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Issuing Office:

EXTRA CARE PLUS

Policy Wordings

SECTION A: PREAMBLE

Whereas the Insured described in the Schedule hereto (hereinafter called 'the Insured') by a Proposal and declaration which shall be the basis of this Contract and is deemed to be incorporated herein has applied to Bajaj Allianz General Insurance Company Limited (hereinafter called 'the Company') for the insurance hereinafter contained and has paid the premium as stated in the Schedule hereto as consideration for the indemnity hereinafter contained. This Policy records the entire agreement between us and sets out what we insure, how we insure it, and what we expect of you.

SECTION B: DEFINITIONS - STANDARD DEFINITIONS

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

2. **Aggregate Deductible**
Aggregate deductible is a cost sharing requirement under this policy that provides the company will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the company. A deductible does not reduce the sum insured. The deductible is applicable in aggregate towards hospitalisation expenses incurred during the policy period

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

4. **AYUSH Hospital**
An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a. Central or State Government AYUSH Hospital; or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy ; or
   c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

   i. Having at least 5 in-patient beds;
   ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
   iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out
   iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

6. **Cashless facility:**
Cashless facility means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorization is approved.

7. **Co-Payment:**
A co-payment means a cost-sharing requirement under a health insurance Policy that provides that the Policyholder/Insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

EXTRA CARE PLUS

8. **Condition Precedent:**
Condition Precedent means a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

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

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

   b. External Congenital Anomaly- Congenital anomaly which is in the visible and accessible parts of the body

10. **Day care centre:**
A day care centre means any institution established for day care treatment of illness and / or injuries or a medical set -up with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:-
    i. Has qualified nursing staff under its employment,
    ii. Has qualified medical practitioner(s) in charge,
    iii. Has a fully equipped operation theatre of its own where surgical procedures are carried out
    iv. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

11. **Day Care Treatment:**
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 required a hospitalization of more than 24 hours.

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

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

13. **Disclosure to information norm:**
The Policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

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

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

16. **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:
    i. Has qualified nursing staff under its employment round the clock;
    ii. 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;
    iii. Has qualified medical practitioner(s) in charge round the clock;
    iv. Has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v. Maintains daily records of patients and makes these accessible to the Insurance Company's authorized personnel.

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

18. **Illness**
Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function 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 for relief of symptoms
   iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
   iv. it continues indefinitely
   v. it recurs or is likely to recur.

19. Injury
Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

20. **Inpatient Care**
Inpatient care means treatment for which the Insured has to stay in a hospital for more than 24 hours for a covered event.

21. **Intensive Care Unit**
Intensive care unit means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

22. **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.

23. **Maternity expenses:**
Maternity expenses means;
   a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
   b. Expenses towards lawful medical termination of pregnancy during the Policy Period.

24. Medical Advice:
Medical advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow up prescription.

25. **Medical expenses:**
Medical Expenses means those expenses that an Insured 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 had not been Insured and no more than other hospitals or Medical practitioners in the same locality would have charged for the same medical treatment.

26. **Medical Practitioner/Doctor/Physician:**
Medical Practitioner means 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 or Ayurvedic and or such other authorities 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 its scope and jurisdiction of license and acceptable to Us.

27. **Medically Necessary Treatment:**
Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
   i. is required for the medical management of the illness or injury suffered by the Insured;
   ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
   iii. must have been prescribed by a medical practitioner,
   iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

30. New Born Baby
Newborn baby means baby born during the Policy Period and is aged up to 90 days.

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

32. Notification of Claim:
Notification of claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

33. OPD treatment:
OPD treatment means 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.

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

35. Pre-Existing Disease:
Pre- existing disease means any condition, ailment or injury or disease

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement Or
b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

36. Pre-hospitalization Medical Expenses:
Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:

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

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

a. Such Medical Expenses are for the same condition for which the Insured Person's hospitalization was required, and
b. The inpatient hospitalization claim for such hospitalization is admissible by the Insurance Company.

38. Qualified Nurse:
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.

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

40. Renewal
Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

41. Room rent
Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

42. Surgery or Surgical Procedure
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 from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

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

SECTION B: DEFINITIONS - SPECIFIC DEFINITIONS

1. Alternative Treatments:
Alternative treatments are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

2. **Bajaj Allianz Network Hospitals / Network Hospitals**
Bajaj Allianz Network Hospitals / Network Hospitals means the Hospitals which have been empanelled by Us as per the latest version of the schedule of Hospitals maintained by Us, which is available to You on request. For updated list please visit our website www.bajajallianz.com.

3. **Bajaj Allianz Diagnostic Centre**
Bajaj Allianz Diagnostic Centre means the diagnostic centers which have been empanelled by us as per the latest version of the schedule of diagnostic centers maintained by Us, which is available to you on request. For updated list please visit our website www.bajajallianz.com.

