

4. Occupational diseases.

5. War, whether war be declared or not, invasion, act of foreign enemy, hostilities, civil war, insurrection, terrorism or terrorist acts or activities, rebellion, revolution, mutiny, military or usurped power, riot, strike, lockout, military or popular uprising, civil commotion, martial law or loot, sack or pillage in connection therewith, confiscation or destruction by any government or public authority or any act or condition incidental to any of the above.

6. Naval or military operations of the armed forces or air force and participation in operations requiring the use of arms or which are ordered by military authorities for combating terrorists, rebels and the like.

7. Any natural peril (including but not limited to storm, tempest, avalanche, earthquake, volcanic eruptions, hurricane, or any other kind of natural hazard).

8. Radioactive contamination

9. Consequential losses of any kind, be they by way of loss of profit, loss of opportunity, loss of gain, business interruption, market loss or

otherwise, or any claims arising out of loss of a pure financial nature such as loss of goodwill or any legal liability of any kind whatsoever.

10. Intentional self-injury and/or the use or misuse of intoxicating drugs and/or alcohol.

Section 3. Personal Accident Cover

Our agreement to insure is based on your Proposal to us, which is the basis of this agreement, and your payment of premium. This Policy records the entire agreement between us and sets out what we insure, how we insure it, and what we expect of you.

A. What we will pay for

Our liability to make payment to You/your family member(s) named in the schedule for one or more of the events described at 1) Death, 2) Permanent Total Disability, 3) Permanent Partial Disability to 4) Temporary Total Disability below; is limited to the Total Sum Assured as specified in the policy schedule for You/your family member(s) named in the schedule, except as we have agreed at 2) Permanent Total Disability

You agree that we shall deduct from any amount we have to pay under 1) Death,2) Permanent Total Disability, 3) Permanent Partial Disability to 4) Temporary Total Disability any amount that we have already paid under any of 1) Death,2) Permanent Total Disability, 3) Permanent Partial Disability to 4) Temporary Total Disability so that our total payments do not exceed the Total Sum Assured opted by you/your family members. However, if we become liable to make payment under 1) Death or 2) Permanent Total Disability, then this insurance will cease as far as You/Your family member(s) named in the schedule are concerned.

1. Death

We will pay the Nominee, 100% of the Sum Insured as specified under the policy schedule, if during the Policy Period You as named in the schedule meet with Accidental Bodily Injury that causes death within 12 Months.

2. Permanent Total Disability

We will pay you 200 % of the Sum Insured shown under the Policy Schedule if You/Your family member(s) named in the schedule meet with Accidental Bodily Injury during the Policy Period that causes Permanent Total Disability within 12 months.

3. Permanent Partial Disability

If you/your family member(s) named in the Schedule meet with Accidental Bodily Injury during the Policy Period that causes Permanent Partial Disability within 12 months, we will pay the percentage shown in the table below applied to the Sum Insured shown under the Policy Schedule.

An arm at the shoulder joint	70%
An arm above the elbow joint	65 %
An arm beneath the elbow joint	60 %
A hand at the wrist	55 %
A thumb	20 %
An index finger	10 %
Any other finger	5 %
A leg above mid-thigh	70 %
A leg up to mid-thigh	60 %
A leg up to beneath the knee	50 %
A leg up to mid-calf	45 %
A foot at the ankle	40 %
A large toe	5 %
Any other toe	2 %
An eye	50%
Hearing of one ear	30 %
Hearing of both ears	75 %
Sense of smell	10 %
Sense of taste	5 %

a) If Disability will be decided by authorized Civil Surgeon according to the degree to which you/your family member(s) normal functional physical capacity has been impaired

b) If you/your family member(s) named in the schedule were already suffering from Permanent Partial Disability before the date

you/your family member(s) met with Accidental Bodily Injury, then the amount we pay will be reduced by that extent You agree that the reduction will be decided by our medical advisors according to the degree of Permanent Partial Disability from which you/your family member(s) named in the schedule were already suffering.

4. Temporary Total Disability

If the insured person (s) named in the schedule except for the dependant children, suffer Accidental Bodily Injury during the Policy Period which completely prevents the insured person(s) from engaging in his/her respective occupation, then we will make a weekly payment under TTD benefit. (As per the plan opted)

a) We will make the first payment when the insured person(s) named in the schedule satisfy us that the Accidental Bodily Injury has completely prevented the insured person (s) from engaging in his/her occupation.

b) We will stop making payments when we are satisfied that the insured person(s) named in the schedule can engage in his/ her occupation again, or when we have made payments for a maximum period of 100 weeks from the date the insured person(s) met with the Accidental Bodily Injury, whichever is earlier .

