

SmartSuper Health Insurance Policy - Prospectus and Sales Literature

I. AGE LIMIT:

1. This Policy covers persons in the age group 91 days to 65 years. The maximum entry age is restricted to 65 years.
2. Children between 91 days and 5 years can be covered provided either parent is getting insured under this Policy.
3. The age at entry for Individual ranges between 5 year and 65 Yrs.
4. There is no maximum cover ceasing age on renewals.
5. This Policy can be issued to an individual and/or family.
6. The family means maximum of five persons including self, spouse and three dependent children up to the age of 23 years.
7. The age considered is the completed number of years as on last birthday.
8. Optional Benefit

Optional benefits are additional benefits which chosen by Insured by paying additional premium, however optional benefits cannot be opted without Base Hospitalization plan

- a. Critical Illness
 - i. Critical Illness Sum Insured opted should not be more than the Sum Insured of base hospitalisation Policy.
 - ii. Critical illness cover is available for Insured/Insured person(s) selected, with each member having Individual limit of coverage, however limits for Insured/Insured person(s) cannot be different from each other.
- b. Hospital Cash
 - i. Hospital Cash allowance if opted has to be opted for all Insured / Insured person(s) in a Policy with common limit for Insured/Insured person(s).
- c. Maternity with New Born Baby Cover
 - i. This benefit is available only under a Family Floater Policy.
 - ii. This benefit is available for Insured / Insured's spouse provided both are covered under the same Policy.
 - iii. This benefit can be opted only with a 3 year term of base plan where both base hospitalization plan and add-on cover term is 3 years only.

Note:

Dependents means only the family members listed below:

- Insured's legally married spouse as long as she/he continues to be married to insured;
- Insured's children aged between 91 days and 23 years if they are unmarried

“Dependent Child” means a child (natural or legally adopted), who is unmarried, aged between 91 days and 23 years, financially dependent on the Insured and does not have his / her independent sources of income.

II. POLICY PERIOD:

The Policy will be issued for annual period of 1 year, 2 years and 3 years as per the requirement of customer.

III. SALIENT FEATURES & BENEFITS:

A. Basic cover upto the Sum Insured limit applicable to all plans

1	In-patient treatment	In-patient treatment covers hospitalization expenses which are reasonable and customary charges incurred for treatment of Disease, Illness contracted or Injury sustained. This includes Hospital room rent or boarding expenses, nursing, Intensive Care Unit charges Operation Theatre charges, Medical Practitioner's charges, fees of Surgeon, Anaesthetist, Qualified Nurse, Specialists, the cost of diagnostic tests, medicines, drugs, blood, oxygen, the cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure. A minimum period of 24 consecutive hours hospitalization as in-patient is must.
2	Pre-hospitalization	Covers relevant medical expenses incurred upto 60 days before hospitalization or day care treatment for treatment of Disease, Illness contracted or Injury sustained.
3	Post-hospitalization	Covers relevant medical expenses incurred upto 90 days after discharge from Hospital / Day Care treatment for continuous and follow up treatment of the Disease, Illness contracted or Injury sustained for which the Insured/ Insured Person was hospitalized.
4	Organ Donor	Covers hospitalization expenses for Medical treatment of the organ donor for harvesting the organ.
5	Day care Treatment	Medical treatment, and/or surgical procedure which is undertaken under General or Local Anesthesia in a Hospital/ Day Care centre in less than 24 hours because of technological advancement, which would have otherwise required a hospitalization of more than 24 hours, In respect of listed treatments as given in the Appendix I at the end of this document.
6	Ayush Treatment	<p>Medical expenses for in-patient treatment taken under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems in a government Hospital or in any institute recognized by government and/ or accredited by Quality Council of India/ National Accreditation Board on Health.</p> <p>Ayush Treatment is also covered provided the treatment has been undergone in</p> <p>i. Teaching hospitals of AYUSH colleges recognised by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH)</p> <p>ii. AYUSH Hospitals having registration with a Government authority under appropriate Act in the State/UT and complies with the following as minimum criteria:</p> <ol style="list-style-type: none"> has at least fifteen in-patient beds; has minimum five qualified and registered AYUSH doctors; has qualified paramedical staff under its employment round the clock; has dedicated AYUSH therapy sections; maintains daily records of patients and makes these accessible to the insurance company's authorized personnel
7	Domiciliary Hospitalization	<p>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:</p> <ol style="list-style-type: none"> The condition of the Patient is such that he/she is not in a condition to be removed to a Hospital or, The Patient takes treatment at home on account of non-availability of room in a Hospital. <p>Treatment of less than 3 days is not covered. (Coverage will be provided for expenses incurred in first three days however this benefit will be applicable if treatment period is greater than 3 days).</p>