4. **Dependent child**
A child is considered a dependent for insurance purposes (even if not enrolled in an educational institution) provided he is financially dependent, on the proposer.

5. **Limit of Indemnity**
Limit of Indemnity represents Our maximum liability to make payment for each and every claim per person and collectively for all persons mentioned in the Schedule during the policy period and in the aggregate for the person(s) named in the schedule during the policy period, and means the amount stated in the Schedule against each Cover and subject to the limits specified.

6. **Named Insured/Insured**
Insured means the persons, or his Family members, named in the Schedule provided that an Insured or his Family Members has attained the age of 3 months and is not older than 80years of age at the commencement of the Policy Period.

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

8. **You, Your, Yourself/ Your Family named in the schedule means the person or persons that We insure as set out in the Schedule.**

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

SECTION C: OPERATIVE PARTS

Tenure of Policy

- "Extra Care Plus-Individual/Family Floater":1year, 2 years or 3 years

Scope of Cover

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

Any claim under this policy shall be payable by the Company only if the aggregate of covered Reasonable Medical Expenses during the policy period exceeds the aggregate deductible limit provided in the Policy Schedule, subject to a maximum of Sum Insured.

I. COVERAGE

1. Medical Expenses

If You are hospitalized on the advice of a Doctor because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then We will pay You, Reasonable and Customary Medical Expenses Medical Expenses incurred, subject to aggregate deductible as specified on the policy document

Aggregate deductible is a cost sharing requirement under this policy that provides that the company will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the company. A deductible does not reduce the sum insured. The deductible is applicable in aggregate towards hospitalisation expenses incurred during the policy period

a. In patient Hospitalisation expenses
   i. Room Rent/Boarding and Nursing Expenses
   ii. ICU Rent/Boarding and Nursing Expenses
   iii. Fees of Medical Practitioner, Surgeon , Anaesthetist, Nurses and Specialist Doctor
   iv. Operation theatre charges, Anesthesia, surgical appliances, diagnostic tests, medicines, blood, oxygen and cost of prosthetic and other devices or equipment if implanted internally like pacemaker during a surgical process

b. Pre- Hospitalisation expenses
   The medical expenses incurred in the 60 days period immediately before you were hospitalised, provided that:
   i. Such medical expenses were incurred for the same condition requiring subsequent Hospitalisation, and;
   ii. We have accepted the claim under In-Patient Hospitalisation expenses.

c. Post- Hospitalization expenses

The medical expenses incurred in the 90 days period immediately after you were discharged, provided that:

i. Such medical expenses were incurred for the same condition requiring earlier Hospitalisation, and;
ii. We have accepted the claim under In-Patient Hospitalisation expenses.

d. Day Care Treatment

We will pay you the medical expenses as listed above under In-patient Hospitalisation Expenses for Day care procedures / Surgeries taken as an inpatient in a hospital or day care centre but not in the outpatient department. List of Day Care Procedures is given in the annexure I of Policy wordings.

e. Modern Treatment Methods and Advancement in Technologies

Modern Treatment Methods and Advancement in Technologies are covered up to Base Sum Insured, subject to policy terms, conditions, coverages, waiting periods and exclusions.

i. Uterine Artery Embolization and HIFU
ii. Balloon Sinuplasty
iii. Deep Brain stimulation
iv. Oral chemotherapy
v. Immunotherapy- Monoclonal Antibody to be given as injection
vi. Intra vitreal injections
vii. Robotic surgeries
viii. Stereotactic radio surgeries
ix. Bronchical Thermoplasty
x. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
xi. IONM -(Intra Operative Neuro Monitoring)
xii. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

2. Maternity Expenses

We will pay the Medical Expenses related to pregnancy, childbirth or medically recommended and lawful termination of pregnancy, limited to maximum 2 deliveries or termination(s) or either, during the lifetime of the insured person as below:-.

i. We will cover the Medical expenses for maternity including complications of maternity over and above the aggregate deductible limit as specified under the policy schedule
ii. We will also cover expenses towards lawful medical termination of pregnancy during the Policy period.
iii. In patient Hospitalization Expenses of pre-natal and post-natal hospitalization
iv. Waiting Period of 12 months from the date of inception of the first Extra Care Plus Policy with us.

However this 12 months exclusion would not be applicable in case of continuous renewal of Extra Care Plus Policy without break in cover.

3. Ambulance Expenses

If a claim under Medical Expenses is accepted, We will also pay the ambulance expenses to a maximum of Rs3000/- per valid hospitalization claim for transferring You/ Your family member(s) named in the schedule to or between Hospitals in the Hospital's ambulance or in an ambulance provided by any ambulance service provider.