5. Additional Insurance

a. Transportation

If we have accepted a claim under 1) Death for death of you/your family member(s) named in the schedule, then we will pay towards the actual cost of transporting the remains of you/your family member(s) from the place of death to a hospital, cremation ground, burial ground or to insured's home. The amount we pay will be limited to `5, 000/-.

b. Children's Education Benefit

If we have accepted a claim under either 1) Death or 2) Permanent Total Disability, then we will make a onetime payment of `5, 000/- each towards the cost of education of up to 2 of your dependent children who were studying in an accredited institution at the time you met with Accidental Bodily Injury.

B: Definitions

Definitions of Part I (Medical Expenses)- Section 2 are applicable to Personal Accident Cover

C: Specific Exclusions applicable for Personal Accident Cover:

What we will not pay for

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

I. Specific exclusions

1. Accidental Bodily Injury that you/your family member named in the schedule meets with:
   - a) Through suicide, attempted suicide or self-inflicted injury or illness.
   - b) While under the influence of liquor or drugs.
   - c) Arising or resulting from the insured person committing any breach of law with criminal intent.
   - d) Whilst participating as the driver, co-driver or passenger of a motor vehicle during motor racing or trial runs.
   - e) As a result of any curative treatments or interventions that you carry out or have carried out on your body.
   - f) Arising out of your participation in any naval, military or air force operations whether in the form of military exercises or war games or actual engagement with the enemy, whether foreign or domestic.
   - g) Whilst engaging in aviation or ballooning. Whilst mounting into, dismounting from or traveling in any balloon or aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world.
2. Consequential losses of any kind or insured person's actual or alleged legal liability.
3. Any injury/disablement/death directly or indirectly arising out of or contributed to any pre-existing condition.
4. Venereal or Sexually transmitted diseases
5. HIV (Human Immunodeficiency Virus) and/or any HIV related illness including AIDS (Acquired Immune Deficiency Syndrome) and/or mutant derivatives or variations thereof however caused.
6. War (whether declared or not), civil war, invasion, act of foreign enemies, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrest, restraint or detainment, confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority.
7. Nuclear energy, radiation.
8. Pregnancy, resulting childbirth, miscarriage, abortion, or complications arising out of these.

Part III: Conditions: Applicable for: Medical Expenses Section and Add on covers

1. Disclosure of information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

2. Conditions Precedent

Where this Policy requires You to do or not to do something, then the complete satisfaction of that requirement by You or someone claiming on Your behalf is a precondition to any obligation We have under this Policy. If You or someone claiming on Your behalf fails to completely satisfy that requirement, then We may refuse to consider Your claim.

3. Condition Precedent to Admission of Liability

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

4. Insured

Only those persons named as the insured in the Schedule shall be covered under this Policy. Cover under this Policy shall be withdrawn from any insured member upon such insured member giving 14 days written notice to be received by Us.

5. Communications

Any communication meant for Us must be in writing and be delivered to Our address shown in the Schedule. Any communication meant for You will be sent by Us to Your address shown in the Schedule.

6. Premium Payment in Instalments (Wherever applicable)

If the insured person has opted for Payment of Premium on an instalment basis i.e. Annual (for long term polices only), Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period of 15 days would be given to pay the instalment premium due for the policy.
ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy

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

8. Claim Settlement (provision for Penal interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2o/o above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

9. Claims Procedure

If You meet with any Accidental Bodily Injury or suffer an Illness that may result in a claim, then as a condition precedent to Our liability, You must comply with the following:

A. Cashless Claims Procedure:

Cashless treatment is only available at Network Hospitals. In order to avail of cashless treatment, the following procedure must be followed by You:

i. For planned treatment or Hospitalization, prior to taking treatment and/or incurring Medical Expenses at a Network Hospital, You or Your representative must intimate Us 48 hours before the planned Hospitalization and request pre-authorisation by way of the written form.
ii. After considering Your request and after obtaining any further information or documentation We have sought, We may, if satisfied, send You or the Network Hospital, an authorisation letter. The authorisation letter, the ID card issued to You along with this Policy and any other information or documentation that We have specified must be produced to the Network Hospital identified in the pre-authorization letter at the time of Your admission to the same.
iii. If the procedure above is followed, You will not be required to directly pay for the bill amount in the Network Hospital that We are liable under Section A1 In-Patient Hospitalisation Treatment above and the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital. Pre-authorisation does not guarantee that all costs and expenses will be covered. We reserve the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy.
iv. In case any treatment or procedure is to be taken on an Emergency basis, You or Your representative must intimate Us in writing immediately within 24 hours of hospitalization.

