Arogya Sanjeevani Policy, Bajaj Allianz General Insurance Company Limited
Policy Wordings

1. PREAMBLE

This Group Policy is a contract of insurance issued by Bajaj Allianz Insurance Co. Ltd. (hereinafter called the 'Company' or "Insurer" or "Insurance Company " or" Us" or "Our") to the Proposer/Insured mentioned in the Group Policy Schedule (herein after called the 'Insured' or "Policy Holder" or "Insured" or "Group Manager") to cover the person(s) named in the Certificate of Insurance (herein after called the 'Insured Beneficiary/ Insured Beneficiary/ies). The Group Policy is based on the statements and declaration provided in the Proposal Form/ or Proposal as mentioned in the transcript of the Proposal of Insured or as per MOU signed by Group Manager with the Insurer, and is subject to receipt of the requisite premium. The COI is based on the statements and declaration provided in the Proposal Form/ or Proposal as mentioned in the transcript of the Proposal of Insured signed by Insured Beneficiary with the Insurer or as per details provided by Group Manager, and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

If during the Cover Period one or more Insured Beneficiary/ies is required to be Hospitalised for treatment of an Illness or Injury at a Hospital/ Day Care Center, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically Necessary expenses towards the Coverage mentioned in the Certificate of Insurance read with the Group Policy.
Provided further that, any amount payable under the Certificate of Insurance shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) specified in the Certificate of Insurance.

Types of Certificate of Insurance:
"Arogya Sanjeevani Policy, Bajaj Allianz General Insurance Company Limited (Group) -Individual"
"Arogya Sanjeevani Policy, Bajaj Allianz General Insurance Company Limited (Group)-Family Floater"
Tenure of Certificate of Insurance:
"Arogya Sanjeevani Policy, Bajaj Allianz General Insurance Company Limited (Group)-Individual": 1year
"Arogya Sanjeevani Policy, Bajaj Allianz General Insurance Company Limited (Group)-Family Floater": 1year

3. DEFINITIONS

The terms defined below and at other junctures in the Group Policy or Certificate of Insurance shall have the meanings ascribed to them wherever they appear in this Group Policy or Certificate of Insurance and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

3.1. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

3.2. **Age** means age of the Insured Beneficiary on last birthday as on date of commencement of the Certificate of Insurance.

3.3. **AnyOne** Illnessmeanscontinuousperiodofillnessanditincludesrelapsewithinfortyfivedaysfromthedateoflastconsultationwith the Hospital where treatment has been taken.

3.4. **AYUSH Treatment** refers to Hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

3.5. **AYUSH Hospital** is a healthcare facility where in 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 the following criterion:
   i. Having at least 5in-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 tobe carried out;
   iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3.6. **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 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 daycare 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; Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3.7. **Break in Policy** means the period of gap that occurs at the end of the existing Cover Period, when the premium due for renewal on a given Certificate of Insurance is not paid on or before the premium renewal date or within 30 days thereof

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

3.9. **Certificate of Insurance ["COI"]** means the document issued by the Company/Insurer to the Insured Beneficiary under the Terms and Conditions of Master Policy/Group Policy detailing the Group Policy Number, Certificate of Insurance number, the Cover Period with the commencement date and end/expiry date of the cover, Insured Beneficiary's name, address, coverage, benefits, Sum Insured, Deductible, condition(s), exclusions and or endorsement(s), and the terms and conditions of the coverage. Pro- vided however if there is any contradiction between what is stated in the wordings attached to Certificate of Insurance and these Group Policy Wordings, then these Group Policy Wordings shall prevail.

3.10. **Condition Precedent** means a Certificate of Insurance term or condition upon which the Company's liability under the Certificate of Insurance read with Group Policy is conditional upon.

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

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

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

3.12. **Co-payment** means a cost sharing requirement under a health insurance policy/Certificate of Insurance that provides that the Insured Beneficiary will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

3.13. **Cover Period**: means period as specified in the respective Certificate of Insurance issued to the Insured Beneficiary during which he/ she is insured as per Terms and Conditions of Certificate of Insurance read with the Master Policy/Group Policy.

3.14. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium .

3.15. **Day Care Centre** means any institution established for daycare treatment of disease/injuries or a medical setup within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

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 shall make these accessible to the Company's authorized personnel.

