Policy wordings - Smart Health Insurance Policy

1) 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.

1.1) Now this policy witnesseth:

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

1) Hospital (Room & Boarding and Operation theatre) charges;
2) Fees of Surgeon, Anaesthetist, 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

2) 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:

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

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

2.3) “Ayush Treatment” refers to the medical and / or hospitalization treatments given under ‘Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems

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

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

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

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

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

2.7) "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 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.

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

2.8) "Day care Centre" means any institution established for day care treatment of illness and / or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

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

2.9) "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.

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

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

2.12) "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.

2.13) "Domiciliary hospitalisation" 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:

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

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

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

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

2.15) "Family" means the Insured, his/her lawful spouse and maximum of two dependant children upto the age of 23 years.

2.16) "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.

2.17) "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:

2.16.1) has qualified nursing staff under its employment round the clock;

2.16.2) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

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

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

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

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

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

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

b) **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

I) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
ii) it needs ongoing or long-term control or relief of symptoms
iii) it requires your/insured person’s rehabilitation or for you/insured member to be specially trained to cope with it
iv) it continues indefinitely
v) it comes back or is likely to come back

2.20 "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

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

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

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

2.24) "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.

2.25)" 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.

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

2.27) "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.

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

2.25.1) is required for the medical management of the illness or injury suffered by the insured;

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

2.25.3) must have been prescribed by a medical practitioner,

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

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

2.30) "Network Provider" means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

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

2.32) "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

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

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

2.35) "Period of insurance" means the Policy period defined hereunder.

2.36) "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.

2.37) "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 Proposer 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.

2.38) "Portability" means transfer by an individual health insurance policyholder (including family cover) of the credit gained for preexisting conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

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

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

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

However this condition will not be apply in case of critical illness cover opted on benefit basis.

2.40) "Pre-Existing Disease" means any condition, ailment or injury or related condition(s) for which you/insured member had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months prior to the first policy issued by the insurer.

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

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

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

However this condition will not be apply in case of critical illness cover opted on benefit basis.

2.42) "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.

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

2.44) "Reasonable and Customary charges" - Reasonable 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.

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

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

2.47) "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.

2.48) "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.

2.49) "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 center by a medical practitioner.

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

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

3) 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.

3.1 SECTION I

a) Hospitalisation Expenses

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

The Insured/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 / Insured Person was hospitalised, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Para 3.1 Section I (a) above and is limited to the available Sum Insured under Para 3.1 Section I (a).

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/Insured Person was hospitalised, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Para 3.1 Section I (a) above and is limited to the available Sum Insured under Para 3.1 Section I (a).

d) Pre-existing diseases

This Policy covers relevant hospitalisation expenses incurred for treatment of pre-existing disease, illness or injury, in a Hospital as an inpatient, after specific waiting period as mentioned in this Policy. This benefit is a part of benefit available under Para 3.1 Section I (a) above and is limited to the available Sum Insured under Para 3.1 Section I (a).

3.2 SECTION II - DAY CARE TREATMENT

This benefit covers relevant hospitalisation expenses incurred by the Insured / 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 Para 3.1 Section I (a) of this Policy as mentioned in the Schedule to this Policy. List of day care treatments as per Annexure - 1

3.3 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 / 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:

I) Asthma
ii) Bronchitis
iii) Chronic nephritis and nephritic syndrome
iv) Diarrhoea & all types of dysenteries including astroenteritis
v) Diabetes mellitus and insipidu
vi) Epilepsy
vii) Hypertension
viii) Influenza, cough and cold
ix) All psychiatric or psychosomatic disorders
x) Pyrexia of unknown origin for less than 10 days
xi) Tonsillitis and upper respiratory tract infection including laryngitis & pharangitis
xii) Arthritis, gout and rheumatism.

c) 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 available Sum Insured for Para 3.1 Section I (a) of this Policy as mentioned in the Schedule to this Policy.

3.4 SECTION IV - CRITICAL ILLNESS

This benefit provides for coverage of treatment for critical illness and the coverage depends upon the type of critical illness cover basis (benefit or hospitalisation reimbursement basis) selected and mentioned in the Schedule to this Policy.

a) In case the type of cover opted is benefit basis:
If, 30 days after the inception of this Policy, the Insured / Insured Person is at any time during the Policy period (after the above waiting period of 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/Insured Person as compensatory benefit. This Section operates as a benefit cover and compensation shall be payable if the Insured / Insured Person is surviving for more than 30 days post diagnosis of any critical illness.