4. Organ Donor Expenses

We will pay for Medical treatment of the organ donor for harvesting the organ i.e. including surgery to remove organs from a donor provided that,

i. The organ donor is any person whose organ has been made available in accordance and in compliance with THE TRANSPLANTATION OF HUMAN ORGANS (AMENDMENT) BILL, 2011
ii. The organ donated is for the use of the Insured Person, and
iii. We have accepted an inpatient Hospitalisation claim for the insured member under medical expenses section

Specific exclusions applicable to Organ Donor Expenses

1. Claims which have NOT been admitted under Medical expenses section
2. Claims not in compliance with THE TRANSPLANTATION OF HUMAN ORGANS (AMENDMENT) BILL, 2011
3. The organ donors Pre and Post-Hospitalisation expenses.

Additional benefits (Additional benefits for which aggregate deductible is not applicable)

5. Free Medical Check-up

At the end of every continuous period of 3 years during which You have held Extra Care Plus policy with us, We will reimburse free medical checkup expenses as below

- The actual amount of medical checkup expenses up to Rs. 1000/- for policy covering 1 member.
- The actual amount of medical checkup expenses up to Rs. 2000/- for policies covering more than 1 member under the same policy.

For the avoidance of doubt, We shall only be liable for medical check-up expenses and any other cost incurred such as for transportation, accommodation, food or sustenance shall not be payable by us.

II. OPTIONAL COVER

1. Air Ambulance Cover

In consideration of payment of additional premium by the Insured to the Company and realization thereof by the Company, it is hereby agreed and declared that Extra Care Plus Policy is extended to pay the expenses incurred for ambulance transportation in an airplane or helicopter for rapid ambulance transportation from the site of first occurrence of the illness / accident to the nearest hospital during policy period which directly and independently of all other causes results in emergency life threatening health conditions provided such hospitalization claim is admissible under the Extra Care Plus Policy. The claim would be reimbursed up to the actual expenses subject to a maximum limit as specified under the Air Ambulance Cover in the Policy Schedule, subject otherwise to all other terms, conditions and Exclusions of the Policy.

Specific Conditions applicable to Air Ambulance Cover

i. Return transportation to the Insured's home by air ambulance is excluded.
ii. Such air ambulance should have been duly licensed to operate as such by competent authorities of the Government/s.
iii. Deductible will not be applied on the claim admissible under Air Ambulance cover

SECTION D EXCLUSIONS UNDER THE POLICY- STANDARD EXCLUSIONS

I. Waiting Period

1. Pre-existing Diseases waiting period (Excl01)
   a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first Extra Care Plus policy with us.
   b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
   d. Coverage under the policy after the expiry of 12 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. Specified disease/procedure waiting period- (Excl02)
   a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first Extra Care Plus policy with us. This exclusion shall not be applicable for claims arising due to an accident.
   b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
   d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
   e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
   f. List of specific diseases/procedures

1. Any types of gastric or duodenal ulcers,	11. Hernia of all types
2. Benign prostatic hypertrophy	12. Fistulae, Fissure in ano
3. All types of sinuses	13. Hydrocele
4. Haemorrhoids	14. Fibromyoma
5. Dysfunctional uterine bleeding	15. Hysterectomy
6. Endometriosis	16. Surgery for any skin ailment
7. Stones in the urinary and biliary systems	17. Surgery on all internal or external tumours/ cysts/ nodules/polyps of any kind including breast lumps with exception of Malignant tumor or growth.
8. Surgery on ears/tonsils/adenoids/paranasal sinuses	18. All Joint Replacement surgeries
9. Surgery for intervertebral disc disorders	19. Internal Congenital
10. Cataracts	

3. 30-day waiting period (Excl03)
    a. Expenses related to the treatment of any illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
    b. This exclusion shall not, however apply if the Insured has Continuous Coverage for more than twelve months.
    c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

II. General Exclusions

1. Investigation & Evaluation (Excl04)

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

2. Rest Cure, rehabilitation and respite care- (Excl05)

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
b. Any services for people who are terminally ill to address medical, physical, social, emotional and spiritual needs.

3. Obesity/Weight Control (Excl06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
    a. greater than or equal to 40 or
    b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
    i. Obesity-related cardiomyopathy
    ii. Coronary heart disease
    iii. Severe Sleep Apnea
    iv. Uncontrolled Type2 Diabetes

4. Change-of-gender treatments (Excl07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

5. Cosmetic or plastic Surgery (Excl08)

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

6. Hazardous or Adventure Sports (Excl09)

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

7. Breach of law (Excl10)

Expenses for treatment directly arising from or consequent upon any Insure Person committing or attempting to commit a breach of law with criminal intent.

8. Excluded Providers (Excl11)

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

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

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

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

12. Refractive Error (Excl15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

13. Unproven Treatments (Excl16)

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

14. Sterility and Infertility (Excl17)

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

SECTION D: EXCLUSIONS UNDER THE POLICY- SPECIFIC EXCLUSIONS

III. Waiting Period for Maternity Expenses

Any treatment arising from or traceable to pregnancy, child birth including cesarean section and/or any treatment related to pre and postnatal care and complications arising out of Pregnancy and Childbirth until 12 months continuous period has elapsed since the inception of the first Extra Care Plus with US. However this exclusion will not apply to Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending medical practitioner.