3.16. **Day Care Treatment** means medical treatment, and/or surgical procedure (as listed in Annexure I) which is:

i. undertaken under general or local anesthesia in a Hospital/day care centre in less than twenty four hours because of technological advancement, and

ii. which would have otherwise required a Hospitalisation of more than twentyfour hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

3.17. **Dental Treatment** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

3.18. **Disclosure to information norm**: The Certificate of Insurance 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.

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

3.20. **Family** means, the Family that consists of the Insured Beneficiary and any one or more of the family members as mentioned below:

i. legally wedded spouse.
ii. Parents and Parents-in-law .
iii. Dependent Children (i.e. natural or legally adopted) between the age 3monthsto 25 years. If the child above 18 years is financially independent, he/she shall be ineligible for coverage in the subsequent renewals.

3.21. **Grace Period**

Grace period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre- existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

3.22. **Group** The definition of a group as per the provisions of Insurance Regulatory and Development Authority of India (Health Insurance) Regulations, 2016, read with group guidelines issued by IRDAI vide circular No. 015/IRDA/Life/Circular/GI Guide- lines/2005 dated 14th July 2005, as amended/modified/further guidelines issued, from time to time.

3.23. **Group Policy or Master Policy** the Proposal//transcript of proposal for Certificate of Insurance, the Group Policy Schedule/AROGYA SANJEEVANI POLICY, BAJAJ ALLIANZ GENERAL INSURANCE COMPANY LIMITED (GROUP) Group Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof either on the effective date or during the Group Policy Period along with these Terms and Conditions, and the Proposal, declaration, of the insurance coverage and exclusions and copay and deductible and under which Certificates of Insurance will be issued to the Insured Beneficiary/ies, either on the Risk Inception Date of Group Policy Schedule or during the Group Policy Period. The validity of the Master Policy shall be for a period of twelve months as mentioned in the Group Policy Schedule.

3.24. **Group Policy Holder/Group Manager/Proposer/Group Administered or "Insured"** is the Organization or Legal Entity [whose name is mentioned in Group Policy Schedule] which has taken the Group Policy on behalf of all Insured Beneficiaries.

3.25. **Group/Master Policy Period** means the date between the commencement date specified in the Master Policy Schedule or Group Policy Schedule with Risk Inception Date to Risk Expiry Date.

3.26. **Group Policy Period** means period of one year as mentioned in the respective Group Policy Schedule issued by the Insurer to Group Manager during which Certificate of Insurance will be issued to Insured Beneficiary/ies.

3.27. **Group Policy Schedule** means the Group Policy Schedule and any annexure to it read with endorsements, if any, read with respective Certificate of Insurance which are forming part of the Group Policy.

3.28. **Group Policy** means these Group Policy wordings, the Group Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Group Policy contains details of the extent of cover available to the Insured Beneficiary, what is excluded from the cover and the Terms& Conditions on which the Group Policy is issued to the Insured Beneficiary.

3.29. **Hospital** means any institution established for in-patient care and day care treatment of disease/ 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 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 ten inpatient beds, in those towns having a population of less than ten lacs and fifteen inpatient 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 shall make these accessible to the Company's authorized personnel.

3.30. **Hospitalisation** means admission in a Hospital for a minimum period of twenty four (24) consecutive 'In-patient care' hours except for specified procedures/treatments, where such admission could be for a period of less than twenty four(24) consecutive hours.

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

i. Acute Condition means a disease, illness or injury that is likely to response 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.
ii. Chronic Condition means a disease, illness, or injury that has one or more of the following characteristics
a. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
b. it needs ongoing or long-term control or relief of symptoms
c. it requires rehabilitation for the patient or for the patient to be special trained to cope withit
d. it continues indefinitely
e. it recurs or is likely to recur

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

3.33. **In-Patient Care** means treatment for which the Insured Beneficiary has to stay in a Hospital for more than 24 hours for a covered event.

3.34. **"Insured Member/s" or "Insured Beneficiary/ies" "Group Member/s"** means individual persons for whom the Group Policy Holder has taken the Group Insurance Group Policy basis which Certificate of Insurance is issued by the Company to the Insured Beneficiary/ Insured Member.

3.35. **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 acritical 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.

3.36. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis 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.

3.37. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

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

3.39. **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 setup by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the license.

3.40. **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 illness or injury suffered by the Insured Beneficiary;
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. mustconformtotheprofessionalstandardswidelyacceptedininternationalmedicalpracticeorbythemedicalcommunityinIndia.