B. Other Benefits available on the basis the selected plan.

1	Restoration of Sum Insured	In case of a situation where the Sum Insured and No claim bonus are exhausted due to claims made and paid during the Policy Year, and the Insured/ Insured Persons have to subsequently, incur any hospitalization expenses due to any Disease / Illness / Injury for which a valid claim is admissible under the Policy, then the Sum Insured shall be restored which is equal to 100% for the particular Policy year for all members in the Policy, provided that;
---	----------------------------	--

		<ol style="list-style-type: none"> I. The Restored Sum Insured will be enforceable only after the Basic Sum Insured and No claim bonus (if any) have been completely exhausted in that year; and the Restored Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in respect of basic cover and additional covers. II. The Restored Sum Insured shall be available only for fresh/ any new Disease / Illness / Injury and not in relation to any Illness/ Injury for which a Claim has already been admitted partially or fully for that Insured person during that Policy Year. III. The Restored Sum Insured will only be allowed once during a Policy Year; IV. Restoration of Sum insured is not applicable for add-on benefits <p>If the Restored Sum Insured is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year.</p>
2	Emergency Surface Ambulance charges	<p>Covers expenses incurred for surface transport by ambulance to Hospital or between Hospitals and/ or diagnostic centre for treatment of Disease, Illness or Injury in a Hospital as an in-patient, provided a valid claim under the Policy is admissible.</p> <p>This benefit is subject to sub limits (per hospitalization claim) as mentioned in Schedule of benefit but within over all limit of the Sum Insured.</p> <p>This benefit is applicable irrespective of the number of occurrences during the Policy period subject to the over all Sum Insured.</p>
3	Convalescence Benefit	<p>This benefit provides for payment to the Insured / Insured Person a fixed allowance as mentioned in the Schedule of benefit, in case the Insured / Insured Person is hospitalized for a continuous period of 10 days or more for treatment for any Disease / Illness / Injury. This benefit is payable once during the Policy period but within over all limit of the Sum Insured opted by the insured.</p>
4	Outpatient emergency treatment (Accident only)	<p>This benefit is payable once during the Policy period but within over all limit of the Sum Insured opted by the insured. 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 only if such Emergency Treatment is administered within 24 hours following the Accident.</p> <p>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. This benefit is subject to sub limits as mentioned in Schedule of benefits but within over all limit of the Sum Insured opted by the Insured.</p>
5	Animal bite (Vaccination)	<p>The Company will cover Medical Expenses of OPD Treatment for vaccinations or immunizations for treatment post an animal bite, up to the limit provided in the Schedule of Benefits. This benefit is available only on reimbursement basis.</p>
6	Domestic Air Ambulance	<p>Covers expenses of transportation in an airplane or helicopter which is certified to use as an ambulance for Emergency care which require immediate and rapid transportation from the site of first occurrence of the Illness / Accident to the nearest Hospital within a reasonable timeframe. This benefit is available only where the medical treatment required and as advised by medical practitioner is not available in any Hospital of the city of first occurrence. The claim would be reimbursed upto the actual expenses subject to the maximum limit as specified in the Schedule of benefit.</p> <p>The Company shall not pay for air ambulance for the transfer on Insured/ Insured person within the same city of first occurrence. Return transportation is excluded.</p>
7	Outpatient Dental emergency (arising out of accident only)	<p>This benefit provides for reimbursement of medical expenses incurred towards emergency treatment given by a Dentist following an Accident where the Insured / Insured Person suffer injuries or damage to his/ her natural teeth and/ or gums. This benefit further provides cover for medical expenses incurred for follow up treatment up to a maximum of 15 days. The benefit under this is subject to sub limits as mentioned in Schedule of benefits but within over all limit of the Sum Insured as opted by the insured.</p>

C. Optional Add-on benefits available to all plans on payment of extra premium

1	Hospital cash allowance	<p>Daily cash amount will be payable per day upto the specified limits opted, if the Insured Person is Hospitalized for treatment of any Disease / Illness / Injury for which a valid claim is admissible under the Policy for each continuous and completed period of 24 hours and if the Hospitalisation exceeds for more than 24 hours. First continuous and completed period of 24 hours will act as deductible.</p> <p>This is paid upto a maximum of 30 days including all the members & all claims for the entire Policy year.</p>
---	-------------------------	---

5.2) No Claim Bonus:

If no claim has been made in a Policy Year by any Insured / Insured Person, Then for each such Policy year, the Company will offer a no claim bonus as mentioned in the Appendix III.