IV. General Exclusions

1. We are not liable for claim(s) amount falling within Aggregate Deductible limit as opted and mentioned on the policy schedule.
2. Any Medical Expenses of the new born baby
3. Dental treatment or surgery of any kind unless requiring hospitalisation and as a result of accidental Bodily Injury to natural teeth.
4. The cost of spectacles, contact lenses, hearing aids, crutches, artificial limbs, dentures, artificial teeth and all other external appliances and/or devices whether for diagnosis or treatment except for intrinsic fixtures used for orthopedic treatments such as plates and K-wires.
5. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority.
6. Circumcision unless required for the treatment of Illness or Accidental bodily injury, cosmetic or aesthetic treatments of any description, treatment or surgery for change of life/gender.
7. 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.
8. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol)
9. Vaccination or inoculation unless forming a part of post bite treatment or if medically necessary and forming a part of treatment recommended by the treating Medical practitioner.
10. All non-medical Items as per Annexure II
11. Any treatment received outside India is not covered under this Policy.
12. Treatment for any other system other than modern medicine (also known as Allopathy)
13. Venereal disease or any sexually transmitted disease or sickness.
14. Congenital external diseases or defects or anomalies, growth hormone therapy, stem cell implantation or surgery except for Hematopoietic stem cells for bone marrow transplant for haematological conditions

SECTION E: GENERAL TERMS AND CLAUSES - STANDARD GENERAL TERMS AND CLAUSES

1. Disclosure of information

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

2. Condition Precedent to Admission of Liability

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

3. Complete Discharge

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

4. Premium Payment in Instalments (Wherever applicable)

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

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

5. Claim Settlement. (provision for Penal interest)

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

6. Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/ she wants to claim the balance amount.
iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

7. Moratorium Period:

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

8. Renewal of Policy

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

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

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

10. Migration
The Insured beneficiary will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the Insured beneficiary will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/Circulars_List.aspx?mid=3.2.3

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

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

Cancellation grid for premium received on annual & long term basis and refund is as under

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

Note:

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

For monthly/quarterly premium modes, no premium is refunded. For half yearly premium payment mode, the premium will be refunded as per the below table:

Period in Risk (From Latest instalment date)	Premium Refund Pro Rate
	% of Half Yearly Premium
Exceeding 15 days but less than or equal to 3 months	30%
Exceeding 3 months but less than or equal to 6 months	0%

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

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

13. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

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

14. Nomination

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

15. Portability

The Insured beneficiary will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed. Insured beneficiary will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/Circulars_List.aspx?mid=3.2.3

16. Fraud

i. If any claim made by the Insured beneficiary, 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 beneficiary or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.
ii. Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.
iii. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured beneficiary or by his agent or the hospital/ doctor/any other party acting on behalf of the Insured beneficiary, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
   a. the suggestion, as a fact of that which is not true and which the Insured beneficiary does not believe to be true;
   b. the active concealment of a fact by the Insured beneficiary having knowledge or belief of the fact;
   c. any other act fitted to deceive; and
   d. any such actor omission as the law specially declares to be fraudulent

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

17. Grievance Redressal Procedure

The company has always been known as a forward-looking customer centric organization. It takes immense pride in its approach of "Caringly Yours". To provide you with top-notch service on all fronts, the company has provided with multiple platforms via which you can always reach out to us at below mentioned touch points

1. Our toll-free number 1-800-209- 5858 or 020-30305858, say Say "Hi" on WhatsApp on +91 7507245858
2. Branches for resolution of your grievances / complaints, the Branch details can be found on our website www.bajajallianz.com/branchlocator.html
3. Register your grievances / complaints on our website www.bajajallianz.com/about-us/customer-service.html
4. E-mail
   a. Level 1: bagichelp@bajajallianz.co.in and for senior citizens to seniorcitizen@bajajallianz.co.in
   b. Level 2: In case you are not satisfied with the response given to you at Level 1 you may write to our Grievance Redressal Officer at ggro@bajajallianz.co.in
   c. Level 3: If in case, your grievance is still not resolved, and you wish to talk to our care specialist, please give a missed call on +91 80809 45060 OR SMS To 575758 and our care specialist will call you back.

5. If you are still not satisfied with the decision of the Insurance Company, you may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. Detailed process along with list of Ombudsman offices are available at www.cioins.co.in/ombudsman.html
   The contact details of the Ombudsman offices are mentioned in Annexure III

SECTION E: GENERAL TERMS AND CLAUSES - SPECIFIC TERMS AND CLAUSES

18. Paying a Claim

i. You agree that We need only make payment when You or someone claiming on Your behalf has provided Us with necessary documentation and information.
ii. We will make payment to You or Your Nominee. If there is no Nominee and You are incapacitated or deceased, We will pay Your heir, executor or validly appointed legal representative and any payment We make in this way will be a complete and final discharge of Our liability to make payment.