3.41. **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.

3.42. **Network Provider** means hospitals enlisted by Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured Beneficiary by a cashless facility.

3.43. **Non- Network Provider** means any Hospital that is not part of the network.

3.44. **Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

3.45. **Out-Patient (OPD) Treatment** means treatment in which the Insured Beneficiary 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 Beneficiary is not admitted as a day care or inpatient.

3.46. **Pre-Existing Disease (PED)** means any condition, ailment or injury or disease
- a. That is/are diagnosed by a physician within 36 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 36 months prior to the effective date of the Certificate of Insurance issued by the Insurer or its reinstatement.

3.47. **Pre-Hospitalisation Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the Hospitalisation of the Insured Beneficiary, provided that:
- i. Such Medical Expenses are incurred for the same condition for which the Insured Beneficiary's Hospitalisation was required, and
- ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

3.48. **Post-Hospitalisation Medical Expenses** means medical expenses incurred during predefined number of days immediately after the Insured Beneficiary is discharged from the Hospital provided that:
- i. Such Medical Expenses are for the same condition for which the Insured Beneficiary's Hospitalisation was required, and
- ii. The inpatient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

3.49. **Policy Year** means a period of twelve months beginning from the date of commencement of the Cover Period and ending on the last day of such twelve month period. For the purpose of subsequent years, Policy Year shall mean a period of twelve months commencing from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Cover Period, as mentioned in the Certificate of Insurance.

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

3.51. **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.

3.52. **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.

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

3.54. **Sub-limit** means a cost sharing requirement under a health insurance Policy in which an insurer would not be liable to pay any amount in excess of the predefined limit.

3.55. **Sum Insured** means the pre-defined limit specified in the Certificate of Insurance. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Certificate of Insurance, in respect of that Insured Beneficiary(on Individual basis) or all Insured Beneficiary/ies (on Floater basis)during the Policy Year

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

3.57. **Third Party Administrator (TPA)** means a Company registered with the Authority, and engaged by an Insurer, for a fee or remuneration, by whatever name called and as may be mentioned in the agreement, for providing health services.

3.58. **Waiting Period** means a period from the inception of Cover Period under Certificate of Insurance during which specified diseases/ treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Certificate of Insurance has been continuously renewed without any break.

4. COVERAGE

The covers listed below are in-built benefits under Certificate of Insurance and shall be available to all Insured Beneficiary/ies in accordance with the procedures set out in this Group Policy.

4.1. Hospitalization

The Company shall indemnify Medical Expense incurred for Hospitalization of the Insured Beneficiary during the Policy Year, upto the Sum Insured and Cumulative Bonus specified in the Certificate of Insurance, for,
- i. Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital/Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.
- ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of the sum insured subject to maximum of Rs.10,000/- , per day.
- iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating Medical Practitioner or to the Hospital.
- iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

4.1.1 Other Expenses
- i. Expenses incurred on treatment of cataract subject to the sublimit stated in Coverage 4.3
- ii. Dental treatment, necessitated due to disease or an injury
- iii. Plastic surgery necessitated due to disease or injury
- iv. All Day Care Treatments
- v. Expenses incurred on road ambulance subject to a maximum of Rs.2000/- per Hospitalisation.

Note:
1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment
2. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, there imbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

4.2. AYUSH Treatment

The Company shall indemnify Medical Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems of medicines during each Policy Yearupto the limit of Sum Insured as specified in the Certificate of Insurance in any AYUSH Hospital.

4.3. Cataract Treatment
The Company shall indemnify Medical Expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs.40,000/-,which ever is lower, per each eye in one Policy Year.

4.4. Pre-Hospitalization
The Company shall indemnify Pre-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, forafixedperiodof30dayspriortothedateofadmissibleHospitalizationcoveredundertheCertificateofInsurance.

4.5. Post Hospitalisation
The Company shall indemnify Post Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 60 days from the date of discharge from the Hospital, following an admissible Hospitalization covered under the Certificate of Insurance.

4.6. The following procedures will be covered (wherever medically indicated) either as In-patient or as part of day care treatment in a Hospital upto 50% of Sum Insured, specified in the Certificate of Insurance, during the Cover Period:

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

The expenses that are not covered in this Policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed intoroomcharges,orprocedurechargesorcostsoftreatmentareplacedunderList-II,List-IIIandList–IVofAnnexure-Arespectively.