No claim bonus will be provided on the expiring Policy Sum Insured, provided that the Policy is renewed continuously.

The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the increase in Cumulative Bonus.

No Claim Bonus will be calculated on the basis of Sum Insured of the last completed Policy Year.

In case of a claim, the no claim bonus earned shall be automatically reduced in the same proportion in the following renewal of the Policy. This will not affect the Sum Insured of the Policy.

5.3) Portability:

i. From another company to Bharti AXA Policy

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

- (1) If Insured person wish to exercise the Portability Benefit, The Company should have received the application for portability and the completed Portability Form with complete documentation at least 45 days before the expiry of the existing insurance Policy.
- (2) This benefit is available only at the time of renewal of the existing health insurance Policy.
- (3) Portability benefit is available only upto 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 upto 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 requests;
- (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.

VI. POLICY SERVICING:

The Policy will be serviced by Third Party Administrator who will provide cash less facility for hospitalization treatment. The scope of cover and the Sum Insured levels under the various Plans available are mentioned in Schedule of Benefits annexed hereto.

VII. EXCLUSIONS:

A. Waiting Period:

A1. 30 days waiting period:

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

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

A2. Specific waiting period:

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

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

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

- Subsequent renewals with the Company without a break post the first 2 years of the Policy
- Portability to the extent of waiting period and sum insured waived off in the Schedule of the Policy.

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

A3. Pre-existing Diseases / Illness / Injury / conditions:

The benefits will not be available for any condition(s) as defined in the Policy, until 48 months of continuous coverage have elapsed, since inception of the first Policy with the Company.

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

A4. Maternity expenses where maternity cover is opted:

The benefits will not be available for any condition(s) as defined in the Policy, until 9 months since inception of the first Policy with the Company. In all other cases where maternity benefit cover is not opted, all claims directly or indirectly related to maternity stands excluded always.

A5. Critical Illness : 60 days waiting period for fresh policy and 30 days survival period.

A6. Internal Congenital Anomalies : 48 months.

A7. Genetic disorders: Covered after a waiting period of 48 months

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

1. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
2. Any Illness or Injury directly or indirectly resulting or arising from or occurring during commission of any breach of any law by the Insured Person with criminal intent.
3. Disease/ Illness/ Injury whilst performing duties as a serving member of a military or a police force.
4. Any loss, Injury/Illness, directly or indirectly caused due to an act of terrorism or terrorist incident, regardless of any contributory causes (if the Company alleges that by reason of this exclusion any loss is not covered by this insurance, the burden of proving the contrary shall be upon the Insured / Insured Person).
5. Expenses following Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
6. Medical Treatment in respect of the Illness / Injury/ Disease caused whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing, potholing, abseiling, deep sea diving, polo, snow and ice sports.
7. Medical treatment in respect of the Injury caused whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular Scheduled commercial airline
8. Circumcision unless necessary for treatment of a Disease, Illness or Injury not excluded hereunder, or, as may be necessitated due to an Accident.
9. Dental treatment or surgery of any kind unless requiring hospitalization or in case of out-patient Dental Emergency Treatment (unless arising out of Accident only as specified under the scope of the Policy).
10. Birth control procedures, hormone replacement therapy, contraceptive supplies or services including complications arising due to supplying services or Assisted Reproductive Technology, treatment arising from or traceable to pregnancy, childbirth including caesarean section and voluntary medical termination of pregnancy during the first 12 weeks from the date of conception. However, this exclusion will not apply to Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.
11. Any treatment arising from or traceable to any fertility, infertility, sub-fertility or assisted conception procedure or sterilization.
12. Charges incurred in connection with cost of spectacles and/or contact lenses, hearing aids, routine eye and ear examinations, laser surgery for correction of refractory errors, dentures, artificial teeth and or all other similar external appliances and/or devices whether for diagnosis or treatment, Issue of medical certificates and examinations as to suitability for employment or travel.
13. Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex syndrome (ARCS) and all Diseases / Illness / Injury caused by and/or related to HIV. Any condition directly or indirectly caused by or associated with venereal Disease, sexually transmitted Disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV-III or IITLB-III) or Lymphadenopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.
14. Vitamins and tonics unless forming part of treatment for Disease, Illness or Injury as certified by the Medical Practitioner.
15. Weight management services and or treatment, services and supplies including treatment of obesity (including morbid obesity).