10. Reimbursement Claims Procedure applicable for all sections

a. You or someone claiming on Your behalf must inform Us in writing immediately with 48 hours of hospitalization in case emergency hospitalization & 48 hours prior to hospitalization in case of planned hospitalization
b. You must immediately consult a Medical Practitioner/Doctor and follow the advice and treatment that he recommends.
c. You must take reasonable steps or measure to minimize the quantum of any claim that may be made under this Policy.
d. You must have Yourself examined by Our medical advisors if We ask for this, and as often as We consider this to be necessary at insurer's cost.

e. You or someone claiming on Your behalf must promptly and in any event within 30 days of discharge from a Hospital give Us the documentation (written details of the quantum of any claim along with all original supporting documentation, including but not limited to first consultation letter, original vouchers, bills and receipts, birth/ death certificate (as applicable)) and other information We ask for to investigate the claim or Our obligation to make payment for it.

f. In the event of the death of the insured person, someone claiming on his behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if any) within 30 days*

g. For out Patient expenses section A7 of Part I, the claim documents can be submitted only twice during the policy period. The claim payment would be up to the OPD Sum Insured as specified under the plan

h. In event of a claim, the original documents to be submitted & after the completion of the claims assessment process the original documents may be returned if requested by the insured in writing, however we will retain the Xerox copies of the claim documents.

i. If the original documents are submitted with the co-insurer, the Xerox copies attested by the co-insurer should be submitted along with the letter confirming the status of the claim & settlement details if any

*Note:

Waiver of conditions (a) and (f) may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible from him or any other person to give notice or file claim within the prescribed time limit.

Waiver of conditions (a) and (f) under applicable for out Patient expenses section A7 of Part I

List of Claims Documents

Documents to be submitted for Medical Expenses section & Ancilliary Expenses cover	Documents to be Submitted for Critical illness
First Consultation letter from the Medical Practitioner/Doctor	Duly completed Claim Form duly signed by the insured
Duly completed claim form signed by the Claimant	Copy of Discharge Summary / Discharge Certifcate
Hospital Discharge Card (Not applicable for Out Patient Expens- es & Physiotherapy Expenses Section)	Copy of Final Hospital Bill
Hospital Bill giving detailed break up of all expense heads men- tioned in the bill. Clear break ups have to be mentioned for OT Charges, Medical Practitioner/Doctor's Consultation and Visit Charges, OT Con- sumables, Transfusions, Room Rent, etc.	Original Policy copy
Money Receipt, duly signed with a Revenue Stamp	First consultation letter for Illness
All original Laboratory and Diagnostic Test Reports. E.g. X-Ray, E.C.G, USG, MRI Scan, Haemogram etc	Medical certifcate for the duration of illness (if required)
In case of a Cataract Operation, IOL Sticker will have to be en- closed	All required Investigation Reports as per the Illness (If required)
Other documents as may be required by Bajaj Allianz to process the claim	Letter from the employer clarifying the type of work
Aaadhar card & PAN card Copies (Not mandatory if the same is linked with the policy while issuance or in previous claim)	Aaadhar card & PAN card Copies (Not mandatory if the same is linked with the policy while issuance or in previous claim)

Documents to be submitted for Personal Accident Claim	
Death Claims	PTD, PPD & TTD Claims
Duly completed claim form signed by the Claimant	Duly completed claim form signed by the Claimant
Attested copy of Death Certifcate	Attested copy of FIR / Panchanama / Inquest Panchanama
Attested copy of Post Mortem Report, if conducted	Copy of Medico Legal Certifcate
Attested copy of Viscera/ Chemical Analysis Report (If Viscera is preserved)	Copy of discharge summary towards hospitalization immedi- ately after injury
Diatoms report from forensic lab in case of death on account of drowning (if sample preserved)	X-ray Films/ Investigation reports supporting the diagnosis
Attested copy of statement of witness (if any)	Disability Certifcate from the Government Authority certifying Insured's disability
Burial certifcate (wherever applicable)	Other documents as may be required by Bajaj Allianz to process the claim
Legal heir certifcate containing affdavit and indemnity bond both duly signed by all legal heirs and notarized is mandatory to process the claim	Leave certifcate from the employer

Insured's / Claimant's photo-identity proof	Aaadhar card & PAN card Copies (Not mandatory if the same is linked with the policy while issuance or in previous claim)
Insured's / Claimant's address proof	
Other documents as may be required by Bajaj Allianz to process the claim	
Aaadhar card & PAN card Copies (Not mandatory if the same is linked with the policy while issuance or in previous claim)	

11. Paying a Claim

i. You agree that We need only make payment when You or someone claiming on Your behalf has provided Us with necessary documentation and information.

ii. If the insurer, for any reasons decides to reject the claim under the policy the reasons regarding the rejection shall be communicated to the insured in writing within 30 days of the receipt of documents. The insured may take recourse to the Grievance Redressal procedure stated under policy.