5. Cumulative Bonus (CB)

Cumulative Bonus will be increased by 5% in respect of each claim free Policy Year (no claims are reported), provided the Certificate of Insurance is renewed with the company without a break subject to maximum of 50% of the sum insured under the current Policy Year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However sum insured will be maintained and will not be reduced in the Policy Year.

Notes:

i. In case where the Policy is on individual basis, the CB shall be added and available individually to the Insured Beneficiary if no claim has been reported. CB shall reduce only in case of claim from the same Insured Beneficiary.
ii. In case where the Policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Beneficiary/ies.
iii. CB shall be available only if the Certificate of Insurance is renewed/premium paid within the Grace Period.
iv. If the Insured Beneficiary/ies in the expiring policy are covered on an Individual basis as specified in the Certificate of Insurance and there is an accumulated CB for such Insured Beneficiary under the expiring policy, and such expiring policy has been renewed on a floater policy basis as specified in the Certificate of Insurance then the CB to be carried forward for credit in such Renewed Certificate of Insurance shall be the one that is applicable to the lowest among all the Insured Beneficiary/ies.
v. In case of floater policies where Insured Beneficiary/ies renew their expiring policy by splitting the Sum Insured into two or more floater policies/individual policies or in cases where the Policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Certificate of Insurance.
vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Certificate of Insurance.
vii. If the Sum Insured under the Certificate of Insurance has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

6. Waiting Period

The Company shall not be liable to make any payment under the Policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

6.1. Pre-Existing Diseases (Code- Excl01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first 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 Beneficiary 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 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

6.2. First Thirty Days Waiting Period (Code- Excl03)

i. 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.

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

6.3. Specific Waiting Period: (Code- Excl02)

a. Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage, as may be the case after the date of inception of the first policy with the Insurer. 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. Ifanyofthespecifieddisease/procedurefallsunderthewaitingperiodspecifiedforpre-existingdiseases,thenthelongerofthetwo 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 Beneficiary 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.

i. 24 Months waiting period	
Benign ENT disorders	Gout and Rheumatism
Tonsillectomy	Hernia of all types
Adenoidectomy	Hydrocele
Mastoidectomy	Non Infective Arthritis
Tympanoplasty	Piles, Fissures and Fistula in anus
Hysterectomy	Pilonidal sinus, Sinusitis and related disorders
All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps	Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
Benign prostate hypertrophy	Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
Cataract and age related eye ailments	Varicose Veins and Varicose Ulcers
Gastric/ Duodenal Ulcer	Internal Congenital Anomalies
ii. 36 Months waiting period	
Treatment for joint replacement unless arising from accident	Age-related Osteoarthritis & Osteoporosis

7. EXCLUSIONS

The Company shall not be liable to make any payment under the Policy, in respect of any expenses incurred in connection with or in respect of:

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

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

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

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

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

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

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

7.8 Excluded Providers: Code- (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 Policy holder/Policy Holder/Insured Beneficiary (ies) 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.

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

7.10 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. (Code- Excl13)

7.11 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 daycare procedure (Code-Excl14)

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

7.13 Unproven Treatments:(Code- 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.

7.14 Sterility and Infertility: (Code- Excl17)
Expenses related to Sterility and Infertility. This includes:
i. Any type of Contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

7.15 Maternity Expenses (Code: Excl 18):
i. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Cover Period.

7.16 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.

7.17 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a. Nuclear attack or weapon means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any illness, in capacitating disablement or death.

b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.

c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.

7.18 Any expenses incurred on Domiciliary Hospitalization and OPD Treatment.

7.19 Treatment taken outside the geographical limits of India

7.20 In respect of the existing diseases, disclosed by the Insured Beneficiary and mentioned in the Policy Schedule (based on Insured Beneficiary's consent),he/she is not entitled to get the coverage for specified ICD codes.