19. Basis of Claims Payment

i. If You suffer a relapse within 45 days of the date when You last obtained medical treatment or consulted a Doctor and for which a claim has been made, then such relapse shall be deemed to be part of the same claim.
ii. We shall not make any payment to You for any period of hospitalisation of less than 24 hours, except for the Day Care Procedures.
iii. We shall make payment in Indian Rupees only.Notwithstanding what is mentioned in clause 7 of SECTION E) GENERAL TERMS AND CLAUSES - STANDARD GENERAL TERMS AND CLAUSES or any other clauses of this Policy:
   a. In-patient Treatment for Mental Illness shall be covered up to Base Sum Insured subject to Policy Terms, Conditions, coverages, Waiting Period and exclusions.
   b. Listed Modern Treatment Methods and Advancement in Technologies (as specified in clause I of SECTION B: DEFINITIONS - SPECIFIC DEFINITIONS and (I)(1)(e) of SECTION C: OPERATIVE PARTS shall be covered up to Base Sum Insured, subject to Policy Terms, Conditions, coverages, Waiting Period and exclusions.

20. Arbitration and Reconciliation

i. If any dispute or difference shall arise as to the quantum of claim to be paid under this Policy (liability/claim being otherwise admitted by the Insurers), such difference shall independently of all other question be referred to the decision of a sole arbitrator to be appointed in writing by the Insurer and the Insured who has made claim under this Policy or if they cannot agree upon a single arbitrator within 30 days of any party [the Insurer or the and the Insured who has made claim under this Policy] invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators one to be appointed by the Insured who has made claim under this Policy and the Insurer, respectively, who are the parties to the dispute/ difference and the third arbitrator to be appointed by such two appointed arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996 as amended from time to time. The law of the arbitration will be Indian law.
ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided if the Insurers has disputed or not accepted/ admitted the liability/claim under the Policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit read with this Policy that the award by such arbitrator/ arbitrators of the amount of the Loss or damage shall be first obtained.
iv. It is also hereby further expressly agreed and declared that if the Insurers shall disclaim/repudiate the liability to the Insured for any claim under the Policy, and such claim shall not, within 12 calendar months from the date of such disclaimer/repudiation have been made the subject matter of a suit in a court of law, then all benefits/ indemnities under the Policy shall be forfeited and the rights of Insured shall stand extinguished and the liability of the Insurers shall also stand discharged.
v. The seat of the arbitration shall be Pune. This condition remains valid, should the Policy become void.
vi. In the event that these arbitration provisions shall be held to be invalid then all such disputes or differences shall be referred to the exclusive jurisdiction of the Indian Courts subject to other Terms and Conditions of this Policy.

21. Sum Insured Enhancement:

i. The Insured member can apply for enhancement of Sum Insured at the time of renewal only. You can apply for enhancement of Sum Insured by submitting a fresh proposal form to the company. No midterm enhancement of Sum Insured during the currency of policy shall be allowed.
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 of the policy.
iii. All waiting periods as defined in the Policy shall apply for this enhanced Sum Insured limit from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

22. Insured

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

23. Communications

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

24. Consideration

The Policy is issued subject to payment of premium in advance. No payment shall be valid unless made under our official receipt. The cover shall not be valid prior to the date and time of receipt of premium.

25. Endorsements

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

26. Discounts

i. Long Term Policy Discount
   a. 4 % discount is applicable if policy is opted for 2 years
   b. 8 % discount is applicable if policy is opted for 3 years

Note: This will not apply to policies where premium is paid in installments.

ii. Employee Discount
20 % Discount applicable for policies issued to employees of Bajaj Allianz General Insurance Limited & its group companies.

27. Territorial Limits & Governing Law

a. We cover insured events arising during the Policy Period for treatment availed within India only. Our liability to make any payment shall be to make payment within India and in Indian Rupees only.
b. The Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by Us, which approval shall be evidenced by an endorsement on the Schedule.
c. The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law. The section headings of this Policy are included for descriptive purposes only and do not form part of this Policy for the purpose of its construction or interpretation.

28. Applicable Law

Indian law governs the construction, interpretation and meaning of the provisions of this Policy and the relationship between us. The section headings in this Policy are included for descriptive purposes only and do not form part of this Policy for the purpose of its construction or interpretation.

29. Policy Disputes

Any dispute concerning the interpretation of the terms, 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. Each party agrees to submit such dispute to a Court of competent jurisdiction and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court.