12. Basis of Claims Payment

a. If You suffer a relapse within 45 days of the date when You last obtained medical treatment or consulted a Medical Practitioner/Doctor and for which a claim has been made, then such relapse shall be deemed to be part of the same claim.

b. We shall make payment in Indian Rupees only.

c. If claim event falls within two policy periods the claims shall be administered taking into consideration the available sum insured in the two policy periods. The claim amount to be payable shall be reduced up to the extent of the premium for renewal, if the same is not received earlier.

13. Cumulative Bonus

Cumulative Bonus is applicable only for Hospitalisation Section A1 of Part I

If You renew Your Health Care Supreme Policy with Us without any break in the Policy Period and there has been no claim in the preceding year, We will increase the Limit of Indemnity by 10% per annum, but:

a. The maximum cumulative increase in the Limit of Indemnity will be limited to 5 years and/ or 50% of Sum Insured.

b. If a claim is made in any year where a cumulative increase has been applied, then the increased Limit of Indemnity shall be reduced by 10%, save that the Limit of Indemnity applicable to Your first Health Care Supreme Policy with Us shall be preserved.

c. This clause does not alter the annual character of this insurance or Our right to decline to renew or to cancel the Policy, under the circumstances described in cancellation clause stated under the policy

d. There is no transfer of Cumulative Bonus from other Company renewals

14. Complete Discharge

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

15. Fraud

a. If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

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

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

i. the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

ii. the active concealment of a fact by the insured person having knowledge or belief of the fact;

iii. any other act fitted to deceive; and

iv. any such actor omission as the law specially declares to be fraudulent

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

16. Multiple Policies

a. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

b. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

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

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

17. Renewal

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

a. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
b. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
c. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
d. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
e. No loading shall apply on renewals based on individual claims experience.

18. Cancellation

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

Cancellation grid for premium received on annual basis or full premium received at policy inception are as under

Period in Risk	Premium Refund		
	Policy Period 1 Year	Policy Period 2 Year	Policy Period 3 Year
Within 15 Days	As per Free Look Period Condition		
Exceeding 15 days but less than or equal to 1 month	75.00%	75.00%	80.00%
Exceeding 1 month but less than or equal to 3 months	50.00	75.00%	80.00%
Exceeding 3 months but less than or equal to 6 months	25.00%	65.00%	75.00%
Exceeding 6 months but less than or equal to 12 months	0.00%	45.00%	60.00%
Exceeding 12 months but less than or equal to 15 months	0.00%	30.00%	50.00%
Exceeding 15 months but less than or equal to 18 months	0.00%	20.00%	45.00%
Exceeding 18 months but less than or equal to 24 months	0.00%	0.00%	30.00%
Exceeding 24 months but less than or equal to 27 months	0.00%	0.00%	20.00%
Exceeding 27 months but less than or equal to 30 months	0.00%	0.00%	15.00%
Exceeding 30 months but less than or equal to 36 months	0.00%	0.00%	0.00%

Cancellation grid for premium received on instalment basis and refund is as under
The premium will be refunded as per the below table:

Period in Risk (from latest instalment date)	Premium Refund	Premium Refund	Premium Refund
	% of Monthly Premium	% of quarterly Premium	% of Half Yearly Premium
Within 15 days from 1st Installment date	As per Free Look Period Condition		
Exceeding 15 days but less than or equal to 3 months	No Refund		30%
Exceeding 3 months but less than or equal to 6 months			0%

Note:

- The first slab of Number of days "within 15 days" in above table is applicable only in case of new business.
  In case of renewal policies, period is risk "Exceeding 15 days but less than 3 months" should be read as "within 3 months".

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.
The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

19. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.
The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

a. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
b. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

20. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.
For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/Circulars_List.aspx?mid=3.2.3

21. Endorsements

This Policy constitutes the complete contract of insurance. This Policy cannot be changed by anyone (including an insurance agent or broker) except Us. Any change that We make will be evidenced by a written endorsement signed and stamped by Us.