16. Any treatments related to sleep disorder, sleep apnoea syndrome, general debility, treatment received in convalescent homes, cure, rundown condition or rest cure, congenital external Diseases / Illness or defects or anomalies, sterility, venereal Disease or intentional self-Injury.
17. Any treatment received in convalescent homes, convalescent Hospitals, health hydros, nature cure clinics or similar establishments.
18. Medical Treatment following use/abuse of intoxicating drugs or alcohol or drug abuse, solvent abuse or any addiction or medical condition resulting from or relating to such abuse or addiction.
19. Sex change or treatment, which results from, or is in any way related to, sex change.
20. All preventive care vaccination including inoculation or immunization of any kind unless forming a part of post animal bite treatment.
21. Treatment by a family member (Father, Mother, Father-in-law, Mother-in-law, Son, Daughter, Son-in-law, Daughter-in-law, Brother or Sister) and or self-medication or any treatment except AYUSH, that is not scientifically recognized.
22. Medical treatment required following involvement in any criminal act of the Insured / Insured Person.
23. Prostheses, corrective devices and medical appliances, which are not, required intra-operatively.
24. Any stay in Hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner.
25. Treatment of mental Disease / Illness, stress, psychiatric or psychological disorders.
26. Aesthetic treatment, cosmetic surgery or plastic surgery unless necessitated due to Accident
27. Experimental and unproven treatment.
28. 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.
29. Cost incurred for medicines which are not under the advice of the Medical Practitioner.
30. Any treatment which is taken as an out-patient without any admission as an in-patient at the Hospital except those that are specifically mentioned as covered specifically in the this Policy.
31. Costs of donor screening or treatment, unless specifically covered and specified in the this Policy.
32. Any treatment received outside India.
33. Treatment taken from persons not registered as Medical Practitioners under respective medical councils.
34. Genetic disorders and stem cell implantation / Surgery or Growth Hormone Therapy
35. Acupressure, acupuncture, magnetic therapies.
36. Treatment for Age Related Macular Degeneration (ARMD), treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy and Robotic surgery.
37. Any kind of Service charges, Surcharges, Luxury Tax and similar charges levied by the Hospital. (other than government taxes).
38. External medical equipment of any kind used at home as post hospitalization care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition.

VIII. GENERAL CONDITIONS:

8.1) Duty of Disclosure:

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

8.2) Floater Policy:

Where the Policy is obtained on floater basis covering the family members, the Sum Insured as specified in the Schedule to this Policy, shall be available to the Insured and all other Insured members. However, the Sum Insured shall be the over all limit including add-on Sum Insured unless otherwise specified, if opted and no claim bonus, if any for the entire period of Insurance/Policy period including all members/Insured persons and all claims.

8.4) 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.

8.5) Material Change:

The Insured / Insured Person shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business, partial disclosure of the medical history at Insured / Insured person own expense. The Company may, adjust the scope of cover and / or the premium, if necessary, accordingly.

8.6) 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.8.1 of this Policy.

8.7) No Constructive Notice:

The Company shall not take notice of any information relating to the Insured person unless such information is submitted in writing by the Insured, even if such information was available with the Company.

8.8) Notice of Charge:

The Company is not under obligation to take note of any trust, assignment, lien or similar charge on or relating to the Policy. However, any payment by the Company to Insured or legal representative or bank shall be binding on all concerned and shall be considered as complete discharge by the company.

8.9) 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.

8.10) Electronic Transaction:

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

8.11) Duty of the Insured on occurrence of loss/event leading to claim

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

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

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

8.12) Right to Inspect:

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

The Company shall bear all cost of examination required under this section

8.13) Position after a claim:

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

8.14) Multiple policies

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

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

8.15) Forfeiture of claims:

If any claim is made and rejected and no court action or suit is commenced within 12 months after such rejection or, in case of arbitration taking place as provided therein, within 12 calendar months after the arbitrator or arbitrators have made their award, all benefits under this Policy shall be forfeited and will not have any rights whatsoever.

8.16) 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.

8.17) Grace Period:

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

However, there is no coverage provided during the break period.