The Sum Insured available for this cover is separate and additional to that of Hospitalisation Sum Insured available under Para 3.1 Section I (a). In case the Insured / Insured Person is diagnosed to be suffering from any of the Critical Illnesses and survives for a period of 30 days, then the Sum Insured specified under Para 3.4 Section IV will be paid as a lump sum. After availing the benefit under Para 3.4 Section IV, if the Insured / Insured Person takes treatment for the Critical Illness in a Hospital, the hospitalization expenses incurred for the same would be payable/reimbursed, subject to the terms and conditions of the Policy, out of the Sum Insured available for Hospitalisation Benefit cover under Para 3.1 Section I (a) of this Policy. However, in case of diagnosis of multiple illnesses qualified as Critical Illness under the Policy, the payment of compensation shall be limited to the Sum Insured as specified above and shall be payable only once.

b) In case the type of cover opted is Hospitalisation Reimbursement basis
If, 60 days after the inception of this Policy, the Insured / Insured Person is at any time during the Policy period (after the above waiting period of 60 days), being diagnosed as contracting any of the Critical Illnesses 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.

The Sum Insured available for this cover is separate and additional to that of Hospitalisation Sum Insured available under Para 3.1 Section I (a). In case the Insured / 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 Para 3.4 Section IV. 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 Para 3.4 Section IV, the excess will be paid / reimbursed out of the available Sum Insured under the Hospitalisation Benefit under Para 3.1 Section I (a). The benefits available under Para 3.1 Section I (b), Para 3.1 Section I (c) and Para 3.1 Section I (d) 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 Para 3.1 Section I (a) of the Policy. In case of diagnosis of multiple critical illnesses requiring treatment covered under this Policy, the maximum liability of the company 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:**

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

Myocardial Infarction (First heart attack - of specified severity):

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

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

II. The following are excluded:

i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

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 (Coronary Artery By-pass Graft):

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

I. Angioplasty and/ or any other intra-arterial procedures

Open Heart Replacement or Repair of Heart Valves:

I. 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 diseaseaffected 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 Ischaemic 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:

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

Aplastic Anaemia:

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

i. Blood product transfusion;
ii. Marrow stimulating agents;
iii. Immunosuppressive agents; or
iv. Bone marrow transplantation

The diagnosis must be confirmed by a haematologist.

End Stage Lung Disease:

I. 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 (PaO2 < 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:
a) Permanent jaundice;
b) Ascites; and
c) Hepatic Encephalopathy.

II. Liver disease secondary to alcohol or drug 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.

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 a 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:

- investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
- 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:

i. Rapid decreasing of liver size;
ii. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
iii. Rapid deterioration of liver function tests;
iv. Deepening jaundice; and
v. Hepatic encephalopathy

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

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.

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:

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

Bacterial Meningitis in the presence of HIV infection is excluded

Critical illness benefit will lapse and no claim for this benefit will be paid if the Insured have already made a claim for the same critical illness.

c) Dread Disease recuperation:
If the Insured/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 for 60 days subject to medical requirement as certified by the treating Physician.

d)Transplantation of Organs:
Where the Insured/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 / 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.

4) 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. These benefits are payable also when there is a Hospitalisation claim for Critical Illness treatment under the Critical Illness Section.

4.1 Hospital Cash Allowance:

In case the Insured / 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/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.

4.2 Home Nursing:
This benefit provides for payment to the Insured/Insured Person of an allowance for medical care services of a nurse at the residence of the Insured/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/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.

4.3 Ambulance Charges:
This benefit provides for reimbursement to the Insured/Insured Person of expenses incurred for his/her transportation by ambulance to and from the Hospital for treatment of disease / illness / injury / 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.

4.4 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/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.

4.5 Recovery Grant:
In case the Insured / 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 / 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.

4.6 Accompanying Person's Expenses:
This benefit provides for payment an allowance to the Insured/Insured Person towards expenses incurred on the accompanying person at the Hospital/Nursing Home during hospitalization treatment of the Insured/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.

4.7 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 the 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.

4.8 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 / Insured Person suffers injuries or damage to his/her 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.

4.9 Out-patient Emergency treatment for accidents:
This benefit provides for reimbursement of medical expenses incurred towards emergency treatment by a Medical Practitioner for the Insured / Insured Person following an accidental injury and 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.

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

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

4.12 Renewal Discount:
The Policy provides for a discount, equivalent to 5% of renewal premium every year on a progressive scale, as Renewal Discount at the time of renewal, provided that the Policy being renewed is claim free in the expiring year. This renewal discount on a progressive scale will be allowed upto a maximum of 25%. In case of renewal of a Policy where there is a claim, the renewal discount allowed will be withdrawn at the same rate for each year in respect of claims reported. The Company offers life long renewal, subject to the renewal being effected before the expiry of the policy or within grace period allowed.

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

4.14 Cost of Health Check-up:
This Policy provides for reimbursement of cost of medical check-up once at the end of a block of every four continuous underwriting years, provided there were no claims reported/made under the Policy during the block. This benefit shall be limited to 1% of the average Sum Insured per person/family as the case may be during the block of four underwriting years.
This additional benefit is available on the policies taken and renewed with the Company for four continuous years, without any claim.