22. Possibility of Revision of Terms of the Policy including the Premium Rates

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

23. Migration of policy

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.
For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/Circulars_List.aspx?mid=3.2.3

24. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

25. Discounts

A) Healthcare Supreme Individual & Floater policy Discount:

1) Discount applicable for New Business

a. Add on Cover Discount: 5% sectional discount on total premium will be extended under the policy, if all the add on covers are opted along with the basic cover.
b. Family Discount: 5% family discount shall be offered if 2 or more than 2 of any of the eligible family members are covered under a single policy. Moreover, this family discount will be offered for both new policies as well as for renewal policies. Family discount is not applicable to floater Health Care Supreme Policies.
c. Total maximum discount of 10% will be extended on published rates for New Business under Individual Health Care Supreme Policies.
d. Total maximum discount of 5% will be extended on published rates for New Business under Floater Health Care Supreme Policies.

2) Discount applicable for Renewal policies

a. Add on Cover Discount: 5% sectional discount on total premium will be extended under the policy,if all the add on covers are opted along with the basic cover.
b. Family Discount: 5% family discount shall be offered if 2 or more than 2 of any of the eligible family members are covered under a single policy. Moreover, this family discount will be offered for both new policies as well as for renewal policies. Family discount is not applicable to floater Health Care Supreme Policies.
c. Claim Free Renewal Discount: if policy is claim free then 5% discount will be extended at the time of renewal
d. Total maximum discount of 15% will be extended on published rates for Renewals Individual Health Care Supreme Policies.
e. Total maximum discount of 10% will be extended on published rates for Renewals of Floater Health Care Supreme Policies.
Note: 10% additional discount will be offered for online policies.

B) **Long term Policy Discount:** 4% discount on premium for 2 years policy term and 8% discount on premium for 3 years policy term.
(Note: This is not applicable on instalment premium option)
This is not applicable if premium is paid in instalments.

26. Loadings

The loading would be applicable for the proposals with adverse health conditions given below: Hypertension, Diabetes, Obesity, Cholesterol Disorder, Cardiovascular diseases, or multiple risk factors.

Condition	Loading on premium
Diabetes	10%

Hypertension	10%
Cholesterol Disorder	10%
Obesity	10%
Cardiovascular diseases	10%

a. For Multiple conditions cumulative loading would be applied on the published premium.
b. The maximum risk loading applicable for an individual shall not exceed 50% of the published premiums, for overall risk per person.
c. These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured).
d. We will inform You about the applicable risk loading through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 7 days.
e. Please note that We will issue Policy only after getting Your consent.

27. Sum Insured Enhancement:

a. The Insured member can apply for enhancement of Sum Insured at the time of renewal. You can apply for enhancement of Sum Insured by submitting a fresh proposal form to the company.
b. The acceptance of enhancement of Sum Insured would be based on the health condition of the insured members & claim history of the policy.

All waiting periods as defined in the Policy shall apply for this enhanced Sum Insured limit from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

Inclusion of Dependant members under the policy:

Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, the pre-existing disease clause, exclusions and waiting periods will be applicable considering such Policy Year as the first year of Policy with the Company for the insured member.

28. Territorial Limits & Governing Law

a. In case of Personal Accident Cover & Critical Illness Cover of this Policy, We cover the Critical illness as specified under the policy & the Accidental Bodily Injury/Critical Illness sustained during the Policy Period anywhere in the world (subject to the travel and other restrictions that the Indian Government may impose), but We will only make payment within India and in Indian Rupees.
b. For all other Covers of this Policy, We cover treatment availed within India only. Our liability to make any payment shall be to make payment within India and in Indian Rupees only.
c. The Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by Us, which approval shall be evidenced by an endorsement on the Schedule.
d. The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law. The section headings of this Policy are included for descriptive purposes only and do not form part of this Policy for the purpose of its construction or interpretation.

29. Arbitration and Reconciliation

a. If any dispute or difference shall arise as to the quantum to be paid under the Policy (liability being otherwise admitted), such difference shall independently of all other questions be referred to decision of a sole arbitrator in writing by the parties 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 the arbitrators comprising of two arbitrators, one appointed by each of the parties to the dispute/ difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996. The law of the arbitration will be Indian law, and the seat of the arbitration and venue for all hearings shall be within India.
b. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if We have disputed or not accepted liability under or in respect of this Policy.
c. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.
d. If these arbitration provisions are held to be invalid, then all such disputes or differences shall be referred to the exclusive jurisdiction of the Indian Courts.

30. Nomination

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

31. Special conditions for Personal Accident Section & Critical Illness sections

Upon the occurrence of an event of Critical Illness section and / or Permanent Total Disability under Personal Accident section (subject to the terms, conditions and exclusions of this Policy) without prejudice to the Company's obligation to make payment, these sections shall immediately cease to exist with reference to that Insured member.