8.18) Cancellation/Termination:

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

Period on Risk	Rate of Premium to be retained by Company for 1 year Policy	Rate of Premium to be retained by Company for 2 years Policy	Rate of Premium to be retained by Company for 3 years Policy
Up to 1 month	25%	15%	10%
Exceeding 1 month Up to 3 months	50%	25%	15%
Exceeding 3 months Up to 6 months	75%	50%	25%
Exceeding 6 months Up to 12 months	100%	75%	50%
Exceeding 12 months Up to 18 months	N.A	85%	75%
Exceeding 18 months Up to 24 months	N.A	100%	85%
Exceeding 24 months Up to 30 months	N.A	N.A	90%
Beyond 30 months	N.A	N.A	100%

8.19) 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.

8.20) 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 within Indian Territory.

8.21) Arbitration:

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

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

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

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

8.22) Terms of renewal:

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

- a. The premium for renewal will be applicable as per the premium chart based on age, sum insured and geography.
- b. Company will not load the premium for any adverse claims experience of particular Insured/ Insured Person at the time of renewal if there is no change in the coverage of continuing Policy.
- c. The Company may change the renewal premium and/or benefits payable subject to approval from regulator (IRDA) and inform the same to the Insured at least 3 months prior to the effective date of revision and/ or modification or renewal
- d. In the likelihood of this Policy being withdrawn in future, the Company will inform the same to the Insured at least 3 months prior to expiry of the Policy. Insured will have the option to migrate to other plan under similar health insurance Policy at the time of renewal, provided the Policy is maintained without a break.

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

However, there is no coverage for Injury sustained or Disease contacted during this grace period/ break period.

8.23) Sum Insured Enhancement:

- i. The Insured member can apply for enhancement of Sum Insured at the time of renewal by submitting a duly filled fresh proposal form to the Company.
 - ii. The acceptance of enhancement of Sum Insured would be at the discretion of the Company, based on the health condition of the Insured members, claim history and subject to acceptance by the company post underwriting
- All waiting periods as defined in the Policy shall apply afresh for this enhanced Sum Insured from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy in respect of such increased Sum Insured.

8.24) Inclusion of Dependent members under the Policy:

New Person can be added to this Policy, either by way of endorsement in case of mid-term inclusion or at the time of renewal. Mid-term inclusion is available only in case of such new person i.e spouse and or new born child post 90 days of birth subject to acceptance by underwriters.

The pre-existing Disease clause, exclusions and waiting periods will be applicable afresh in respect of such newly added person.

8.25) Renewal:

The Company shall allow renewal of the Policy and accept renewal premium in all cases except in case of noncooperation of the Insured/Insured Person in implementing the terms and conditions of this Policy.

8.26) 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

9: Claim Procédure:

9.1 Claim Notification - Multi Model Intimation:

It is the endeavor of Company to give multiple options to the Insured/covered person/patient's care taker to intimate the claim to the Third party administrator (TPA)/Company. The intimation can be given in following ways:

- Toll Free call Centre of the TPA (24x7) -
- Toll Free call Centre of the Insurance Company(24x7) - 1800-103-2292
- Login to the website of the Insurance Company and intimate the claim – <http://www.bharti-axagi.co.in/contact-us>
- Send an email to the TPA/Company- customer.service@bharti-axagi.co.in
- Post/courier to TPA/Company - Bharti AXA General Insurance Company Limited, 1st Floor, Ferns Icon, Survey No.28, Doddanekundi, Bangalore – 560037
- Directly Contacting our Company office but in writing. - Bharti AXA General Insurance Company Limited, 1st Floor, Ferns Icon, Survey No.28, Doddanekundi, Bangalore – 560037, Dial :+ 91 80 49123900

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

9.2 Information Details

When the Insured/ covered person/ patient's care taker intimate the claim as mentioned above the following information should be given for prompt services :

- Policy number
- Name of the Insured
- Name of Covered person/ Insured member making the claim
- Contact details
- Nature of the Disease, illness or injury
- Name and address, phone number of the attending medical practitioner/Hospital.
- Date of hospitalization.