5) PORTABILITY:

i. From another company to Bharti AXA Policy

(i) If the proposed Insured Person was insured continuously and without a break under another Indian retail health insurance Policy with any other Indian General Insurance company or stand-alone Health Insurance Company, it is understood and agreed that:
   (1) If Insured person wish to exercise the Portability Benefit, The Company should have received the application for portability and the completed Portability Form with complete documentation at least 45 days before the expiry of the existing insurance Policy.
   (2) This benefit is available only at the time of renewal of the existing health insurance Policy.
   (3) Portability benefit is available only up to the existing cover. If the proposed Sum Insured is higher than the Sum Insured under the expiring policy, waiting periods would be applied on the amount of proposed increase in Sum Insured only, in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.
   (4) Waiting period credits would be extended to Pre-existing Diseases and time bound exclusions / waiting periods in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.
   (5) The Portability Benefit shall be applied by the Company within 15 days of receiving the completed Application and Portability Form from the proposer subject to the following:
      (a) Proposer shall provide the Company all additional documentation and/or information requested;
      (b) The proposer shall pay the Company the applicable premium in full;
      (c) The Company may, subject to medical underwriting, restrict the terms upon which the Company may offer cover, the decision as to which shall be in the Company sole and absolute discretion; This is subject to Company's Board approved Underwriting policy filed with Authority.
      (d) There is no obligation on the Company to insure all Insured Persons or to insure all Insured Persons on the proposed terms, even if the proposer have given all documentation to the Company; This is subject to Company's Board approved Underwriting policy filed with Authority.
      (e) The Company shall be received necessary details of medical history and claim history from the previous insurance company for the Insured Person's previous health insurance Policy through the IRDA's web portal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6) EXCLUSIONS:

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

1) Pre-existing diseases / illness / injury / conditions - The benefits will not be available for any condition(s) as defined in the policy, until 48 months of continuous coverage have elapsed, since inception of the first policy with the Company.

The waiting period specified above shall be reduced by number of continuous preceding months in case of insured or insured member having been covered under similar health policy with any other general insurance company or health insurance company in India or Group insurance scheme with us (company) and subject to same being renewed with us without any break.

2) Any benefit under Critical Illness Section within 30 days from the date of inception in case of benefit plan and 60 days from the date of inception in case of reimbursement plan. Further this

exclusion shall not apply in case of the Insured / Insured Person having been covered under any similar health insurance policy of any other general insurance company or health insurance company in india or group insurance schemes with us (company) for a continuous period of preceding 12 months without any break.

3) Hospitalisation expenses incurred for treatment undertaken for disease or illness and/or for critical illness within 30 days of the inception date of this Policy. This exclusion, however, doesn't apply for subsequent renewals with the Company without a break. Further this exclusion shall not apply in case of the Insured / Insured Person having been covered under any similar health insurance policy of any other general insurance company or health insurance company in india or group insurance schemes with us (company) for a continuous period of preceding 12 months without any break.

4) Hospitalisation Expenses incurred on treatment of following diseases, illness, injury within the first two years from the inception of this Policy, will not be payable:

- Cataract
- Benign Prostatic Hypertrophy
- Myomectomy, Hysterectomy or menorrhagia or fibromyoma unless because of malignancy
- Dilation and curettage
- Hernia, hydrocele, fistula in anus, sinusitis
- Skin and all internal tumors / cysts / nodules / polyps of any kind including breast lumps unless malignant / adenoids and hemorrhoids
- Dialysis required for chronic renal failure
- Gastric and Duodenal ulcers
- Joint Replacement Surgeries unless necessitated by accident

This exclusion, however, doesn't apply for subsequent renewals with the Company without a break. Further this exclusion shall not apply in case of the Insured / Insured Person having been covered under any similar health insurance policy of any other general insurance or health insurance company in India or under group insurance schemes with us (Company) for a continuous period of preceding 24 months without any break.

The waiting period specified above shall be reduced by 12 months in case of insured or insured member having been covered under similar health policy with any other general insurance company or health insurance company in India or Group insurance scheme with us (company) and subject to same being renewed with us without any break.

5) Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or, as may be necessitated due to an accident.

6) Dental treatment or surgery of any kind unless requiring hospitalisation.

7) Birth control procedures, hormone replacement therapy, treatment arising from or traceable to pregnancy, childbirth including caesarean section and voluntary medical termination of pregnancy during the first 12 weeks from the date of conception. However, this exclusion will not apply to Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.

8) Any fertility, sub-fertility or assisted conception operation

9) Routine medical, eye and ear examinations, cost of spectacles, laser surgery, contact lenses or hearing aids, issue of medical certificates and examinations as to suitability for employment or travel.

10) Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex syndrom (ARCS) and all diseases / illness / injury caused by and/or related to HIV.

11) Vitamins and tonics unless forming part of treatment for disease, illness or injury as certified by the Medical Practitioner.

12) Treatment of obesity, general debility, convalescence, rundown condition or rest cure, congenital internal and external diseases / illness or defects or anomalies, sterility, venereal disease or intentional self-injury and use of intoxicating drugs/alcohol.

13) Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics or similar establishments.