SECTION E: GENERAL TERMS AND CLAUSES – OTHER TERMS AND CLAUSES

30. Claims Procedure

All Claims will be settled by In House claims settlement team of the Company and TPA is engaged.
If You meet with any Accidental Bodily Injury or suffer an Illness that may result in a claim, then as a condition precedent to Our liability, You must comply with the following:

a. Cashless Claims Procedure
Cashless treatment is only available at a Network Hospital. In order to avail cashless treatment, the following procedure must be followed by You.

i. Prior to taking treatment and/or incurring Medical Expenses at a Network Hospital, You must call Us and request pre- authorization by way of the written form We will provide. Waiver of this condition shall be considered in case of emergency hospitalisation arising out of accidental bodily injury. In the event of
   - Planned Hospitalization- Insured member should intimate such admission at least 72 hours prior to the planned admission.
   - Emergency Hospitalization- the Insured member or his representative should intimate such admission within 24 hours of such admission.

ii. After considering Your request and after obtaining any further information or documentation we have sought, We may if satisfied send You or the Network Hospital, a pre- authorization letter. The pre- authorization letter, the ID card issued to You along with this Policy and any other information or documentation that We have specified must be produced to the Network Hospital identified in the pre-authorization letter at the time of Your admission to the same.
iii. If the procedure above is followed, You will not be required to directly pay for the Medical Expenses above the Aggregate deductible in the Network Hospital that We are liable to indemnify under the policy and the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital. Preauthorization does not guarantee that all costs and expenses will be covered. We reserve the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy. You shall, in any event, be required to settle all other expenses directly.

b. Reimbursement Claim Procedure
If pre-authorization under Cashless Claims Procedure mentioned above is denied by Us or if treatment is taken in a Hospital other than a Network Hospital or if You do not wish to avail cashless facility, then following procedure must be followed by You:
i. You or someone claiming on Your behalf must inform Us in writing immediately within 48 hours of hospitalization in case of emergency hospitalization and 48 hours prior to hospitalization in case of planned hospitalization

ii. You must immediately consult a Doctor and follow the advice and treatment that he recommends

iii. You must take steps or measure to minimize the quantum of any claim that may be made under this Policy.
iv. You must have Yourself examined by Our medical advisors if We ask for this, at the Our cost.
v. You or someone claiming on Your behalf must promptly and in any event within 30 days of discharge from a Hospital give Us the documentation.
vi. In the event of the death of the insured person, someone claiming on his behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if conducted) within 30 days.
vii. We shall make claim payment in Indian Rupees only.
viii. In event of a claim, the original documents to be submitted & after the completion of the claims assessment process the original documents may be returned if requested by the insured in writing, however we will retain the Photocopies of the claim documents.

Note: Waiver of conditions (i), (v) and (vi) may be considered where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible from him or any other person to give notice or file claim within the prescribed time limit.

*Note: In case You are claiming for the same event under an indemnity based policy of other insurer and it is required to submit the original documents related to Your treatment with that particular insurer, then You may provide Us with the attested Photocopies of such documents along with a declaration from the particular insurer specifying the availability of the original copies of the specified treatment documents with it.

Documents to be submitted for Claims

1. First Consultation letter from the Doctor
2. Duly completed claim form and NEFT Form signed by the Claimant
3. Original Hospital Discharge Card
4. Original Hospital Bill giving detailed break up of all expense heads mentioned in the bill. Clear break ups have to be mentioned for OT Charges, Doctor's Consultation and Visit Charges, OT Consumables, Transfusions, Room Rent, etc.
5. Original Money Receipt, duly signed with a Revenue Stamp
6. All original Laboratory and Diagnostic Test Reports. E.g. X-Ray, E.C.G, USG, MRI Scan, Haemogram etc.
7. In case of a Cataract Operation, IOL Sticker will have to be enclosed
8. Claim decision letter from the other insurer in case of partial settlement
9. In cases where a fraud is suspected, we may call for any additional document(s) in addition to the documents listed above

List of Claim Document Specific to Air Ambulance Cover (if Opted)

1. Duly completed claim form signed by the Claimant
2. Original bills and receipts paid for the transportation from Registered Ambulance Service Provider
3. In cases where a fraud is suspected, we may call for any additional document(s) in addition to the documents listed above. All documents related to claims should be submitted to:

Health Administration Team
Bajaj Allianz General Insurance Company Ltd 2nd Floor, Bajaj Finserv Building,
Behind Weikfield IT park,
Off Nagar Road, Viman Nagar
Pune 411014| Toll free: 1800-209-5858/1800-209-0144

Annexure I

List of Day Care Procedures:

1.	Suturing - CLW -under LA or GA	66.	Incision and excision of tissue in the perianal region
2.	Surgical debridement of wound	67.	Surgical treatment of anal fistula
3.	Therapeutic Ascitic Tapping	68.	Surgical treatment of hemorrhoids
4.	Therapeutic Pleural Tapping	69.	Sphincterotomy/Fissurectomy
5.	Therapeutic Joint Aspiration	70.	Laparoscopic appendicectomy
6.	Aspiration of an internal abscess under ultrasound guidance	71.	Laparoscopic cholecystectomy
7.	Aspiration of hematoma	72.	TURP (Resection prostate)
8.	Incision and Drainage	73.	Varicose vein stripping or ligation
9.	Endoscopic Foreign Body Removal - Trachea/- pharynx-larynx/bronchus	74.	Excision of dupuytren's contracture
10.	Endoscopic Foreign Body Removal -Oesophagus/stomach /rectum.	75.	Carpal tunnel decompression
11.	True cut Biopsy - breast/- liver/- kidney-Lymph Node/-Pleura/-lung/-Muscle biopsy/-Nerve biopsy/Synovial biopsy/-Bonetrephine biopsy/-Pericardial biopsy	76.	Excision of granuloma

EXTRA CARE PLUS

12. Endoscopic ligation/banding	77. Arthroscopic therapy
13. Sclerotherapy	78. Surgery for ligament tear
14. Dilatation of digestive tract strictures	79. Surgery for meniscus tear
15. Endoscopic ultrasonography and biopsy	80. Surgery for hemoarthrosis/pyoarthrosis
16. Nissen fundoplication for Hiatus Hernia /Gastro esophageal reflux disease	81. Removal of fracture pins/nails
17. Endoscopic placement/removal of stents	82. Removal of metal wire
18. Endoscopic Gastrostomy	83. Incision of bone, septic and aseptic
19. Replacement of Gastrostomy tube	84. Closed reduction on fracture, luxation or epiphyseolysis with osetosynthesis
20. Endoscopic polypectomy	85. Suture and other operations on tendons and tendon sheath
21. Endoscopic decompression of colon	86. Reduction of dislocation under GA
22. Therapeutic ERCP	87. Cataract surgery
23. Brochoscopic treatment of bleeding lesion	88. Excision of lachrymal cyst
24. Brochoscopic treatment of fistula /stenting	89. Excision of pterigium
25. Bronchoalveolar lavage & biopsy	90. Glaucoma Surgery
26. Tonsillectomy without Adenoidectomy	91. Surgery for retinal detachment
27. Tonsillectomy with Adenoidectomy	92. Chalazion removal (Eye)
28. Excision and destruction of lingual tonsil	93. Incision of lachrymal glands
29. Foreign body removal from nose	94. Incision of diseased eye lids
30. Myringotomy	95. Excision of eye lid granuloma
31. Myringotomy with Grommet insertion	96. Operation on canthus & epicanthus
32. Myringoplasty /Tympanoplasty	97. Corrective surgery for entropion&ectropion
33. Antral wash under LA	98. Corrective surgery for blepharoptosis
34. Quinsy drainage	99. Foreign body removal from conjunctiva
35. Direct Laryngoscopy with or w/o biopsy	100. Foreign body removal from cornea
36. Reduction of nasal fracture	101. Incision of cornea
37. Mastoidectomy	102. Foreign body removal from lens of the eye
38. Removal of tympanic drain	103. Foreign body removal from posterior chamber of eye
39. Reconstruction of middle ear	104. Foreign body removal from orbit and eye ball
40. Incision of mastoid process & middle ear	105. Excision of breast lump /Fibro adenoma
41. Excision of nose granuloma	106. Operations on the nipple
42. Blood transfusion for recipient	107. Incision/Drainage of breast abscess
43. Therapeutic Phlebotomy	108. Incision of pilonidal sinus
44. Haemodialysis/Peritoneal Dialysis	109. Local excision of diseased tissue of skin and subcutaneous tissue
45. Chemotherapy	110. Simple restoration of surface continuity of the skin and subcutaneous tissue
46. Radiotherapy	111. Free skin transportation, donor site
47. Coronary Angioplasty (PTCA)	112. Free skin transportation recipient site
48. Pericardiocentesis	113. Revision of skin plasty
49. Insertion of filter in inferior vena cava	114. Destruction of the diseases tissue of the skin and subcutaneous tissue
50. Insertion of gel foam in artery or vein	115. Incision, excision, destruction of the diseased tissue of the tongue

51. Carotid angioplasty	116. Glossectomy
52. Renal angioplasty	117. Reconstruction of the tongue
53. Tumor embolisation	118. Incision and lancing of the salivary gland and a salivary duct
54. TIPS procedure for portal hypertension	119. Resection of a salivary duct
55. Endoscopic Drainage of Pseudopancreatic cyst	120. Reconstruction of a salivary gland and a salivary duct
56. Lithotripsy	121. External incision and drainage in the region of the mouth, jaw and face
57. PCNS (Percutaneous nephrostomy)	122. Incision of hard and soft palate
58. PCNL (percutaneous nephrolithotomy)	123. Excision and destruction of the diseased hard and soft palate
59. Suprapubiccytostomy	124. Incision, excision and destruction in the mouth
60. Tran urethral resection of bladder tumor	125. Surgery to the floor of mouth
61. Hydrocele surgery	126. Palatoplasty
62. Epididymectomy	127. Transoral incision and drainage of pharyngeal abscess
63. Orchidectomy	128. Dilatation and curettage
64. Herniorrhaphy	129. Myomectomies
65. Hernioplasty	130. Simple Oophorectomies