9.3 Claim Form

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

9.4 Claim Procedure

9.4.1 Cashless hospitalisation:

- Company will work with one or more TPAs for providing cashless facility to the Insured/Covered person.
- List of network Hospitals is provided to the Insured/Covered person along with the Policy .Insured/Covered person can view the updated Hospitals 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 after necessary discussion(approval) with insurance company. 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 guide issued along with the Policy, and also will be available in the Hospitals or can be downloaded from the website of the TPA/Company or can request for the same to the TPA/Company via email or fax or can be collected in person from the branches of the TPA/Company.
- Denial of the cashless does not mean the claim has been rejected. Such claims will be examined on merits and will be paid on reimbursement basis later if admissible.
- The Insured/covered person can send the requisite claim documents to the TPA/Company seeking reimbursement.
- The Insured/covered person need not pay any amount to the Hospital if he/she has received the authorization letter except;
 - If the bill amount is in excess of the Sum insured
 - Non-medical expenses
 - Unrelated treatments
 - Excess/deductible, if any which has to be borne by insured
- The Hospital will receive the payment from Company within 21 days from the date of receipt of complete claim documents.

9.4.2 Reimbursement claims

- All reimbursement claims should be intimated to TPA/Insurance company within 7 days from date of discharge.
- Insured/covered person admitted in a non-network Hospital can send the claim documents to the TPA/ Company for the reimbursement within 30 days from the date of discharge. However Pre and post hospitalization bills can be sent within 15 days from the end of post hospitalization period as specified in the Policy.

9.5 Claim Service Guarantee

9.5.1. Re-imbursment Claims :

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

9.5.2. Cashless Claim:

In the event of delay in approval / rejection of cashless claim, a penalty of Rs.500/- for every delay of 6 hours beyond 6 hours in case of emergency hospitalization. For planned hospitalization The Company shall pay the penalty for every 6 hours beyond 48 hours. This penalty shall apply after receipt of all information / documents and will be subject to a maximum amount of Rs.5000/-.

10. PRE-POLICY CHECKUP

- No pre-Policy checkup would be required upto 45 years and/or Rs. 10 Lakh Sum Insured, subject to no adverse medical history declaration in the proposal form
- Medical tests (pre-Policy check-up) are mandatory for members aged 46 years and above and/or in respect of sum insured INR. 10 Lakhs and above. Medical test shall be undertaken at company designated Hospitals/centres only.
- The Company will reimburse 50% of the cost of medical examination underwent by the Insured person(s) at the designated Hospital/ Diagnostic centre, if the proposal is accepted. The medical reports are valid for a period of 30 days from the date of pre-Policy checkup.

Pre Policy Medical Grid												
Sum Insured in Lakhs												
Age Band	5	7.5	10	15	20	30	50	60	70	80	90	100
18-35	NIL	Nil	Nil	Level 3	Level 3	Level 3	Level 4	Level 5	Level 5	Level 6	Level 6	Level 6
36-45	NIL	Nil	Nil	Level 3	Level 3	Level 3	Level 5	Level 6	Level 6	Level 7	Level 7	Level 7
46-55	Level 3	Level 4	Level 4	Level 5	Level 5	Level 5	Level 6	Level 7	Level 7	Level 8	Level 8	Level 8
56-65	Level 3	Level 6	Level 6	Level 7	Level 7	Level 7	Level 8	Level 8	Level 8	Level 8	Level 8	Level 8

Level 3	FMR, RUA, HbA1c, ECG, CBC, Total Cholesterol
Level 4	FMR, RUA, HbA1c, ECG, Lipid profile, CBC, Serum Creatinine
Level 5	FMR, RUA, HbA1c, ECG, Lipid profile, CBC, Serum Creatinine, SGOT, SGPT
Level 6	FMR, RUA, HbA1c, ECG, Lipid profile, CBC, KFT, LFT, HBsAg
Level 7	FMR, RUA, HbA1c, Lipid profile, CBC, KFT, LFT, HBsAg, TMT
Level 8	FMR, RUA, HbA1c, Lipid profile, CBC, KFT, LFT, TMT, USG Whole abdomen, HBsAg, PSA (Males)

Pre Policy Medical Grid – Critical Illness									
Age Band/ SI	2 Lakhs	3 Lakhs	5 Lakhs	7.5 Lakhs	10 Lakhs	15 Lakhs	20 Lakhs	25 Lakhs	30 Lakhs
18-35	NIL*	NIL*	NIL*	NIL*	NIL*	Level 3	Level 3	Level 3	Level 3
36-45	NIL*	NIL*	NIL*	NIL*	NIL*	Level 3	Level 3	Level 3	Level 3
46-55	Level 4	Level 4	Level 4	Level 4	Level 4	Level 5	Level 5	Level 5	Level 5
56-65	Level 5	Level 5	Level 5	Level 5	Level 5	Level 6	Level 6	Level 6	Level 6

* Level 3 applicable if the proposer answers to any of the health related questions in the proposal form as unfavorable

- The Company can call for additional medical test(s) on the basis of declaration in proposal form or based on findings of first set of medical reports.