14) Medical Treatment following use of intoxicating drugs and alcohol or drug abuse, solvent abuse or any addiction or medical condition resulting from or relating to such abuse or addiction.

15) Sex change or treatment, which results from, or is in any way related to, sex change.

16) Vaccination and inoculation of any kind.

17) Treatment by a family member and self-medication or any treatment that is not scientifically recognized.

18) Medical treatment required following any criminal act of the Insured / Insured Person.

19) Disease / illness / injury / critical illness directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, riot, strike, lockout, military or popular uprising or civil commotion.

20) Disease / illness / injury whilst performing duties as a serving member of a military or a police force.

21) Prostheses, corrective devices and medical appliances, which are not, required intra-operatively or for the disease/ illness/ injury for which the Insured / Insured Person was hospitalised which is not excluded hereunder.

22) Any stay in Hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner.

23) Treatment of mental disease / illness, stress, psychiatric or psychological disorders.

24) Aesthetic treatment, cosmetic surgery and plastic surgery unless necessitated due to accident or as a part of any disease/ illness / injury not excluded hereunder.

25) Any loss, directly or indirectly, due to contamination , due to an act of terrorism or terrorist incident, regardless of any contributory causes (if the Company alleges that by reason of this exclusion any loss is not covered by this insurance, the burden of proving the contrary shall be upon the Insured / Insured Person).

26) Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.

27) Disease, illness, injury, directly or indirectly, caused by or contributed to by nuclear weapons/materials or radioactive contamination.

28) Experimental and unproven treatment.

29) Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any disease, illness or injury, for which confinement is required at a Hospital/Nursing Home or at home under domiciliary hospitalisation as defined.

30) Cost incurred for medicines which are not under the advice of the Medical Practitioner and which are not consistent with or incidental to the diagnosis and treatment.

31) Any treatment which is undertaken as an out-patient without any admission as an in-patient at the Hospital except those that are specifically mentioned as covered in the Schedule to this Policy.

32) Costs of donor screening or treatment, unless specifically covered and specified in the Schedule to this Policy.

33) Naturopathy treatment.

34) Any treatment received outside India.

35) Treatment taken from persons not registered as Medical Practitioners under respective medical councils.

36) Medical Treatment in respect of the Insured/Insured Person following participation whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports.

37) Medical Treatment in respect of the Insured/Insured Person following participation in flying or taking part in aerial activities (including cabin crew) except as a fare paying passenger in a regular Scheduled airline or air charter company.

7) GENERAL CONDITIONS:

7.1) Duty of Disclosure:

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the proposal form, personal statement, declaration and connected documents, or

any material information having been withheld, or a claim being fraudulent or any fraudulent` means or device being used by the Insured/Insured Person or any one acting on their behalf to obtain a benefit under this Policy.

7.2) Floater Policy:

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

7.4) Observance of terms and conditions:

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

7.5) Material Change:

The Insured / Insured Person shall immediately notify the Company 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.

7.6) Fraudulent Claims:

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

7.7) No Constructive Notice:

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

7.8) 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 his legal representative, as the case may be, of any compensation or benefit under the Policy shall in all cases be an effectual discharge to the Company.

7.9) Special Provisions:

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

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7.11) Electronic Transaction:

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

7.12) Duty of the Insured on occurrence of loss/event:

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

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

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

7.13) Right to Inspect:

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

7.14) Position after a claim:

As from the day of receipt of the claim amount by the Insured / Insured Person, the Sum Insured for the remainder of the period of insurance shall stand reduced by a corresponding amount. On payment of any claim under Section IV of this Policy (in case of benefit basis), the Insured / Insured Person shall not be eligible for any further claim/benefit against the same disease any further including subsequent renewals.

7.17) Multiple policies and Contribution:

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

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

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

7.19) 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.

7.20) Free Look Period:

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

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

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

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

7.21) Grace Period:

All applications for renewal of the policy must be received by us before the end of the policy. A Grace Period of 30 days for renewing the Policy is provided under this Policy.

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

7.22) Cancellation/Termination:

The Company may cancel this Policy, by giving 15 days notice in writing by Registered Post Acknowledgment Due to the Insured at his / their last known address. The company shall exercise its right to cancel only in case of non-cooperation of the Insured / Insured Person in implementing the terms and conditions of this Policy in which case the Company shall be liable to repay on demand a rateable proportion of the premium for the unexpired term from the date of the cancellation. The Insured may also give 15 days notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of notice cancel the Policy and retain the premium for the period this Policy has been in force at the Company's short period scales. Provided however that refund on cancellation of Policy by the Insured shall be made only if no claim has occurred up to the date of cancellation of this Policy.

Period on Risk	Rate of Premium to be retained
Up to 1 month	25% of annual rate
Up to 3 months	50% of annual rate
Up to 6 months	75% of annual rate
Exceeding six months	100%

7.23) Cause of action/Currency of payment:

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

7.24) Policy Disputes:

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

7.25) Arbitration:

If any dispute or difference shall arise as to the quantum to be paid under this policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole Arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single Arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 Arbitrators, comprising of 2 Arbitrators and 1 to be appointed by each of the parties to the dispute/difference and the third Arbitrator to be appointed by such 2 Arbitrators.

Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996.

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

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

7.26)Terms of renewal:

- The Company offers life-long renewal unless the Insured Person or any one acting on behalf of an Insured Person has acted in an improper, dishonest or fraudulent manner or has made misrepresentation in relation to this policy or the Policy poses a moral hazard.
- The premium for renewal will be applicable as per the premium chart based on age and company will not load the premium for any adverse claims experience of particular insured.
- The Company may change the renewal premium and/or benefits payable subject to approval from regulator (IRDA) and inform the same to the Insured at least 3 months prior to the date of revision and/ or modification or renewal

i. The Insured member can apply for enhancement of Sum Insured at the time of renewal by submitting a duly filled fresh Proposal Form to the Company.

ii. The acceptance of enhancement of Sum Insured would be at the discretion of the Company, based on the health condition of the Insured members, claim history and subject to acceptance by the Company post underwriting.

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

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

All applications for renewal of the policy must be received by us before the end of the policy. A Grace Period of 30 days for renewing the Policy is provided under this Policy.

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

7.27) Renewal Notice:

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

7.28) Notices:

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

a) In case of the insured, at the address given in the Schedule to the policy.

b) In case of the Company, to the policy issuing office/nearest office of the Company.

7.29) Grievances:

The Company is committed to extend the best possible services to its customers. However, If Policyholder/Insured Person have a grievance that he/she wish us to redress, he/she may contact the Company with the details of their grievance via:

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

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

Escalation Level 1

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

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

Escalation Level 2

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

Email : CGRO@bhartiaxa.com

Escalation Level 3

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

Grievance of Senior Citizens:

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

•Website: www.bharti-axagi.co.in
•Email: customer.service@bhartiaxa.com
•Phone: 18001032292
•Courier: Any of the Company's Branch office or corporate office
Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday.

Grievance Redressal Cell of the Consumer Affairs Department of IRDAI
The insurance company should resolve the complaint within a reasonable time. In case if it is not resolved within 15 days or if the Insured/Insured Person is unhappy with their resolution you can approach the Grievance Redressal Cell of the Consumer Affairs Department of IRDAI.
•Website: igms.irda.gov.in
•Email: complaints@irda.gov.in
•Toll Free Number 155255 (or) 1800 4254 732

LIST OF INSURANCE OMBUDSMEN

Office Details
AHMEDABAD - Shri/Smt..... Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202

Office Details
Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
BHUBANESHWAR - Shri/Smt..... Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
DELHI - Shri/Smt..... Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in
GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM).

Office Details
Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in
HYDERABAD - Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in
KOLKATA - Shri/Smt..... Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
LUCKNOW -Shri/Smt..... Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj,

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

7.31) Claim Notification Multi Model Intimation:

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

• Toll Free call Centre of the Insurance Company(24x7) - 1800-103-2292
• Login to the website of the Insurance Company and intimate the claim – http://www.bharti-axagi.co.in/contact-us
• Send an email to the Company- customer.service@bhartiaxa.com
• Post/courier to TPA/Company - Claims, Bharti AXA General Insurance Company Limited spectrum Tower, 3rd flr, Chincholi Bunder Rd, Rajan Pada, Mindspace, Malad West, Mumbai, Maharashtra 400064
• Directly contact our Company office but in writing. - Bharti AXA General Insurance Company Limited, 19th Floor, Parinee Crescenzo, G-Block, Bandra Kurla Complex, Opposite MCA Club, Bandra (E), Mumbai - 400051

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

Information Details

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

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

Claim Form

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

7.32) Claim Procedure

Cashless hospitalisation:

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

- Denial of the cashless does not mean the claim has been rejected.
- The insured/covered person can send the requisite claim documents to the TPA/Company seeking reimbursement.
- The insured/covered person need not pay any amount to the hospital if he has received the authorization letter except
  - If the bill amount is in excess of the sum insured
  - Non-medical expenses
  - Unrelated treatments
  - Excess, if any
- The hospital will receive the payment from TPA/Company within 21 days from the date of receipt of complete claim documents

. **Reimbursement claims**

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

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

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

After receiving the complete documents, the 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.

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Checklist of documents for settling Claims

SL. NO	CHECKLIST	TICK THE BOXES
1	Claim form duly signed along with attending physician statement	
2	Pre auth form-if cashless claim	
3	Discharge summary	
4	Hospital final bill	

5	Attending Surgeon's/Physician's Prescription advising hospitalization	
6	Surgery/consultation bills and receipts	
7	Operation theatre and pharmacy bills	
8	Medicines bill with doctor's prescription	
9	Pre hospitalization bills with receipts	
10	Post hospitalization bills with receipts Hospital payment receipt in case of reimbursements	
11	Diagnostic reports with doctor's prescription	

7.33) Documents

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

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

7.34) Repudiations

The power to repudiate claims is vested in the corporate office to ensure transparency and standardization across the country. This is also with a view to keep the guidelines of regulator in mind. In the unfortunate event of repudiation, the customers will be informed of the existence of forums for grievance redressal.