32. Grievance Redressal Procedure

Welcome to Bajaj Allianz and Thank You for choosing us as your insurer.

Please read *Your* Policy and Policy Schedule.
The Policy and Policy Schedule set out the terms of *Your* contract with us. Please read *Your* Policy and Policy Schedule carefully to ensure that the cover meets *Your* needs.
We do our best to ensure that our customers are delighted with the service they receive from Bajaj Allianz. If *You* are dissatisfied we would like to inform *You* that we have a procedure for resolving issues. Please include *Your* Policy number in any communication. This will help us deal with the issue more efficiently. If *You* don't have it, please call our Branch office.
Initially, we suggest *You* contact the Branch Manager/ Regional Manager of the local office which has issued the Policy. The address and telephone number will be available in the Policy. Naturally, we hope the issue can be resolved to *Your* satisfaction at the earlier stage itself. But if *You* feel dissatisfied with the suggested resolution of the issue after contacting the local office, please e-mail or write to:

Bajaj Allianz General Insurance Co. Ltd
Bajaj Allianz House, Airport Road
Yerawada, Pune 411006
E-mail: bagichelp@bajajallianz.co.in
Call : 1800-225858 (free calls from BSNI/MTNL lines only)
1800-1025858 (free calls from Bharti users – mobile /landline) or020-30305858

Grievance Redressal Cell for Senior Citizens
Senior Citizen Cell for Insured who are Senior Citizens
'Good things come with time' and so for our customers who are above 60 years of age we have created special cell to address any health insurance related query. Our senior citizen customers can reach us through the below dedicated channels to enable us to service them promptly
Health toll free number: 1800-103-2529
Exclusive Email address: seniorcitizen@bajajallianz.co.in

If *You* are still not satisfied, *You* can approach the Insurance Ombudsman in the respective area for resolving the issue. The contact details of the Ombudsman offices are mentioned below:

Office Details	Jurisdiction of Office Union Territory,District)
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	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR - Shri/Smt..... Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
CHENNAI - Shri M. Vasantha Krishna	Tamil Nadu,

Office Details	Jurisdiction of Office Union Territory,District)
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	Pondicherry Town and Karaikal (which are part of Pondicherry).
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	Delhi.
GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA - Shri/Smt..... Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW -Shri/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	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.

Office Details	Jurisdiction of Office Union Territory,District)
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	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri/Smt..... Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE - Shri/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	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Note: Address and contact number of Governing Body of Insurance Council
Secretary General - Governing Body of Insurance Council
JeevanSevaAnnexe, 3rd Floor, S.V. Road, Santacruz (W), Mumbai - 400 054
Tel No: 022-2610 6889, 26106245, Fax No. : 022-26106949, 2610 6052, E-mail ID: inscoun@vsnl.net

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Table of Benefits

Medical Expenses Section - Sum Insured in INR									
Plans		Hospitalisation SI (Hospitalisation Expenses +Pre Hospitalisation+ Post Hospitalisation+ Road Ambulance +Day care Procedures+ Ayurvedic and Homoeopathic Treatment Hospitalisation) in `	OPD SI in `	Physiotherapy on OPD basis in `	Maternity SI (Including New Born baby cover) in `	Donor Expenses in `	Air Ambulance Reimbursement Expenses in `	Recovery benefit in `	Total Sum Insured in `
Health Care Supreme - Vital	Plan A	500000	2500	5000	25000	50000	50000	10000	642500
	Plan B	800000	4000	8000	30000	80000	80000	10000	1012000
	Plan C	1000000	5000	10000	35000	100000	100000	10000	1260000
Health Care Supreme - Smart	Plan D	1500000	10000	15000	40000	150000	150000	25000	1890000
	Plan E	2000000	15000	20000	40000	200000	200000	25000	2500000
	Plan F	2500000	15000	25000	40000	250000	250000	25000	3105000

	Plan G	3000000	15000	30000	50000	300000	300000	25000	3720000
Health Care Supreme - Ultimo	Plan H	3500000	17500	35000	75000	350000	350000	50000	4377500
	Plan I	4000000	20000	40000	75000	400000	400000	50000	4985000
	Plan J	4500000	25000	45000	75000	450000	450000	50000	5595000
	Plan K	5000000	25000	50000	100000	500000	500000	50000	6225000

Annexure I

Indicative List of "DAY CARE PROCEDURES"