11. CUSTOMER SERVICE – SENIOR CITIZENS

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

- Website : www.bharti-axagi.co.in
- Email : customerservice@bharti-axagi.co.in
- Phone : 080-49123900
- 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

12. PREMIUM PAYABLE

- As per the Premium Schedule
- The premium under individual coverage will be charged as per the completed age, Sum insured and geography of the individual Insured member
- The premium under family floater coverage will be charged as per the completed age of the eldest Insured member
- Premium rates can be revised post approval from the IRDA, as said above.

PREMIUM SCHEDULE – As per Enclosure I attached to Prospectus and Sales Literature.

13. GENERAL NOTE

- The Proposer can contact the agent/intermediary/any of our offices for a full version of the Policy document.
- This Policy is subject to IRDA - Protection of Policyholder's Interests Regulations, 2002.

14. PROHIBITION OF REBATES (UNDER SECTION 41 OF INSURANCE ACT, 1938)

No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an Insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurers which shall be in conformity with regulations.

Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to ten lakh rupees.

Disclaimer

This document is only a summary of the product features. The actual benefits available are as described in the Policy, and will be subject to the Policy terms, conditions and exclusions. Please approach your insurance advisor if you require any further information or clarification.

This document gives summary of the main features. For more details you may refer to the Policy wordings which may be collected on request

We suggest our prospective customers to kindly have a detailed look at our Policy wording for full information

Schedule of Benefits													
SALIENT FEATURES & BENEFITS	Value		Classic			Uber							
	5L	7.5L	10L	15L	20L	20L	30L	50L	60L	70L	80L	90L	100L
Basic cover (upto the sum insured limit applicable to all plans)	Up to S.I		Up to S.I			Up to S.I		Up to S.I					
In-patient Treatment													
Pre-hospitalization - 60 Days													
Post-hospitalization- 90 Days													
Organ Donor													
Day care Treatment (As per Appendix I)													
Ayush Treatment													
Domiciliary Hospitalization													
Other Benefits (Per Policy Period including all members)													
No Claim Bonus	As per Appendix - II		As per Appendix - II			As per Appendix - II							
Health Check-up	Annual – Basic As per Appendix – III		Annual – extended As per Appendix – III			Annual – comprehensive As per Appendix – III							
Restoration of Sum Insured	Upto 100% of S.I		Upto 100% of S.I			Upto 100% of S.I							
Emergency Surface Ambulance charges	Rs.3000/event		Rs.3000/event			Rs.3000/event							
Convalescence Benefit (on continuous 10 days hospitalization or more)	Not Available		Rs.10,000			Rs.15,000		Rs.20,000					
Outpatient emergency treatment (Accident only)	Not Available		Rs.2,500			Rs.10,000		Rs.10,000					
Animal bite (Vaccination)	Not Available		Rs.2,500			Rs.5,000		Rs.5,000					
Domestic Air Ambulance (max once in a Policy year / per life)	Not Available		Not Available			Up to Rs. 1,00,000		Up to Rs. 2,00,000					
Outpatient Dental emergency (arising out of Accident only)	Not Available		Not Available			Rs.5,000		Rs.7,500					
Optional Add-on Benefit (on payment of additional premium): Covered only if specified in Policy schedule													
Hospital cash allowance (Up to Maximum up to 30 days with one day deductible)#	Option of Rs.500, 1000 / day		Option of Rs.500, 1000, 2000 / day			Option of Rs.500, 1000, 2000, 3000 / day							
Maternity Benefit: -Maternity Benefit with 9 month waiting period, up to first 2 deliveries/MTP in lifetime (available only with 3 yr. Policy term) -New Born Baby for first 90 days	Rs.35,000 - Maternity Rs. 25000 - New Born		Rs.50,000 - Maternity Rs.50,000 - New Born			Rs.75,000 - Maternity Rs. 75,000 - New Born		Rs.1,00,000 - Maternity Rs.1,00,000- New Born					
Lump sum benefit for critical illnesses (over and above theS.I)*	Option of Rs.2L, 3L, 5L, 7.5L, 10L, 15L, 20L, 25L, 30L												

*Critical Illness Sum Insured opted should not be more than the Sum Insured under section 2.1 , Critical Illness cover is available for Insured/Insured person(s) selected, with each member having Individual limit of coverage, however limits for Insured/Insured person(s) cannot be different from each other.