8. Moratorium Period:

After completion of sixty continuous months of coverage (including portability and migration) no look back would be applied. This period of sixty months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the 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

9. Claim Procedure

1.1 Procedure for Cashless Claims:
i. Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA.
ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for the authorization
iii. In order to avail of cashless treatment, the following procedure must be followed by You or your representative:
a. 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.
b. In case of Planned hospitalization , You/the Insured Person/ Insured's representative shall intimate such admission within 48 hours of such hospitalization.
c. In case of Emergency hospitalization, You/ Insured Person/ Insured's representative shall intimate such admission within 24 hours of such hospitalization.
d. We offer Cashless Everywhere, even in hospitals which are not part of our network subject to hospitals fullfiing IRDAI definition of Hospital facility
e. On receipt of your pre-authorization form duly filled and signed by you, our representative then within 1 hour will respond with Approval,

Rejection or more information.

f. Once the final authorization request is received for discharge, the same will be processed within 3 hours from the final documents received.

iv. The Company/TPA upon getting cashless request form and related medical in formation from the Insured Beneficiary/network provider will issue pre-authorization letter to the Hospital after verification.
v. At the time of discharge, the Insured Beneficiary has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
vi. The Company/TPA reserves the right to deny pre-authorization in case the Insured Beneficiary is unable to provide the relevant medical details
vii. In case of denial of cashless access, the Insured Beneficiary may obtain the treatment as per the treating Medical Practitioner's
viii. advice and submit the claim documents to the Company / TPA for reimbursement.

1.2 Procedure for reimbursement of claims:
For reimbursement of claims the Insured Beneficiary may submit the necessary documents to TP A(if applicable)/Company within the prescribed time limit as specified hereunder.

Sl. No.	Type of Claim	Prescribed Time Limit
1.	Reimbursement of hospitalization, day care and pre hospitalization expenses	Within 30 days of date of discharge of Hospital
2.	Reimbursement of post hospitalization expenses	Within 15 days from completion of post hospitalization treatment

9.1 Notification of Claim
Notice with full particulars shall be sent to the Company / TPA (if applicable) asunder:
i. Within 24 hours from the date of emergency hospitalization required or before the Insured Beneficiary's discharge from Hospital, whichever is earlier.
ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

9.2 Documents to be submitted:
The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.
i. Duly completed claim form
ii. Photo identity proof of the patient
iii. Medical practitioner's prescription advising admission.
iv. Original bills with itemized break-up
v. Payment receipts
vi. Discharge summary including complete medical history of the patient along with other details
vii. Investigation / Diagnostic test reports etc. supported by the prescription from attending Medical Practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases)
ix. Sticker/Invoice of the Implants, wherever applicable.
x. MLR (Medico Legal Report) copy if carried out and FIR (First Information Report) if registered, wherever applicable.
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii. KYC (identity proof with address) of the proposer, where claim liability is above Rs. 1 Lakh asper AML Guidelines.
xiii. Legal heir/ succession certificate, wherever applicable
xiv. AnyotherrelevantdocumentrequiredbyCompany/TPAforassessmentoftheclaim.

Note:
1. The company shall only accept bills/invoices/medical treatment related documents only in the Insure Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Certificate of Insurance and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Beneficiary

9.3 Co-payment
Each and every claim under the Certificate of Insurance shall be subject to a Copayment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Certificate of Insurance read with Group Policy. The amount payable shall be after deduction of the copayment.

9.4 Claim Settlement (provision for Penal Interest)
i. The Company shall settle or reject a claim, as the case may be, within 15 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 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 the claim within 15 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 15 days the Insurer shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

9.5 Services Offered by TPA
Servicing of claims, i.e., claim admissions and assessments, under the Certificate of Insurance by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the Certificate of Insurance read with the Group Policy.
The services offered by a TPA shall not include
i. Claim settlement and claim rejection;
ii. Any services directly to any Insured Beneficiary or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

9.6 Payment of Claim

All claims under the Policy shall be payable in Indian currency only.

10. GENERALTERMS& CONDITIONS

10.1 Disclosure of Information
The Certificate of Insurance 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.

10.2 Condition Precedent to Admission of Liability
The due observance and fulfillment of the terms and conditions of the Policy, by the Insured Beneficiary, shall be a condition precedent to any liability of the Company to make any payment for claims(s) arising under the Policy.

10.3 Material Change
TheInsuredBeneficiaryshallnotifytheCompanyinwritingofanymaterialchangeintheriskinrelationtothedeclarationmadeinthe proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

10.4 Records to be Maintained
The Insured Beneficiary shall keep an accurate record containing all relevant medical records and shall allow the Insurer or its representatives to inspect such records. The Insured Beneficiary shall furnish such information as the Company may require for settlement of any claim under the Certificate of Insurance, within reasonable time limit and within the time limit specified in the Certificate of Insurance.