1. Suturing - CLW -under LA or GA	2. Surgical debridement of wound
3. Therapeutic Ascitic Tapping	4. Therapeutic Pleural Tapping
5. Therapeutic Joint Aspiration	6. Aspiration of an internal abscess under ultrasound guidance
7. Aspiration of hematoma	8. Incision and Drainage
9. Endoscopic Foreign Body Removal - Trachea /- pharynx-larynx/ bronchus	10. Endoscopic Foreign Body Removal -Oesophagus/stomach / rectum.
11. True cut Biopsy - breast/- liver/- kidney-Lymph Node/-Pleura/-lung/-Muscle biopsy/- Nerve biopsy/-Synovial biopsy/-Bone trephine biopsy/-Pericardial biopsy	12. Endoscopic ligation/banding
13.Sclerotherapy	14. Dilatation of digestive tract strictures
15. Endoscopic ultrasonography and biopsy	16. Nissen fundoplication for Hiatus Hernia /Gastro esophageal reflux disease
17. Endoscopic placement/removal of stents	18. Endoscopic Gastrostomy
19. Replacement of Gastrostomy tube	20. Endoscopic polypectomy
21. Endoscopic decompression of colon	22. Therapeutic ERCP
23. Brochoscopic treatment of bleeding lesion	24. Brochoscopic treatment of fistula /stenting
25. Bronchoalveolar lavage & biopsy	26. Tonsillectomy without Adenoidectomy
27. Tonsillectomy with Adenoidectomy	28. Excision and destruction of lingual tonsil
29. Foreign body removal from nose	30. Myringotomy
31. Myringotomy with Grommet insertion	32. Myringoplasty /Tympanoplasty
33. Antral wash under LA	34. Quinsy drainage
35. Direct Laryngoscopy with or w/o biopsy	36. Reduction of nasal fracture
37.Mastoidectomy	38. Removal of tympanic drain
39. Reconstruction of middle ear	40. Incision of mastoid process & middle ear
41. Excision of nose granuloma	42. Blood transfusion for recipient
43. Therapeutic Phlebotomy	44. Haemodialysis/Peritoneal Dialysis
45. Chemotherapy	46.Radiotherapy
47. Coronary Angioplasty (PTCA)	48. Pericardiocentesis
49. Insertion of filter in inferior vena cava	50. Insertion of gel foam in artery or vein
51. Carotid angioplasty	52. Renal angioplasty
53. Tumor embolisation	54. TIPS procedure for portal hypertension
55. Endoscopic Drainage of Pseudopancreatic cyst	56. Lithotripsy
57. PCNS (Percutaneous nephrostomy)	58. PCNL (percutaneous nephrolithotomy)
59. Suprapubic cytostomy	60. Tran urethral resection of bladder tumor

61. Hydrocele surgery	62. Epididymectomy
63. Orchidectomy	64. Herniorrhaphy
65. Hernioplasty	66. Incision and excision of tissue in the perianal region
67. Surgical treatment of anal fistula	68. Surgical treatment of hemorrhoids
69.Sphincterotomy/Fissurectomy	70. Laparoscopic appendicectomy
71. Laparoscopic cholecystectomy	72. TURP (Resection prostate)
73. Varicose vein stripping or ligation	74. Excision of dupuytren's contracture
75. Carpal tunnel decompression	76. Excision of granuloma
77. Arthroscopic therapy	78. Surgery for ligament tear

79. Surgery for meniscus tear	80. Surgery for hemoarthrosis/pyoarthrosis
81. Removal of fracture pins/nails	82. Removal of metal wire
83. Incision of bone, septic and aseptic	84. Closed reduction on fracture, luxation or epiphyseolysis with osetosynthesis
85. Suture and other operations on tendons and tendon sheath	86. Reduction of dislocation under GA
87. Cataract surgery	88. Excision of lachrymal cyst
89. Excision of pterigium	90. Glaucoma Surgery
91. Surgery for retinal detachment	92. Chalazion removal (Eye)
93. Incision of lachrymal glands	94. Incision of diseased eye lids
95. Excision of eye lid granuloma	96. Operation on canthus & epicanthus
97. Corrective surgery for entropion & ectropion	98. Corrective surgery for blepharoptosis
99. Foreign body removal from conjunctiva	100. Foreign body removal from cornea
101. Incision of cornea	102. Foreign body removal from lens of the eye
103. Foreign body removal from posterior chamber of eye	104. Foreign body removal from orbit and eye ball
105. Excision of breast lump /Fibro adenoma	106. Operations on the nipple
107. Incision/Drainage of breast abscess	108. Incision of pilonidal sinus
109. Local excision of diseased tissue of skin and subcutane- ous 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 subcuta- neous tissue
115. Incision, excision, destruction of the diseased tissue of the tongue	116. Glossectomy
117. Reconstruction of the tongue	118. Incision and lancing of the salivary gland and a salivary duct
119. Resection of a salivary duct	120. Reconstruction of a salivary gland and a salivary duct
121. External incision and drainage in the region of the mouth, jaw and face	122. Incision of hard and soft palate
123. Excision and destruction of the diseased hard and soft palate	124. Incision, excision and destruction in the mouth
125. Surgery to the floor of mouth	126. Palatoplasty
127. Transoral incision and drainage of pharyngeal abscess	128. Dilatation and curettage
129. Myomectomies	130. Simple Oophorectomies