Hospital Cash allowance if opted has to be opted for all Insured/Insured person(s) in a Policy with common limit for Insured/Insured person(s)

Appendix I: Day Care Procedures

1. Suturing - CLW -under LA or GA
2. Surgical debridement of wound
3. Therapeutic Ascitic Tapping
4. Therapeutic Pleural Tapping
5. Therapeutic Joint Aspiration
6. Aspiration of an internal abscess under ultrasound guidance
7. Aspiration of hematoma
8. Incision and Drainage
9. Endoscopic Foreign Body Removal - Trachea /- pharynx-larynx/ bronchus
10. Endoscopic Foreign Body Removal -Oesophagus/stomach /rectum.
11. True cut Biopsy - breast/- liver/- kidney-Lymph Node/-Pleura/-Lung/- Muscle biopsy/-Nerve biopsy/-Synovial biopsy/-Bone trephine biopsy/-Pericardial biopsy
12. Endoscopic ligation/banding
13. Sclerotherapy
14. Dilatation of digestive tract strictures
15. Endoscopic ultrasonography and biopsy
16. Nissen fundoplication for Hiatus Hernia /Gastro esophageal reflux disease
17. Endoscopic placement/removal of stents
18. Endoscopic Gastrostomy
19. Replacement of Gastrostomy tube
20. Endoscopic poly pectomy
21. Endoscopic decompression of colon
22. Therapeutic ERCP
23. Brochosopic treatment of bleeding lesion
24. Brochosopic 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 Pseudo pancreatic cyst
56. Lithotripsy
57. PCNS (Percutaneous nephrostomy)
58. PCNL (percutaneous nephrolithotomy)
59. Suprapubic cystostomy
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 osseosynthesis
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
112. Free skin transportation recipient site
113. Revision of skin plasty
114. Destruction of the diseased 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.

Appendix II - Health Check-up tests on Policy renewal

Value	Classic	Uber
Age band <35 years		
Complete Blood Count and ESR Tests	Complete Blood Count and ESR Tests	Complete Blood Count and ESR Tests
Urine Routine Analysis	Urine Routine Analysis	Urine Routine Analysis
Pre and Post Fasting Blood Sugar Test	Pre and Post Fasting Blood Sugar Test	Pre and Post Fasting Blood Sugar Test
Age band 36-50 years		
Complete Blood Count and ESR Tests	Complete Blood Count and ESR Tests	Complete Blood Count and ESR Tests
Urine Routine Analysis	Urine Routine Analysis	Urine Routine Analysis
Pre and Post Fasting Blood Sugar Test	Pre and Post Fasting Blood Sugar Test	Pre and Post Fasting Blood Sugar Test
Serum Cholesterol & Triglycerides	Chest X-Ray	Chest X-Ray
ECG	ECG	ECG
	Blood test for blood sugar levels status in past 90 days	Blood test for blood sugar levels status in past 90 days
	Serum Cholesterol and Triglycerides	Serum Cholesterol and Triglycerides
		Kidney Function Test
		PSA (males only)
		Prostate Exams (males only)
		Mammography (females only)
		Cervical Smear (females only)
Age band > 50 years		
Complete Blood Count and ESR Tests	Complete Blood Count and ESR Tests	Complete Blood Count and ESR Tests
Urine Routine Analysis	Urine Routine Analysis	Urine Routine Analysis
Pre and Post Fasting Blood Sugar Test	Pre and Post Fasting Blood Sugar Test	Pre and Post Fasting Blood Sugar Test
Lipid Profile	Chest X-Ray	Chest X-Ray
ECG	ECG	ECG
	Blood test for average plasma sugar concentration in past 90 days	Blood test for average plasma sugar concentration in past 90 days
	Serum Cholesterol and Triglycerides	Serum Cholesterol and Triglycerides
	Liver Function Test	Liver Function Test
	Kidney Function Test	Kidney Function Test
		Hepatitis B surface Antigen
		Tread Mill Test or Stress Test
		Abdominal Ultrasound
		Prostate Exams (males only)
		Mammography (females only)

Appendix III - No Claim Bonus

No Claim Bonus	
Age at the inception of 1st Policy year <45 yrs.	50% of expiring Policy S.I per annum not exceeding Cumulative Bonus of 100% of current Policy S.I
Age at the inception of 1st Policy year >45 yrs. and <65 yrs.	20% of expiring Policy S.I per annum not exceeding Cumulative Bonus of 100% of current Policy S.I