10.5 Complete Discharge
Any payment to the Insured Beneficiary or his/her nominees or his/her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Certificate of Insurance read with the Group Policy shall in all cases be a full ,valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

10.6 Notice & Communication
i. Anynotice,direction,instructionoranyothercommunicationrelatedtothePolicyshouldbemadeinwriting.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Certificate of Insurance read with Group Policy.
iii. The Company shall communicate to the Insured Beneficiary at the address or through any other electronic mode mentioned in the Certificate of Insurance.

10.7 Territorial Limit
All medical treatment for the purpose of this insurance will have to be taken in India only.

10.8 Multiple Policies
1. In case of multiple policies taken by an Insured Beneficiary during a period from the same or one or more insurers to indemnify treatment costs, the Insured Beneficiary 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 if chosen by the Insured Beneficiary 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. Insured Beneficiary having multiple policies shall also have the right to prefer claims under this Certificate of Insurance for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this Certificate of Insurance read with Group Policy.
3. If the amount to be claimed exceeds the sum insured under a single policy after, the Insured Beneficiary shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an Insured Beneficiary has policies from more than one insurer to cover the same risk on indemnity basis, the Insured Beneficiary shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

10.9 Fraud
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 Certificate of Insurance, all benefits under this Certificate of Insurance shall be forfeited.
Any amount already paid against Claims which are found fraudulent later under this Certificate of Insurance shall be repaid by all person(s)named in the Certificate of Insurance, who shall be jointly liable for such repayment.
For the purpose of this clause, the expression “fraud” means any of the following acts committed by the Insured Beneficiary or by his agent, with intent to deceive the Insurer or to induce the Insurer to issue an Certificate of Insurance:-
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 brief of the fact;
c. any other act fitted to deceive; and
d. any such act or omission as the law specially declares to be fraudulent
The Company shall not repudiate the claim under Certificate of Insurance on the ground of fraud, if the Insured Beneficiary/beneficiary can prove that the mis-statement was true to the best of his knowledge and there was node liberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer. Onus of disproving is upon the Insured Beneficiary, if alive, or beneficiaries.

10.10 Cancellation
(A) Cancellation by the Policyholder
The Policyholder can cancel this Policy by providing a written notice of 7 days. In such a case, the Company will refund the premium for the unexpired policy period as detailed below:

1. Cancellation of policy where full premium received at policy inception -

- Annual Policy: The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the policy year.
- Multi-year Policy:
  - For any policy year where the risk date has not yet started, the premium will be refunded without any deduction.

- For any policy year where the risk has started, the premium will be refunded on a pro-rata basis for that policy year, provided no claim has been made during the policy year and in full for future policy years.

2. Cancellation of policy where Premium Received on Instalment Basis
The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the policy year.

(B) Additional Deductions - Notwithstanding the above, if (i) the risk under the Policy has already commenced, or (ii) only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then expenses incurred by the Company on medical examination of the Policyholder will also be deducted before refunding of premium.

(C) Cancellation by the Company
The Company may cancel the Policy at any time on the grounds of misrepresentation, non-disclosure of material facts, or fraud by the Policyholder/insured person, by providing 15 days' written notice. There will be no refund of premium for cancellations on these grounds.

10.11 Automatic change in Coverage under the Certificate of Insurance
The coverage for the Insured Beneficiary(s) shall automatically terminate:

1. In the case of his/her(Insured Beneficiary) demise.
However the cover shall continue for the remaining Insured Beneficiary/ies till the end of Cover Period. The other Insured Beneficiary/ ies may also apply to renew the Certificate of Insurance. In case, the other Insured Beneficiary is minor, the Certificate of Insurance shall be renewed only through any one of his/her natural guardian or guardian appointed by Court. All relevant particulars in respect of such person (including his/her relationship with the Insured Beneficiary) must be submitted to the Company along with the application. Provided no Claim has been made, and termination takes place on account of death of the Insured Beneficiary, pro-rata refund of premium of the deceased Insured Beneficiary for the balance Cover Period of the Certificate of Insurance will be effective.
2. Upon exhaustion of Sum insured and Cumulative Bonus, for the Policy Year. However, the Certificate of Insurance is subject to renewal on the due date as per the applicable terms and conditions.

10.12 Territorial Jurisdiction
All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Certificate of Insurance shall be determined by the Indian court and according to Indian law.

10.13 Dispute Resolution (Applicable only in cases where this Policy is issued under Commercial Lines of Business)
"The Insurer and Insured may mutually agree and enter into a separate Arbitration Agreement to settle any and all disputes in relation to this Policy. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996."

Note : 1. Wherever this Policy is issued under retail lines of business, Arbitration clause shall not be applicable.
2. Arbitration clause shall not be applicable in case of Policies issued under commercial lines of business where Insured has specifically consented for no arbitration clause and no arbitration terms have been annexed to the Policy Schedule/Policy.

10.14 Migration
The Insured Beneficiary will have the option to migrate the Certificate of Insurance to other health insurance products/plans offered by the company as per the extant guidelines related to 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, as per Guidelines on migration, the proposed Insured Beneficiary will get all the accrued continuity benefits in waiting periods as below:

i. The waiting periods specified in Section 6 shall be reduced by number of continuous preceding years of coverage of the Insured Beneficiary under the previous health insurance policy.
ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.)
For detailed Guidelines on Migration, kindly refer the link: https://irdai.gov.in/document-detail?documentId=393128
(Please note referred link is of the IRDAI website and subject to change from time to time.)

10.15 Portability
The Insured Beneficiary will have the option to port the Certificate of Insurance to other insurers as per extant Guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance planwithanIndianGeneral/HealthinsurerasperGuidelinesonportability,theproposedInsuredBeneficiarywillgetalltheaccrued continuity benefits in waiting periods as under:

i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Beneficiary under the previous Health Insurance Policy
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased sum insured.

For detailed Guidelines on Portability , kindly refer the link: https://irdai.gov.in/document-detail?documentId=393128
(Please note referred link is of the IRDAI website and subject to change from time to time.)

10.16 Renewal of Certificate of Insurance
The Certificate of Insurance shall ordinarily be renewable [during the Group Policy Period/renewed Group Policy Period] except on grounds of fraud, moral hazard, misrepresentation by the Insured Beneficiary. The Company is not bound to give notice that it is due for renewal.

i. Renewal shall not be denied on the ground that the Insured Beneficiary had made a claim or claims in the preceding Policy Years
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Cover Period.
iii. At the end of the Cover Period, the Certificate of Insurance shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
iv. If not renewed within Grace Period after due renewal date, the Certificate of Insurance shall terminate.

10.17 Premium Payment in Installments
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. The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium.
ii. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for

pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.

iii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.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. 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.

v. No interest will be charged If the instalment premium is not paid on due date.

vi. In case of instalment premium due not received within the grace period, the policy will get cancelled.vii.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.

10.18 Possibility of Revision of Terms of the Certificate of Insurance or Group Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the Group Policy and Certificate of Insurance including the premium rates. The Insured Beneficiary shall be notified three months before the changes are affected.

10.19 Free look period

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

The Insured Beneficiary shall be allowed a period of thirty days from date of receipt of the Certificate of Insurance to review the terms and conditions of the Certificate of Insurance and Group Policy, and to return the same if not acceptable.

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

i. A refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Beneficiary and the stamp duty charges ;or

ii. Where the risk has already commenced and the option of return of the Certificate of Insurance is exercised by the Insured Beneficiary, 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;

10.20 Endorsements (Changes in the Certificate of Insurance)

i. This Certificate of Insurance read with Group Policy constitutes the complete contract of insurance. This Certificate of Insurance cannot be modified by anyone (including an insurance agent or broker) except the Company. Any change made by the Company shall be evidenced by a written endorsement signed and stamped.

ii. The Insured Beneficiary may be changed only at the time of renewal. The new Insured Beneficiary must be the legal heir/immediate family member. Such change would be subject to acceptance by the Company and payment of premium (if any). The renewed Certificate of Insurance shall be treated as having been renewed without break.

iii. The Insured Beneficiary may be changed during the Cover Period only in case of his/her demise or him/her moving out of India.

10.21 Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

10.22 Terms and condition of the Certificate of Insurance

The terms and conditions contained herein under Group Policy Wordings and in the Certificate of Insurance shall be deemed to form part of the Certificate of Insurance and shall be read together as one document.

10.23 Nomination

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

11. 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+917507245858
2. Branches for resolution of your grievances/complaints, the Branch details can be found on our website www.bajajallianz.com/branch-locator.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) Level3: 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 To575758 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 ThecontactdetailsoftheInsuranceOmbudsmanofficesarementionedinAnnexureB

No loading shall apply on renewals based on individual claims experience. Insurance is the subject matter of solicitation

12. TABLEOFBENEFITS

Name	Arogya Sanjeevani Policy, Bajaj Allianz General Insurance Company Limited
Product Type	Individual/Floater

Category of Cover	Indemnity
Sum insured	INR ₹1,00,000, ₹ 1,50,000,₹ 2,00,000, ₹ 2,50,000, ₹ 3,00,000, ₹ 3,50,000, ₹ 4,00,000, ₹4,50,000, ₹5,00,000, ₹7,50,000, ₹ 10,00,000, ₹ 12,50,000,₹ 15,00,000, ₹ 20,00,000 and ₹ 25,00,000 On Individual basis – SI shall apply to each individual family member On Floater basis – SI shall apply to the entire family
Cover Period	1 year
Eligibility	Policy can be availed by persons between the age of 18 years and 65years, as Proposer. Proposer with higher age can obtain policy for family, without covering self. Policy can be availed for Self and the following family members a. Legally wedded Spouse b. Parents and Parents-in-law c. Dependent Children (i. e natural or legally adopted) between the age of 3months to 25years. If the child above 18 years is financially independent or if the girl child is married, he or she shall be in eligible for a. coverage in the subsequent renewals. Legally wedded Spouse b. Parents and Parents-in-law c. Dependent Children (i.e natural or legally adopted) between the age of3monthsto 25 years. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.
Grace Period	For Yearly payment of mode, a fixed period of 30 days is to be allowed .as Grace Period The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium.
Hospitalisation Expenses	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible Time limit of 24 hrs shall not apply when the treatment is undergone in a Day Care Center
Pre Hospitalisation	For 30 days prior to the date of hospitalization
Post Hospitalisation	For 60 days from the date of discharge from the Hospital
Sublimit for room/ Medical Practitioner fee	1. Room Rent, Boarding, Nursing Expenses all inclusive as provided by the Hospital/Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day. 2. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all inclusive as provided by the Hospital/ Nursing Home up to 5% of the sum insured subject to maximum of Rs.10,000/-, per day
Cataract Treatment	Up to25%ofSuminsured orRs.40,000/-, whichever is lower, per eye, undergone Policy Year.
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems of medicines shall be covered upto sum insured, during each Policy Year as specified in the Policy Schedule.
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered after a waiting period of 36 months
Cumulative bonus	Increase in the sum insured by 5% in respect of each claim free year subject to a maximum of 50% of SI. In the event of claim the cumulative bonus shall be reduced at the same rate.
Co Pay	5% co pay on all claims
Pre-Policy Check-up	• No Medical tests upto 45years, subject to no adverse health conditions. • Pre- medical tests are mandatory for 46 years and above. • The pre-policy checkup would be arranged at our empaneled diagnostic centres. • The validity of the test reports would be 30days from date of medical examination. • 100 % cost of pre-policy check-up would be refunded if the proposal is accepted & policy is issued. • Medical Tests required as listed below: Full Medical Report, ECG with reporting, FBG, CBC WITH ESR , Cholesterol, HDL Cholesterol, Triglycerides, Creatinine, GGTP, SGOT, SGPT, HbA1c, Urinalysis, Total Protein, Sr. Albumin, Sr. Globulin, A:GRatio

Annexure-A

List I: List of Non-Medical Items

SL No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS

8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS
21	SERVICE CHARGES WHERE NURSING CHARGES ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHA RGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/S HOULDER IMMOBILIZER
47	LUMBOSACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets

54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT , RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER , URINE JUG
68	VASOFIX SAFETY

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

List lll- 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-B

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

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD - 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, 1st floor, “Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. 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, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 – 4646394 / 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 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)
DELHI – Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 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).	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

Office Details	Jurisdiction of Office Union Territory, District)
Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	
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 / 2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCHI– Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 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, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 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 - 4002082 / 3500613 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..
MUMBAI - Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/ 27/ 29/ 31/ 32/ 33 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,	Bihar, Jharkhand.

Office Details	Jurisdiction of Office Union Territory, District)
Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	
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- 24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

Note: Address and contact number of Governing Body of Insurance Council:
Council for Insurance Ombudsmen,
3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W),Mumbai - 400 054.
E-mail: inscoun@cioins.co.in
Tel: 022 -69038800/69038812
Website: https://www.cioins.co.in