Schedule of Benefits:

Smart Health Insurance Policy															
Plans	**Basic**					**Premium**					**Optimum**				
Sum Insured	**0.5 L**	**1L**	**2L**	**3L**	**5L**	**1L**	**2L**	**3L**	**4L**	**5L**	**1L**	**2L**	**3L**	**4L**	**5L**
In-patient Treatment	Upto SI					Upto SI					Upto SI				
Room Rent (per day) - Normal	1000	1000	2000	3000	No cap	1000	2000	3000	No cap	No cap	1000	2000	3000	No cap	No cap
Room Rent (per day) - ICU	2000	2500	3000	4500	No cap	2500	3000	4500	No cap	No cap	2500	3000	4500	No cap	No cap
Pre-Hospitalisation -	Upto SI - 30 days					Upto SI - 45 days					Upto SI - 60 days				

30/45/60 days											
Post Hospitalization - 60/90 days	Upto SI - 60 days				Upto SI - 90 days				Upto SI - 90 days		
Day Care Treatment	Upto SI				Upto SI				Upto SI		
AYUSH Treatment	Covered with No limits				Covered with No limits				Covered with No limits		
Domiciliary Hospitalization	10% of Sum Insured				10% of Sum Insured				10% of Sum Insured		
Critical Illness	Not covered		Additional 100% SI on hospitalisation expenses		Not covered		Additional 100% SI on hospitalisation expenses		Additional 100% SI on hospitalisation expenses	Additional Sum Insured of 100% of SI on Benefit Basis	
Basis of payment			Indemnity				Indemnity		Indemnity	Benefit	
Dread disease Recouperation Benefit in case of critical illness	Not covered		Rs 200 per day for a max of 45 days		Not covered		Rs 300 per day for a max of 45 days		Rs 500 per day for a max of 45 days	Not covered	
Organ Donor	Not covered		10% of SI over and above the Original SI		Not covered		15% of SI over and above the Original SI		20% of SI over and above the Original SI	Not covered	
	Available In case of critical illness				Available In case of critical illness				Available In case of critical illness		
Hospital Cash Allowance	Not covered	Rs 200 per day	Rs 250 per day	Rs 350 per day	Not covered	Rs 250 per day	Rs 350 per day	Rs 500 per day	Rs 500 per day	Rs 750 per day	Rs 1000 per day
		10 Days - deductible 3 days				15 Days - deductible 3 days			30 days - deductible 3 days		
Home Nursing (10 days - 3 days deductible)	Not covered				Not covered	Rs 200 per day	Rs 250 per day	Rs 300 per day	Rs 500 per day		
Emergency Surface Ambulance Charges	Rs 1500				Rs 2000				Rs 2500		
Inpatient Physiotherapy	Not covered				1% of SI				2% of SI		
Convalescence Benefit	Not covered				Not covered				12500 (on continuous 8 days hospitalisation or more)		
Accompanying Person Expenses	Rs 250 for 5 days after first three days				Rs 250 for 5 days after first three days				Rs 250 for 10 days after first three days		
Parent Accommodation as Companion for Child:	Not covered				Rs 250 for 10 days after first three days				Rs 250 for 30 days after first three days		
Out-patient Dental Emergency Treatment:(Accidents only)	Not covered				Not covered				1% of SI		

Out-patient Emergency Treatment for Accidents	Not covered	Not covered	2% of SI
Mortal Remains	Not covered	Not covered	1% of SI
Children Education Funds	Not covered	Not covered	1% of SI
No Claim Bonus	Renewal discount - 5% to 25% maximum		
Health Check-up	Once in block of 4 years		

Annexure I: Day Care Treatment

1. Suturing - CLW -under LA or GA
2. Surgical debridement of wound
3. Therapeutic Ascitic Tapping
4. Therapeutic Pleural Tapping
5. Therapeutic Joint Aspiration
6. Aspiration of an internal abscess under ultrasound guidance
7. Aspiration of hematoma
8. Incision and Drainage
9. Endoscopic Foreign Body Removal - Trachea /- pharynx-larynx/ bronchus
10. Endoscopic Foreign Body Removal -Oesophagus/stomach /rectum.
11. True cut Biopsy - breast/- liver/- kidney-Lymph Node/-Pleura/-lung/-Muscle biopsy/-Nerve biopsy/-Synovial biopsy/-Bone trephine
biopsy/-Pericardial biopsy
12. Endoscopic ligation/banding
13. Sclerotherapy
14. Dilatation of digestive tract strictures
15. Endoscopic ultrasonography and biopsy
16. Nissen fundoplication for Hiatus Hernia /Gastro esophageal reflux disease
17. Endoscopic placement/removal of stents
18. Endoscopic Gastrostomy
19. Replacement of Gastrostomy tube
20. Endoscopic polypectomy
21. Endoscopic decompression of colon
22. Therapeutic ERCP
23. Brochoscopic treatment of bleeding lesion
24. Brochoscopic treatment of fistula /stenting
25. Bronchoalveolar lavage & biopsy
26. Tonsillectomy without Adenoidectomy
27. Tonsillectomy with Adenoidectomy
28. Excision and destruction of lingual tonsil
29. Foreign body removal from nose
30. Myringotomy

31. Myringotomy with Grommet insertion
32. Myringoplasty /Tympanoplasty
33. Antral wash under LA
34. Quinsy drainage
35. Direct Laryngoscopy with or w/o biopsy
36. Reduction of nasal fracture
37. Mastoidectomy
38. Removal of tympanic drain
39. Reconstruction of middle ear
40. Incision of mastoid process & middle ear
41. Excision of nose granuloma
42. Blood transfusion for recipient
43. Therapeutic Phlebotomy
44. Haemodialysis/Peritoneal Dialysis
45. Chemotherapy
46. Radiotherapy
47. Coronary Angioplasty (PTCA)
48. Pericardiocentesis
49. Insertion of filter in inferior vena cava
50. Insertion of gel foam in artery or vein
51. Carotid angioplasty
52. Renal angioplasty
53. Tumor embolisation
54. TIPS procedure for portal hypertension
55. Endoscopic Drainage of Pseudopancreatic cyst
56. Lithotripsy
57. PCNS (Percutaneous nephrostomy)
58. PCNL (percutaneous nephrolithotomy)
59. Suprapubic cytostomy
60. Tran urethral resection of bladder tumor
61. Hydrocele surgery
62. Epididymectomy
63. Orchidectomy
64. Herniorrhaphy
65. Hernioplasty
66. Incision and excision of tissue in the perianal region
67. Surgical treatment of anal fistula
68. Surgical treatment of hemorrhoids
69. Sphincterotomy/Fissurectomy
70. Laparoscopic appendicectomy
71. Laparoscopic cholecystectomy

72. TURP (Resection prostate)
73. Varicose vein stripping or ligation
74. Excision of dupuytren's contractureHG/V004/wef 1st Oct 2013 16
75. Carpal tunnel decompression
76. Excision of granuloma
77. Arthroscopic therapy
78. Surgery for ligament tear
79. Surgery for meniscus tear
80. Surgery for hemoarthrosis/pyoarthrosis
81. Removal of fracture pins/nails
82. Removal of metal wire
83. Incision of bone, septic and aseptic
84. Closed reduction on fracture, luxation or epiphyseolysis with osetosynthesis
85. Suture and other operations on tendons and tendon sheath
86. Reduction of dislocation under GA
87. Cataract surgery
88. Excision of lachrymal cyst
89. Excision of pterigium
90. Glaucoma Surgery
91. Surgery for retinal detachment
92. Chalazion removal (Eye)
93. Incision of lachrymal glands
94. Incision of diseased eye lids
95. Excision of eye lid granuloma
96. Operation on canthus & epicanthus
97. Corrective surgery for entropion & ectropion
98. Corrective surgery for blepharoptosis
99. Foreign body removal from conjunctiva
100. Foreign body removal from cornea
101. Incision of cornea
102. Foreign body removal from lens of the eye
103. Foreign body removal from posterior chamber of eye
104. Foreign body removal from orbit and eye ball
105. Excision of breast lump /Fibro adenoma
106. Operations on the nipple
107. Incision/Drainage of breast abscess
108. Incision of pilonidal sinus
109. Local excision of diseased tissue of skin and subcutaneous tissue
110. Simple restoration of surface continuity of the skin and subcutaneous tissue
111. Free skin transportation, donor site
112. Free skin transportation recipient site

113. Revision of skin plasty
114. Destruction of the diseases tissue of the skin and subcutaneous tissue
115. Incision, excision, destruction of the diseased tissue of the tongue
116. Glossectomy
117. Reconstruction of the tongue
118. Incision and lancing of the salivary gland and a salivary duct
119. Resection of a salivary duct
120. Reconstruction of a salivary gland and a salivary duct
121. External incision and drainage in the region of the mouth, jaw and face
122. Incision of hard and soft palate
123. Excision and destruction of the diseased hard and soft palate
124. Incision, excision and destruction in the mouth
125. Surgery to the floor of mouth
126. Palatoplasty
127. Transoral incision and drainage of pharyngeal abscess
128. Dilatation and curettage
129. Myomectomies
130. Simple Oophorectomies
Note: The standard exclusions and waiting periods are applicable to all of the above procedures depending on the medical condition/disease under treatment. Only 24 hours hospitalization is not mandatory..