Note:

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

ii. The standard exclusions and waiting periods are applicable to all of the above procedures depending on the medical condition/disease under treatment. Only 24 hours hospitalization is not mandatory

Annexure II:

List I: List of Non-Medical Items

SL No	Item	
1	BABY FOOD	Not Payable
2	BABY UTILITIES CHARGES	Not Payable
3	BEAUTY SERVICES	Not Payable
4	BELTS/ BRACES	Not Payable
5	BUDS	Not Payable
6	COLD PACK/HOT PACK	Not Payable
7	CARRY BAGS	Not Payable
8	EMAIL I INTERNET CHARGES	Not Payable
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
10	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
11	LAUNDRY CHARGES	Not Payable
12	MINERAL WATER	Not Payable
13	SANITARY PAD	Not Payable
14	TELEPHONE CHARGES	Not Payable

EXTRA CARE PLUS

15	GUEST SERVICES	Not Payable
16	CREPE BANDAGE	Not Payable
17	DIAPER OF ANY TYPE	Not Payable
18	EYELET COLLAR	Not Payable
19	SLINGS	Not Payable
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Not Payable
21	SERVICE CHARGES WHERE NURSING CHARGES ALSO CHARGED	Not Payable
22	Television Charges	Not Payable
23	SURCHA RGES	Not Payable
24	ATTENDANT CHARGES	Not Payable
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Not Payable
26	BIRTH CERTIFICATE	Not Payable
27	CERTIFICATE CHARGES	Not Payable
28	COURIER CHARGES	Not Payable
29	CONVEYANCE CHARGES	Not Payable
30	MEDICAL CERTIFICATE	Not Payable
31	MEDICAL RECORDS	Not Payable
32	PHOTOCOPIES CHARGES	Not Payable
33	MORTUARY CHARGES	Not Payable
34	WALKING AIDS CHARGES	Not Payable
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
36	SPACER	Not Payable
37	SPIROMETRE	Not Payable
38	NEBULIZER KIT	Not Payable
39	STEAM INHALER	Not Payable
40	ARMSLING	Not Payable
41	THERMOMETER	Not Payable
42	CERVICAL COLLAR	Not Payable
43	SPLINT	Not Payable
44	DIABETIC FOOT WEAR	Not Payable
45	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
46	KNEE IMMOBILIZER/S HOULDER IMMOBILIZER	Not Payable
47	LUMBOSACRAL BELT	Not Payable
48	NIMBUS BED OR WATER OR AIR BED CHARGES	Not Payable
49	AMBULANCE COLLAR	Not Payable
50	AMBULANCE EQUIPMENT	Not Payable
51	ABDOMINAL BINDER	Not Payable
52	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES	Not Payable
53	SUGAR FREE Tablets	Not Payable
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Not Payable
55	ECG ELECTRODES	Not Payable
56	GLOVES	Not Payable
57	NEBULISATION KIT	Not Payable
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable

59	KIDNEY TRAY	Not Payable
60	MASK	Not Payable
61	OUNCE GLASS	Not Payable
62	OXYGEN MASK	Not Payable
63	PELVIC TRACTION BELT	Not Payable
64	PAN CAN	Not Payable
65	TROLLY COVER	Not Payable
66	UROMETER , URINE JUG	Not Payable
68	VASOFIX SAFETY	Not Payable

List II

Items that are to be subsumed into Room Charges

S. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED /INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CARDLE CHARGES
6	COMB
7	EAU-DE-COLOGNE/ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINEFCTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES/ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCTDENTAL EXPENSES / MtSC. CHARGES (NOT EXPLATNED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

EXTRA CARE PLUS

List III

Items that are to be subsumed into Procedure Charges

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

List IV

Items that are to be subsumed into costs of treatment

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

16	SCRUB SOLUTION / STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Annexure III:

Contact details of the Ombudsman offices

Office Details	Jurisdiction of Office Union Territory,District)
AHMEDABAD - Insurance Ombudsman 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@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU - Insurance Ombudsman 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@cioins.co.in	Karnataka.
BHOPAL - Insurance Ombudsman 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 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR – Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH - Insurance Ombudsman 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 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
CHENNAI - Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry)

EXTRA CARE PLUS

Office Details	Jurisdiction of Office Union Territory,District)
DELHI – Insurance Ombudsman 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@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Insurance Ombudsman 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 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM – Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA – Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW – Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar..

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Office Details	Jurisdiction of Office Union Territory,District)
MUMBAI - Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
NOIDA - Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA – Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE - Insurance Ombudsman 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@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

"List of Ombudsman offices established by the Central Government for redressal of grievance are also available at https://www.cioins.co.in/Ombudsman"