Note:

i) Above mentioned list is a indicative list of procedures, any other surgeries/procedures requiring less than 24 hours hospitalisation due to technological advances will also be covered under this policy provided such procedures comply with the standard definition of Day Care Centre and Day Care treatment mentioned in the definitions.

ii) 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:-

List 1 - List of Non-Medical Items

SL. No.	Item	
1	BABY FOOD	Not Payable
2	BABY UTILITIES CHARGES	Not Payable
3	BEAUTY SERV ICES	Not Payable
4	BELTS/ BRACES	Not Payable
5	BUDS	Not Payable
6	COLD PACK/HOT PACK	Not Payable
7	CARRY BAGS	Not Payable
8	EMAIL I INTERNET CHARGES	Not Payable
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY	Not Payable
10	LEGGINGS	Essential in bariatric and varicose vein surgery and should be
11	LAUNDRY CHARGES	Not Payable
12	MINERAL WATER	Not Payable
13	SANITARY PAD	Not Payable
14	TELEPHONE CHARGES	Not Payable
15	GUEST SERVICES	Not Payable
16	CREPE BANDAGE	Not Payable
17	DIAPER OF ANY TYPE	Not Payable
18	EYELET COLLAR	Not Payable
19	SLINGS	Not Payable
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS	Not Payable
21	SERVICE CHARGES WHERE NURSING CHARGES ALSO CHARGED	Not Payable
22	Television Charges	Not Payable
23	SURCHA RGES	Not Payable
24	ATTENDANT CHARGES	Not Payable
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Not Payable
26	BIRTH CERTIFICATE	Not Payable
27	CERTIFICATE CHARGES	Not Payable
28	COURIER CHARGES	Not Payable
29	CONVEYANCE CHARGES	Not Payable
30	MEDICAL CERTIFICATE	Not Payable
31	MEDICAL RECORDS	Not Payable
32	PHOTOCOPIES CHARGES	Not Payable
33	MORTUARY CHARGES	Not Payable
34	WALKING AIDS CHARGES	Not Payable
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
36	SPACER	Not Payable
37	SPIROMETRE	Not Payable
38	NEBULIZER KIT	Not Payable
39	STEAM INHALER	Not Payable
40	ARMSLING	Not Payable

41	THERMOMETER	Not Payable
42	CERVICAL COLLAR	Not Payable
43	SPLINT	Not Payable
44	DIABETIC FOOT WEAR	Not Payable
45	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
46	KNEE IMMOBILIZER/S HOULDER IMMOBILIZER	Not Payable
47	LUMBOSACRAL BELT	Not Payable
48	NIMBUS BED OR WATER OR AIR BED CHARGES	Not Payable
49	AMBULANCE COLLAR	Not Payable
50	AMBULANCE EQUIPMENT	Not Payable
51	ABDOMINAL BINDER	Not Payable
52	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES	Not Payable
53	SUGAR FREE Tablets	Not Payable
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Not Payable
55	ECG ELECTRODES	Not Payable
56	GLOVES	Not Payable
57	NEBULISATION KIT	Not Payable
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT,	Not Payable
59	KIDNEY TRAY	Not Payable
60	MASK	Not Payable
61	OUNCE GLASS	Not Payable
62	OXYGEN MASK	Not Payable
63	PELVIC TRACTION BELT	Not Payable
64	PAN CAN	Not Payable
65	TROLLY COVER	Not Payable
66	UROMETER , URINE JUG	Not Payable
68	VASOFIX SAFETY	Not Payable

List ll - ltems that are to be subsumed into Room Charges

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

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

List lll- ltems that are to be subsumed into Procedure Charges

S. No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES(for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD ,CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPE AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES,HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET

23	ORTHOBUNDLE, GYNAEC BUNDLE

List lV - ltems that are to be subsumed into costs of treatment

S. No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALIZATION FOR EVALUATION/DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/CAPD EQUIPMENTS
7	INFUSION PUMP-COST
8	HYDROGEN PERPOXIDE\SPIRIT\DISINFECTION ETC
9	NUTTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION / STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG