Bharti AXA General Insurance Company Limited
Group Health Insurance Policy

PREAMBLE

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

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

1. Hospital (Room & Boarding and Operation theatre) charges,
2. Fees of Surgeon, Anesthetist, Nurse, Specialists etc.,
3. Cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.
4. Pre and post hospitalization expenses
5. Ambulance charges

in manner, for the period and to the extent of the Sum Insured as specified in this Policy.

DEFINITIONS

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

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

"Any one Illness" means continuous period of Illness and it includes a relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.
"Ayush Treatment" refers to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

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

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

"Critical Illnesses" mean diseases / illnesses limited to the following:

1. Cancer
2. First Heart Attack
3. Coronary Artery Disease
4. Coronary Artery Bypass Surgery

5. Heart Valve Surgery
6. Surgery to Aorta
7. Stroke
8. Kidney Failure
9. Aplastic Anaemia
10. End Stage Lung Disease
11. End Stage Liver Failure
12. Coma
13. Major Burns
14. Major Organ/Bone Marrow Transplantation
15. Multiple Sclerosis
16. Fulminant Hepatitis
17. Motor Neurone Disease
18. Primary Pulmonary Hypertension
19. Terminal Illness
20. Benign Brain Tumour
21. Bacterial Meningitis

"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 of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

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

"Congenital Anomaly" means condition which is present since birth, and which is abnormal with reference to form, structure or position.

1. Internal Congenital Anomaly - Congenital Anomaly which is not in the visible and accessible parts of the body
2. External Congenital Anomaly - Congenital anomaly which is in the visible and accessible parts of the body.

Co-Payment:

Co-payment means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A copayment does not reduce the Sum Insured.

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

"Disclosure to information norm" means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

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

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

I. Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and

II. Which would have otherwise require a hospitalization of more than 24 hours.
Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

"Dependent Child" refers to a child (natural or legally adopted) below the age of 23 years, who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

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

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

Domiciliary Hospitalization:
Domiciliary hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

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

"Emergency care" means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

"Family" means the Insured Person, his/her lawful spouse, dependent parents/ parents-in-law and maximum of two dependent children upto the age of 23 years.

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

"Hospital" - 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;

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

"Hospitalisation" means admission in a Hospital for a minimum period of 24 consecutive "In-patient Care" hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

"Illness" means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
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.
Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
ii. it needs ongoing or long-term control or relief of symptoms

iii. it requires your/insured person's rehabilitation or for you/insured member to be specially trained to cope with it
iv. it continues indefinitely
v. it recurs or is likely to recur

"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.

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

"Insured" means the individual who has a permanent place of residence in India and on whose name the Policy is issued. In case of group policies it means the group, organization, institution, firm, society or body corporate engaged in any trade or business in India on whose name the Policy is issued.

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

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.

ICU Charges:

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

Maternity expenses:

Maternity expenses means;

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
ii. expenses towards lawful medical termination of pregnancy during the policy period.

"Medical Practitioner" is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government

of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.
The term Medical Practitioner includes a physician, specialist and surgeon, provided that this person is not a member of the Insured/Insured Person's family.

"Medical expenses" means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

"Medically Necessary" treatment 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.

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

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

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

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

"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.

New Born Baby:
Newborn baby means baby born during the Policy Period and is aged upto 90 days.

OPD treatment:

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

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

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

"Policy" means this document of Policy describing the terms and conditions of this contract of insurance including the Company's covering letter to the Insured, if any, the Schedule attached to and forming part of this Policy, the Insured's Proposal Form and any applicable endorsement thereon. The Policy contains details of the scope and extent of cover available to the Insured/Insured Person, the exclusions from the scope of cover and the terms and conditions of the issue of the Policy.

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

"Post-hospitalization Medical Expenses" means medical expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the hospital provided that:

1. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
2. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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

"Pre-hospitalization Medical Expenses" means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

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

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

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

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

"Renewal" means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

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

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

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

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

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

"Terrorism/Terrorist Incident" means any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption, or the commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not. Robberies or other criminal acts, primarily committed for personal gain and acts arising primarily

from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorist activity. Terrorism shall also include any act, which is verified or recognized by the relevant Government as an act of terrorism.

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

SCOPE OF COVER

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

Section I

a) Hospitalisation Expenses

Hospitalisation Expenses benefit provides cover for reimbursement / payment of hospitalisation expenses which are reasonably and necessarily incurred by the Insured Person for treatment of disease, illness contracted or injury sustained by the Insured Person during the Policy Period as specified in the Schedule to this Policy, in a Hospital in India as in-patient which among other things, includes, Hospital (Room & Boarding and Operation theatre) charges, admission and registration charges in the Hospital, fees of Surgeon, Anesthetist, Nurses, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.

The Insured Person should have been hospitalized as an in-patient for a minimum period of 24 hours. However in respect of Day Care treatment undertaken in a Hospital, 24 hours hospitalization is not necessary. The benefit under this Section is limited to the Sum Insured specified for this Section in the Schedule to this Policy.

b) Pre-hospitalisation

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

c) Post Hospitalisation

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

Section II. Day Care Treatment

This benefit covers relevant hospitalisation expenses incurred by the Insured Person in case of day care treatment (where 24 hours of hospitalisation is not required) which includes treatments such as dialysis, chemotherapy, radiotherapy, eye surgery, lithotripsy (kidney stone removal), D & C, tonsillectomy undertaken in a Hospital. The benefit under this Section is limited to the available Sum Insured under Section 1a of this Policy as mentioned in the Schedule.

The treatment given in respect of

a) Dialysis
b) Chemotherapy
c) Radiotherapy
d) Eye surgery
e) Dental surgery
f) Lithotripsy (kidney stone removal)
g) Tonsillectomy
h) Dilatation & Curettage
i) Cardiac Catheterization
j) Hydrocele surgery
k) Hernia repair surgery
l) TURP (Prostate Surgery)
m) Surgeries/procedures that require less than 24 hours hospitalisation due to medical/ technological advancement and infrastructural facilities.

Section III. Domiciliary Hospitalisation

This benefit covers payment of expenses incurred for medical treatment pertaining to domiciliary hospitalisation for a period exceeding three days for disease, illness or injury, which in the normal course, would require care and treatment at a Hospital/Nursing Home, but is actually taken whilst the Insured Person is confined at home in India, under any of the following circumstances namely: -

a. the condition of the patient is such that he/she cannot be removed to Hospital/Nursing Home, or
b. the patient cannot be admitted to Hospital/Nursing Home for lack of accommodation therein.

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

a. Pre and Post Hospital treatment,
b. Treatment of any of the following diseases / illness / injury
   Asthma
   Bronchitis
   Chronic nephritis and nephritic syndrome
   Diarrhoea & all types of dysenteries including gastroenteritis
   Diabetes mellitus and insipidus
   Epilepsy
   Hypertension
   Influenza, cough and cold
   All psychiatric or psychosomatic disorders
   Pyrexia of unknown origin for less than 10 days
   Tonsillitis and upper respiratory tract infection including laryngitis & pharangitis
   Arthritis, gout and rheumatism.

Domiciliary hospitalisation benefits also cover expenses on nurses engaged on the recommendation of the attending Medical Practitioner. The benefit under this Section is limited to the Sum Insured for Section 1a of this Policy as mentioned in the Schedule.
The Insured has the option to opt out of Domiciliary Hospitalisation benefit if the same is specifically agreed to and mentioned in the Schedule to this Policy.

ADDITIONAL BENEFITS
Benefits under this Section are payable as Additional Benefits upto the limits specified in the Schedule to this Policy. A valid claim should have been admitted under the Hospitalisation Section of the Policy, for admission of liability under this Section.

Pre-existing diseases
This Policy covers relevant hospitalisation expenses incurred for treatment of pre-existing disease, illness or injury, in a Hospital as an in-patient, after a specific waiting period as mentioned in the Schedule to this Policy. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a.
Critical Illness
This benefit provides for coverage of treatment for critical illness and the coverage depends upon the type of critical illness cover (benefit basis or hospitalisation & reimbursement basis) selected and mentioned in the Schedule to this Policy.
In case the type of cover opted is benefit basis:
If, 30 days after the inception of this Policy, the Insured Person is at any time during the Policy period (after the above waiting period of 30 days), being diagnosed as contracting any Critical Illness and

surviving for more than 30 days post such diagnosis, the Sum Insured specified in the Schedule to this Policy for this benefit shall be payable to the Insured Person as compensatory benefit.

This Section operates as a benefit cover and compensation shall be payable if the Insured Person is surviving for more than 30 days post diagnosis of any critical illness.

Where this cover is forming part of Hospitalisation Policy, the Sum Insured available for this cover is separate and additional to that of Hospitalisation Sum Insured available under Section Ia. In case the Insured Person is diagnosed to be suffering from any of the Critical Illnesses and survives for a period of 30 days, then Sum Insured specified under Section III will be paid as a lump sum. After availing the benefit under Section III, if the Insured Person takes treatment for the Critical Illness in a Hospital, the hospitalisation expenses incurred for the same would be payable/ reimbursed, subject to the terms and conditions of the Policy, out of the Sum Insured available for Hospitalisation benefit cover under Section 1a of this Policy.

If the type of cover opted is Hospitalisation Reimbursement Basis:

If, 30 days after the inception of this Policy, the Insured Person is at any time during the Policy period (after the above waiting period of 30 days), being diagnosed as contracting any Critical Illness and is required to undertake treatment in a Hospital for the same, the Hospitalisation expenses incurred towards such treatment is covered under this benefit upto the specific Sum Insured stated against this benefit.

Where this cover is forming part of Hospitalisation Policy, the Sum Insured available for this cover is separate and additional to that of Hospitalisation Sum Insured available under Section 1a. In case the Insured Person is diagnosed to be suffering from any of the Critical Illnesses and takes treatment for the same in a Hospital, the hospitalisation expenses incurred for the same would be payable/ reimbursed, subject to the terms and conditions of the Policy, first out of the Sum Insured available for Critical Illness cover under Section III. Where the hospitalisation expenses incurred for the treatment of the Critical Illness are in excess of the Sum Insured available under Critical Illness Cover under Section III, the excess may be paid / reimbursed out of the available Sum Insured under the Hospitalisation benefit under Section Ia of this Policy.

The benefits available under Section 1b and 1c of this Policy as mentioned above are also applicable and available under Critical Illness Section in case the type of cover opted is Hospitalisation Reimbursement basis. In respect of pre-hospitalisation and post hospitalisation the limits of benefits are the same as per the respective Sections of the Policy and mentioned in the Schedule to this Policy. Where the Sum Insured under Critical Illness is exhausted the excess amounts (which are within the limits of these respective benefits) can be paid / reimbursed out of the available Sum Insured under Section Ia of this Policy. In case of diagnosis of multiple critical illnesses requiring treatment covered under this Policy, the maximum liability under this Section shall not exceed the Sum Insured as mentioned against this particular Section in the Schedule to this Policy.

Critical Illnesses in respect of which benefits are payable under this Policy are as set out below:

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

a. 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.

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

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

d. 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

e. All thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

f. Chronic lymphocytic leukaemia less than rai stage 3

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

h. 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;

i. All tumors in the presence of hiv infection.

MYOCARDIAL INFARCTION

(First Heart Attack of specific 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

CORONARY ARTERY DISEASE:

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

OPEN CHEST CABG

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

II. The following are excluded:
    1. Angioplasty and/or any other intra-arterial procedures

OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

SURGERY TO AORTA-

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

Angioplasty and all other intra arterial, catheter based techniques, “keyhole” or laser procedures are excluded

STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the

brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

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

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 (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner

APLASTIC ANAEMIA:

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

a) Blood product transfusion;
b) Marrow stimulating agents;
c) Immunosuppressive agents; or
d) Bone marrow transplantation

The diagnosis must be confirmed by a haematologist.

END STAGE LUNG FAILURE

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
iv. Dyspnea at rest.

END STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
   i. Permanent jaundice; and
   ii. Ascites; and
   iii. Hepatic encephalopathy.
II. Liver failure secondary to drug or alcohol abuse is excluded.

COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i. No response to external stimuli continuously for at least 96 hours;
   ii. Life support measures are necessary to sustain life; and
   iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

THIRD DEGREE BURNS

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

MAJOR ORGAN /BONE MARROW TRANSPLANT

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

II. The following are excluded:
   i. Other stem-cell transplants
   ii. Where only islets of langerhans are transplanted

MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

FULMINANT HEPATITIS-

A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

(a) rapid decreasing of liver size;
(b) necrosis involving entire lobules, leaving only a collapsed reticular framework;
(c) rapid deterioration of liver function tests;
(d) deepening jaundice; and
(e) Hepatic encephalopathy.

MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

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

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PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

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

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

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

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

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

TERMINAL ILLNESS:

The conclusive diagnosis of an illness that is expected to result in the death of the Insured Person within 12 months. This diagnosis must be supported by a specialist and confirmed by the Company's appointed Doctor.

Terminal illness in the presence of HIV infection is excluded. ,

BENIGN BRAIN TUMOR

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

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
    i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
    ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded:
Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord

BACTERIAL MENINGITIS:

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

a) The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
b) A consultant neurologist supported by medical examination reports.

Bacterial Meningitis in the presence of HIV infection is excluded.

Dread Disease recuperation-

If the Insured Person contracts any of the Critical Illnesses and undertakes treatment for the same in a Hospital as an in-patient for which a valid claim under the Policy is admissible, a daily allowance for certain number of days as specified in the Schedule to this Policy towards Recuperation Expenses incurred post discharge from the Hospital after the treatment for the specified critical illness, is payable under this benefit subject to medical requirement as certified by the treating Medical Practitioner.

Transplantation of Organs

Where the Insured Person contracts any of the critical illnesses requiring major Organ Transplantation surgery and undergoes surgery and treatment in a Hospital as an in-patient for which a valid claim under this Policy is admissible, the hospitalisation expenses incurred by/on the Donor towards donation of the major organ for the Insured Person for this treatment is covered under this benefit, subject to overall limit of the Sum Insured as specified in the Schedule to this Policy.

Hospital Cash Allowance

In case the Insured Person is hospitalized for treatment of any disease / illness / injury / critical illness for which a valid claim is admissible under the Policy and if the hospitalisation exceeds a specified

number of days mentioned in the Schedule to this Policy, this benefit provides for payment to the Insured Person of a daily hospital allowance up to the specified limits as mentioned in the Schedule to this Policy.
This benefit is applicable irrespective of the number of occurrences during the Policy period subject to overall Sum Insured.

ICU Allowance
In case the Insured Person who is hospitalized for treatment of any disease / illness / injury / critical illness for which a valid claim is admissible under the Policy has been treated under ICU in the Hospital and if the stay in ICU exceeds a specified number of days mentioned in the Schedule to this Policy, this benefit provides for payment to the Insured Person of a daily allowance up to the specified limits as mentioned in the Schedule to this Policy.
This benefit is applicable irrespective of the number of occurrences during the Policy period subject to overall Sum Insured.

Second Opinion Cover
In case the Insured Person would like to have a second opinion on his / her medical report before undergoing any surgical treatment or major ailment treatment, the Section would provide for payment or reimbursement of the charges / fees incurred for availing a second opinion in case of hospitalisation for surgical treatment or major ailment treatment upto a limit specified and agreed.

Home Nursing
This benefit provides for payment to the Insured Person of an allowance for medical care services of a nurse at the residence of the Insured Person following discharge from hospital after a treatment for a disease / illness / injury / critical illness for which a valid claim under this Policy is admissible provided such medical care services are confirmed as being necessary by the attending Medical Practitioner and the same relate directly to the disease/ illness/ injury / critical illness for which the Insured Person has undertaken treatment during the hospitalisation, subject to the limit prescribed in the Schedule to this Policy.
This benefit is applicable irrespective of the number of occurrences during the Policy period subject to the overall Sum Insured.

Ambulance Charges
This benefit provides for reimbursement to the Insured Person of expenses incurred for his /her transportation by ambulance to and from the Hospital for treatment of disease / illness / injury / critical illness in a Hospital as an in-patient for which a valid claim under this Policy is admissible, subject to the limits as specified in the Schedule to this Policy.

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

In-patient Physiotherapy Charges

This benefit provides for reimbursement of charges incurred towards physiotherapy in the Hospital that is confirmed as being necessary by the attending Medical Practitioner and the same relates directly to the disease / illness / injury / critical illness for which the Insured Person has undertaken treatment in the Hospital for which a valid claim is admissible under this Policy, subject to limits as specified in the Schedule to this Policy.

Recovery Grant

In case the Insured Person is hospitalized for a period of 8 days or more for treatment of any disease / illness / injury / critical illness for which a valid claim is admissible under the Policy, this benefit provides for payment to the Insured Person of a fixed allowance as mentioned in the Schedule to this Policy.

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

Accompanying Person's Expenses

This benefit provides for payment an allowance to the Insured Person towards expenses incurred 0n the accompanying person at the Hospital/Nursing Home during hospitalisation treatment of the Insured Person for the disease / illness / injury / critical illness necessitating hospitalization, subject to the limit of Sum Insured as mentioned in the Schedule to this Policy.

Parent Accommodation as Companion for Child

This benefit provides for payment of a fixed daily allowance towards meeting the expenses for the stay of one of the parents at the Hospital/Nursing Home when an Insured Person who is a child below the age of 12 years is hospitalized, subject to the limit of Sum Insured as mentioned in the Schedule to this Policy.

Parents Cover

This benefit provides for reimbursement or payment of hospitalisation expenses incurred for the parents of the employee / member covered under the Policy.

This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a.

The manner and limit of cover shall be as mentioned in the Schedule to this Policy.

Corporate Buffer

This benefit provides for a buffer amount as mentioned in the Schedule to this Policy. Insured Persons can avail benefit from this buffer whenever they exhaust their respective Sum Insured limit. The manner and method of availing this benefit shall be as mentioned in the Schedule to this Policy.

Out-patient Dental Emergency Treatment (arising out of Accident only)

This benefit provides for reimbursement of medical expenses incurred towards emergency treatment by a Dentist following an accident where the Insured Person suffers injuries or damage to his natural teeth and/or gums. This benefit further provides cover for medical expenses incurred for follow up treatment for the same accidental dental injury up to a maximum of 15 days by the same Dentist. This benefit is subject to overall limit of indemnity as specified in the Schedule to this Policy.

Out-patient Emergency treatment for accidents

This benefit provides for reimbursement of medical expenses incurred towards emergency treatment by a Medical Practitioner following an accidental injury to the Insured Person and such Emergency Treatment administered within 24 hours following the accident.

It also provides cover for medical expenses incurred for follow-up treatment by the same Medical Practitioner up to 30 days from the date of accident, including expenses incurred for medication prescribed on a written basis by the attending Medical Practitioner for that same treatment or consultation.

Children Education Fund

This benefit provides for payment of a fixed amount, to a maximum of two dependent children upto the age of 23 years pursuing studies, in the event of death of the Insured Person at Hospital whilst under treatment for disease / illness / injury / critical illness, as specified in the Schedule to this Policy.

Mortal Remains

This benefit provides for reimbursement of expenses incurred for transportation of the mortal remains of the Insured Person from Hospital to his/her place of residence in the event of death of the Insured Person at the Hospital while under treatment for disease / illness / injury / critical illness, as specified in the Schedule to this Policy.

Maternity Benefit

This benefit provides cover for Maternity hospitalisation expenses. The benefit under this Section is limited to the Sum Insured as specified in the Schedule to this Policy.

These benefits are applicable only if the expenses are incurred in Hospital/Nursing Home as an in-patient. A waiting period of 9 months is applicable for payment of any claim relating to normal delivery or caesarean section or abdominal operation for extra uterine pregnancy. The waiting

period may be relaxed only in case of delivery, mis-carriage or abortion induced by accident or other medical emergency.

Where specifically agreed for and mentioned in the Schedule to this Policy, the waiting period condition may be relaxed.

Claim in respect of delivery for only first two children and/or operations associated therewith will be considered in respect of any one Insured Person covered under the Policy or any renewal thereof.

Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered. Pre-natal and post-natal expenses are not covered unless admitted in Hospital/Nursing Home and treatment is taken there.

Floater Cover

Where agreed the cover can be offered on family floater basis covering the family members of member / employee of the Group on a floater Sum Insured basis. Where the Policy is obtained on floater basis covering the family members, the Sum Insured will be available to the Insured and all and any one of the Insured Persons for one or more claims during the Policy period.

Other add-on benefits

Where it is specifically agreed and mentioned in the Schedule to this Policy, the Policy can be extended to cover the following additional benefits

a. Removal of 30 days waiting period

This benefit provides for waiver of exclusion No 2 of the Policy and the coverage under the Policy will commence from the day one of the Policy period.

b. Removal of first year exclusion

This benefit provides for waiver of exclusion No 3 of the Policy and treatment in respect of diseases, illness, injury as mentioned in exclusion No 3 of this Policy shall stand covered from day one of the Policy period without any waiting period.

c. Baby cover for first three months

This benefit provides for coverage of hospitalisation expenses incurred on the new born baby upto three months of birth. The amount of coverage under this benefit is limited to the Sum Insured as specified in the Schedule to this Policy.

d. Doctor on call for emergency for suggestion and guidance

This benefit provides for suggestion and guidance from a Medical Practitioner on a call in case of any medical emergency. This service is of advisory nature and the Company holds no responsibility.

Modern Treatment Methods and Advancement in Technologies:

Claims pertaining to the following treatment methods will be also admissible under this policy and claims, if payable, would be paid in accordance with the Endorsement Wording:

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 conditons to be covered.

EXCLUSIONS

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

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48/36/24 months of continuous coverage after the date of inception of the first policy with insurer as selected by the Insurer.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability / migration norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures

1. Any types of gastric or duodenal ulcers
2. Benign prostatic hypertrophy
3. All types of sinuses
4. Hemorrhoids
5. Dysfunctional uterine bleeding
6. Endometriosis
7. Stones in the urinary and biliary systems
8. Surgery on ears/tonsils/adenoids/ paranasal sinuses
9. Cataracts,
10. Hernia of all types and Hydrocele
11. Fistulae in anus
12. Fissure in anus
13. Fibromyoma
14. Hysterectomy
15. Surgery for any skin ailment
16. Surgery on all internal or external tumours/ cysts/ nodules/polyps of any kind including breast lumps with exception of Malignancy
17. Dialysis required for Chronic Renal Failure.
18. Joint Replacement Surgeries unless necessitated by Accident happening after the Policy risk inception date.
19. Dilatation and curettage
20. Varicose Veins and Varicose Ulcers
21. Non Infective Arthritis and other form arthritis
22) Gout and Rheumatism
23) Prolapse inter Vertebral Disc and Spinal Diseases including spondylitis/spondylosis unless arising from Accident

C. 30-day waiting period- Code- Excl03
a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

D. Investigation & Evaluation- Code- Excl04
a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

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

G. Change-of-Gender treatments: Code- Excl07
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

H. Cosmetic or plastic Surgery: Code- Excl08

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

I. Hazardous or Adventure sports: Code- Excl09
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

J. Breach of law: Code- Excl10
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

K. Excluded providers: Code- Excl 11
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the lnsurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

L. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl 12**

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

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

O. Refractive Error: Code- Excl15
Expenses related to the treatment for correction of eye sight due to refractive error less than 7. 5 dioptres.

P. Unproven Treatments: Code- Exel 16
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

Q. Sterility and Infertility: Code- Excl 17
Expenses related to sterility and infertility. This includes:
(i)Any type of contraception, sterilization
(ii)Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii)Gestational Surrogacy
(iv)Reversal of sterilization

R. Maternity: Code Excl18
i. Medical treatment expenses traceable to childbirth (including complicated
deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

S. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

T. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

U. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

V. Treatment taken outside the geographical limits of India

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

STANDARD GENERAL TERMS AND CLAUSES

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, misdescription or non-disclosure of any material fact by the policyholder.

2. Floater Policy

Where the Policy is obtained on floater basis covering family members, the Sum Insured as specified in the Schedule to this Policy, shall be available to the Insured and all and any one of the Insured Persons for one or more claims during the Policy period.

3. Reasonable Care:

The Insured Person shall take all reasonable steps to safeguard his/her interests against accidental loss or damage that may give rise to a claim.

4. Condition Precedent to Admission of Liability:

5. 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.**Material Change:**

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

6. Fraud:

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

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

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

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

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

c) any other act fitted to deceive; and

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

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

7. No Constructive Notice;

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

8. Notice of Charge

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

9. Overriding effect

The terms and conditions contained herein and in the Schedule shall be deemed to form part of the Policy and shall be read as if they are specifically incorporated herein.

10. Electronic Transaction:

The Insured/Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof)or by means of electronic, computer, automated machines network or through other means of telecommunication established by or on behalf of the Company for and in respect of the Policy or its terms or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. The Insured/Insured Persons agrees that the Company may exchange, share or part with any information to or with other Group Companies, or other persons in connection with the Policy as may be determined by the Company and shall not hold the Company liable for such use/application.

11. Duty of the Insured Person on occurrence of loss:

On the occurrence of loss within the scope of cover under the Policy, the Insured Person shall:

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

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

12. Right to Inspect

If required by the Company, an agent/representative of the Company including a Medical Practitioner appointed in that behalf shall in case of any loss or any circumstances that have given rise to a claim to the Insured Person be permitted at all reasonable times to examine into the circumstances of such loss. The Insured Person shall on being required so to do by the Company produce all relevant documents relating to or containing reference relating to the loss or such circumstance in his/her possession including presenting himself for examination and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or will in any way assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy.

13. Position after a claim

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

14. Multiple policies and Contribution:

- 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.
- 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.
- 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.
- 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.

15. Forfeiture of claims:

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

16. Cancellation/Termination:

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

Period On Risk	Rate Of Premium to be retained
Up to l month	25% of annual rate
Up to 3 months	50% of annual rate

Up to 6 months	75% of annual rate
Exceeding six months	100% of annual rate

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

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

17. Cause of action/Currency of payment:

No claim shall be payable under this Policy unless the cause of action arises in India. All claims shall be payable in India in Indian Rupees only.

18. Policy Disputes:

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

19. Arbitration:

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole Arbitrator to be appointed in writing by the parties to the dispute/difference, or if they can not agree upon a single Arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 Arbitrators, comprising of two Arbitrators, one to be appointed by each of the parties to the dispute/difference and the third Arbitrator to be appointed by such two Arbitrators and the arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliations Act 1996.

It is hereby agreed and understood that no dispute or difference shall be referable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

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

20. Renewal Notice:

The Company shall not be bound to accept any renewal premium or to give notice that such is due. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration hereinbefore mentioned and that nothing is known to the Insured/Insured Person that may result to enhance the risk of the Company. No renewal receipt shall be valid unless it is on the printed form of the Company and signed by an authorized official of the Company.

Disclosure on continuity: (applicable to group policy)- In case the group policy is not renewed or discontinued, the individual members have the option of applying for any of the similar individual health insurance policies with in 30 days from such termination of group cover. It is understood that company shall offer such insurance cover subject to underwriting guidelines and with time waivers including 30 days waiting period and waiver of exclusions for the first 1 or 2 years as applicable.

21. Notices:

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post or facsimile to -

(a) in case of the Insured/Insured Person, at the address given in the Schedule to the Policy.
(b) in case of the Company, to the Policy issuing office/nearest office of the Company.

Notice and instruction will be deemed served 7 days after posting or immediately on receipt in the case of hand delivery, facsimile or e-mail.

22. Customer Service:

If at any time the Insured/Insured Person requires any clarification or assistance, he/she may contact the Policy issuing office or any other office of the Company or the TPA.

23. Grievances:

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

•Website: www.bharti-axagi.co.in
•Email: customer.service@bhartiaxa.com
•Phone: 18001032292
•Courier: Any of the Company's Branch office or corporate office

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at

Escalation Level 1

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

Write to: Bharti AXA General Insurance, Spectrum Towers, 3rd floor, Malad Link Road, Malad (west), Mumbai- 400064
Call: 022-48815939
Email: NGRO@bhartiaxa.com
3rd floor, Spectrum Tower, Rajan Pada
Mindspace, Malad (W), Mumbai - 400 064

Escalation Level 2

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

Escalation Level 3

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

Grievance of Senior Citizens:

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

•Website: www.bharti-axagi.co.in
•Email: customer.service@bhartiaxa.com
•Phone: 18001032292
•Courier: Any of the Company's Branch office or corporate office

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

Grievance Redressal Cell of the Consumer Affairs Department of IRDAI

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

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

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

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

- The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- 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.
- No loading shall apply on renewals based on individual claims experience.is

Free Look Period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

The insured shall be allowed a period of fifteen days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured shall be entitled to:

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or
ii. where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

Grace Period

Portability

The insured person will have the option to port the policy to other insurers by applying to suchinsurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health

insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.
For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

Migration
The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast30 days before the policy renewal date as per lRDAl guidelines on Migration. If such person is presently co\/ered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per lRDAl guidelines on migration.
For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

Withdrawal of policy
- 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.
- 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 cumulati\ie bonus, waiver of waiting period. as per lRDAl guidelines, provided the policy has been maintained without a break.

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

Possibility of Revision of Terms of the Policy Including the Premium Rates
The Company, with prior approval of lRDAl, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

Nomination
The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination

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

Claim Settlement

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

CLAIMS PROCEDURE

It is a condition precedent to the Company's liability that upon the discovery or happening of a disease, illness or injury that may give rise to a claim under this Policy, the Insured Person shall undertake the following:

1. **Claim Notification**

The Insured Person shall give immediate notice to the Third Party Administrator (TPA) named in the Schedule to this Policy, by calling the toll free number as specified in the Schedule to this Policy or by sending written communication to the address of the TPA shown in the Schedule with particulars as below

a) Policy Number
b) Name of Insured Person availing treatment
c) Nature of disease, illness or injury
d) Name and address of the attending Medical Practitioner/Hospital
e) Probable cost of treatment
f) Any other relevant information.

2. **Cashless Hospitalisation**

The Third Party Administrator of the Company upon receipt of satisfactory information from the Insured Person about the hospitalisation / proposed hospitalisation will arrange for cashless hospitalisation to the

Insured Person, where the treatment is in a net work Hospital. The Company shall notify from time to time, the list of hospitals within the TPA network. The Insured Person can avail cashless hospitalisation up to the limit of the Sum Insured specified in the Schedule to this Policy subject to obtaining pre-authorisation from the TPA.

The Insured Person is required to submit to the TPA complete information of the disease, illness or the injury requiring treatment to be undertaken in a Hospital, along with certification from the Medical Practitioner and/or Hospital. Taking into account the information provided as above, the TPA will issue pre-authorisation to the Hospital concerned for cashless hospitalisation for the treatment of the Insured Person up to the limit of the Su m Insured specified in the Schedule to this Policy. Where cashless hospitalisation is pre-authorised by the TPA, the Insured Person need not pay the hospitalisation expenses for the treatment undertaken for the disease, illness or the injury which are covered under the Policy and the same shall be paid by the TPA directly to the Hospital. Cashless Hospitalisation benefit shall be limited exclusively to the hospitalisation expenses incurred for the treatment undertaken for the disease, illness or injury in a network Hospital and shall not extend to other benefits.

However, cashless hospitalisation will not be available if the treatment is undertaken in a non-network hospital, in which case, the Insured Person shall, after due intimation about the hospitalisation details to the TPA as mentioned hereinabove, shall pay the hospitalisation expenses directly to the Hospital concerned and claim reimbursement from the Company for the same.

3. Claim Processing

The TPA appointed by the Company and named in the Schedule to the Policy, will process the claim on behalf of the Company and make all payments.

The Company requires the Insured Person to deliver to the TPA at his/her own expense within 30 days of the Insured Person's discharge from the Hospital (for post-hospitalisation expenses, completion of post-hospitalisation period or completion of treatment, whichever is earlier), any and all information and documents concerning the claim or the Company's liability for it, including but not limited to:

a) Duly filled in claim form(s)
b) Original bills, receipts, discharge/cards from the hospital/Medical Practitioner
c) Original bills from chemists supported by proper prescription.
d) Original investigation test reports and payment receipts
e) Medical Practitioner's referral letter advising hospitalisation
f) Original bills and receipts for claiming the Ambulance charges
g) Original bills, receipts and the Medical Practitioner's prescription for claiming benefits under external mobility aids and appliances.

If so requested by the Company, the Insured Person will have to submit himself for a Medical Examination by the Company's or the TPA's Medical Practitioner as often as the Company considers necessary.

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

Notwithstanding the above, upon the receipt of all required documents and processing of the claim, the offer of settlement will be made to the insured in any case not later than 30 days maximum. Settlement (payment) of claim will be made within 7 days of receipt of acceptance in response to offer of settlement, failing which penal interest (in compliance with applicable regulations) at a rate 2% higher than bank rate(prevailing as on the date of beginning of financial year in which the claim is reviewed) will be paid

Claims Notification- Claims Multi Media Model

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

- Toll Free call Centre of the Insurance Company(24x7) - 1800-103-2292
- Toll Free call Centre of TPA (24x7) - 1800-103-2292 (TPA Toll Free Number shall not be included in case of general insurance products)
- Login to the website of the Insurance Company and intimate the claim – http://www.bharti-axagi.co.in/contact-us
- Send an email to the Company- customer.service@bhartiaxa.com
- Post/courier to TPA/Company - Claims, Bharti AXA General Insurance Company Limited spectrum Tower, 3rd flr, Chincholi Bunder Rd, Rajan Pada, Mindspace, Malad West, Mumbai, Maharashtra 400064
- Directly contact our Company office but in writing. - Bharti AXA General Insurance Company Limited, 19th Floor, Parinee Crescenzo, G-Block, Bandra Kurla Complex, Opposite MCA Club, Bandra (E), Mumbai - 400051

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

LIST OF INSURANCE OMBUDSMEN

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

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

This list has to be included in the policy wording and sales literature:

List and Details of Insurance Ombudsman:

Office Details	
AHMEDABAD – Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	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, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048/26652049

	Email: bimalokpal.bengaluru@ecoi.co.in
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201/2769202 Fax: 0755 – 2769203 Email: bimalokpal.bhopal@ecoi.co.in	BHUBANESHWAR – Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel: 0674 – 2596461/2596455 Fax: 0674 – 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
CHANDIGARH – Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel: 0172 – 2706196/2706468 Fax: 0172 – 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	CHENNAI – Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel: 044 – 24333668/24335284 Fax: 044 – 24333664 Email: bimalokpal.chennai@ecoi.co.in
DELHI – Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel: 011 – 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	GUWAHATI – Shri Kiriti B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S. S. Road, Guwahati – 781001 (ASSAM). Tel: 0361 – 2632204/2602205 Email: bimalokpal.guwahati@ecoi.co.in
HYDERABAD - Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	KOLKATA – Shri P.K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in

LUCKNOW –Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
NOIDA – Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	PATNA – Shri N.K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in
PUNE – Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	

List I: Optional Items

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES

16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)

55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II- Items that are to be subsumed into room charges

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

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

List III- Items that are to be subsumed into Procedure charges

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

19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV- Items that are to be subsumed into Costs of Treatment

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


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suraksha ka
naya nazariya