Annexure II - List of Generally excluded in Hospitalization Policy

List of Generally excluded in Hospitalization Policy		
SNO	**List of Expenses Generally Excluded ("Non-Medical")in Hospital Indemnity Policy -**	**SUGGESTIONS**
TOILETRIES/COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS		
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable

3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	MOISTUR1SER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine.
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable

38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable/ Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling in case of upper arm fractures should be considered
ITEMS SPECIFIC ALL Y EXCLUDED IN THE POLICIES		
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in Policy unless otherwise specified
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Exclusion in Policy unless otherwise specified
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALIZATION	Exclusion in Policy unless otherwise specified
62	HORMONE REPLACEMENT THERAPY	Exclusion in Policy unless otherwise specified
63	HOME VISIT CHARGES	Exclusion in Policy unless otherwise specified
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in Policy unless otherwise specified
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Exclusion in Policy unless otherwise specified
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Exclusion in Policy unless otherwise specified
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in Policy unless otherwise specified

68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in Policy unless otherwise specified
69	DONOR SCREENING CHARGES	Exclusion in Policy unless otherwise specified
70	ADMISSION/REGISTRATION CHARGES	Exclusion in Policy unless otherwise specified
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in Policy unless otherwise specified
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not payable - Exclusion in Policy unless otherwise specified
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not payable as per HIV/AIDS exclusion
74	STEM CELL IMPLANTATION/ SURGERY and storage	Not Payable except Bone Marrow Transplantation where covered by Policy
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS		
75	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
77	MICROSCOPE COVER	Payable under OT Charges, not payable separately
78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not payable separately
79	SURGICAL DRILL	Payable under OT Charges, not payable separately
80	EYE KIT	Payable under OT Charges, not payable separately
81	EYE DRAPE	Payable under OT Charges, not payable separately
82	X-RAY FILM	Payable under Radiology Charges, not as consumable
83	SPUTUM CUP	Payable under Investigation Charges, not as consumable
84	BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
86	Antiseptic or disinfectant lotions	Not Payable -Part of Dressing Charges
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES,SYRINGES	Not Payable -Part of Dressing Charges

88	COTTON	Not Payable -Part of Dressing Charges
89	COTTON BANDAGE	Not Payable -Part of Dressing Charges
90	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed , otherwise included as Dressing Charges
91	BLADE	Not Payable
92	APRON	Not Payable -Part of Hospital Services/Disposable linen to be part of OT/ICU charges
93	TORNIQUET	Not Payable (service is charged by hospitals,consumables can not be separately charged)
94	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
95	URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE		
96	LUXURY TAX	Actual tax levied by government is payable .Part of room charge for sub limits
97	HVAC	Part of room charge not payable separately
98	HOUSE KEEPING CHARGES	Part of room charge not payable separately
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
100	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
101	SURCHARGES	Part of room charge not payable separately
102	ATTENDANT CHARGES	Not Payable - Part of Room Charges
103	IM IV INJECTION CHARGES	Part of nursing charges, not payable
104	CLEAN SHEET ^	Part of Laundry/Housekeeping not payable separately
105	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
106	BLANKET/WARMER BLANKET ADMINISTRATIVE OR NON-MEDICAL CHARGES	Not Payable- part of room charges
107	ADMISSION KIT	Not Payable
108	BIRTH CERTIFICATE	Not Payable
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
110	CERTIFICATE CHARGES	Not Payable
111	COURIER CHARGES	Not Payable
112	CONVENYANCE CHARGES	Not Payable
113	DIABETIC CHART CHARGES	Not Payable

114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
115	DISCHARGE PROCEDURE CHARGES	Not Payable
116	DAILY CHART CHARGES	Not Payable
117	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
119	FILE OPENING CHARGES	Not Payable
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
121	MEDICAL CERTIFICATE	Not Payable
122	MAINTENANCE CHARGES	Not Payable
123	MEDICAL RECORDS	Not Payable
124	PREPARATION CHARGES	Not Payable
125	PHOTOCOPIES CHARGES	Not Payable
126	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
127	WASHING CHARGES	Not Payable
128	MEDICINE BOX	Not Payable
129	MORTUARY CHARGES	Payable up to 24 hrs,shifting charges not payable
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES		
131	WALKING AIDS CHARGES	Not Payable
132	BIPAP MACHINE	Not Payable
133	COMMODE	Not Payable
134	CPAP/ CAPD EQUIPMENTS Device	Not Payable
135	INFUSION PUMP - COST Device	Not Payable
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
137	PULSEOXYMETER CHARGES Device	Not Payable
138	SPACER	Not Payable
139	SPIROMETRE Device	Not Payable
140	SP0 2PROB E	Not Payable
141	NEBULIZER KIT	Not Payable
142	STEAM INHALER	Not Payable
143	ARMSLING	Not Payable
144	THERMOMETER	Not Payable (paid by patient)
145	CERVICAL COLLAR	Not Payable

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

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

195	AMBULANCE	Payable as per Plan
196	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs an d then 1 in 24 hrs
197	URINE BAG P	Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs
198	SOFTOVAC	Not Payable
199	STOCKINGS	Essential for case like CABG etc. where it should be paid.