BAJAJ ALLIANZ HEALTH INSURANCE COMPLETE GUIDE & FAQ

Comprehensive Information Guide with Tricky Questions for Informed Decision Making

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COMPANY OVERVIEW

Bajaj Allianz General Insurance Company Limited

- **IRDAI Registration Number:** 113
- **CIN:** U66010PN2000PLC015329
- **Claim Settlement Ratio:** 98%
- **Network Hospitals:** 18,400+ across India
- **Customer Service:** 1800-210-1030

Key Highlights

- ISO 27001:2013 Certified Company
- Joint venture between Bajaj Finserv and Allianz SE
- One of India's leading general insurance companies
- Strong financial backing and market reputation

HEALTH INSURANCE PLANS AVAILABLE

1. MY HEALTH CARE PLAN (Most Popular)

- **Type:** Comprehensive Individual/Family Floater
- **Sum Insured:** ₹50,000 to ₹50 Lakhs
- **Key Feature:** Personalized bouquet of features
- **Special Benefit:** Customizable coverage options

2. HEALTH CARE SUPREME

- **Variants:** Vital, Smart, Ultimo
- **Sum Insured:** Up to ₹50 Lakhs
- **Key Features:**
  - Free annual health check-ups
  - Quick claim settlements
  - 100% sum insured restoration

3. HEALTH GUARD PLANS

- **Gold Variant:** Mid-range coverage
- **Platinum Variant:** Premium coverage
- **Sum Insured:** Up to ₹35 Lakhs
- **Special Features:**
  - Daily cash allowance ₹500/day
  - 399 daycare procedures covered
  - AYUSH treatment coverage

4. HEALTH ENSURE PLAN

- **Sum Insured:** ₹50,000 to ₹10 Lakhs
- **Coverage:** In-patient treatment, AYUSH, daycare procedures
- **Target:** Budget-conscious individuals

5. EXTRA CARE PLUS

- **Type:** Enhanced coverage plan
- **Features:** Additional benefits beyond basic coverage

6. GLOBAL HEALTH CARE

- **Type:** International coverage plan
- **Coverage:** Emergency care overseas

7. SENIOR CITIZEN PLANS

- **Age Group:** 60+ years
- **Sum Insured:** Individual basis selection
- **Features:** Age-related condition coverage

COVERAGE DETAILS

WHAT'S COVERED (INCLUSIONS)

Core Coverage

1. **In-patient Hospitalization**
   - Room rent charges
   - ICU charges
   - Doctor's fees
   - Nursing charges
   - Surgery costs
   - Medical tests and investigations
2. **Pre & Post Hospitalization**
   - 30-60 days pre-hospitalization expenses
   - 60-90 days post-hospitalization expenses
   - Diagnostic tests
   - Consultations
   - Medications
3. **Day Care Procedures**
   - 399+ procedures covered
   - Less than 24-hour treatments
   - Same-day surgeries
4. **Advanced Treatment Coverage**
   - Modern technological procedures
   - Specialized treatments
   - Advanced medical equipment usage
5. **Emergency Care**

- Ambulance charges
- Emergency room treatment
- Accident-related injuries

Additional Coverage Options

1. **AYUSH Treatment**
   - Ayurveda
   - Yoga & Naturopathy
   - Unani
   - Siddha
   - Homeopathy
2. **Maternity & Newborn Care**
   - Normal delivery
   - Cesarean delivery
   - Complications during pregnancy
   - Newborn baby expenses (up to 90 days)
3. **Organ Donor Expenses**
   - Medical expenses for organ donor
   - Coverage when insured is recipient
4. **External Medical Aid**
   - Wheelchair
   - Crutches
   - Walker
   - Hearing aids

SPECIAL FEATURES

COVID-19 Coverage

- Hospitalization expenses
- Home care treatment
- Domiciliary hospitalization
- Pre & post hospitalization
- Mental health support
- Teleconsultations

Wellness Benefits

- Free annual health check-ups
- Preventive care coverage
- Wellness programs
- Health prime rider benefits

EXCLUSIONS & LIMITATIONS

WHAT'S NOT COVERED

Waiting Periods

1. **Initial Waiting Period:** 30 days (except accidents)
2. **Pre-existing Diseases:** 12/24/36 months continuous waiting
3. **Specific Illnesses:** 12/24/36 months for:
   - Hernia
   - Gout
   - Endometriosis
   - Cataract
   - Kidney stones
   - Benign prostatic hypertrophy
4. **Maternity Coverage:** 12/24/36 months waiting period

General Exclusions

1. **Treatment for Self-inflicted Acts**
   - Suicide attempts
   - Self-harm
   - Substance abuse consequences
2. **Cosmetic Surgery**
   - Aesthetic procedures
   - Plastic surgery (unless medically necessary)
3. **Dietary Supplements**
   - Vitamins without prescription
   - Nutritional supplements
   - Health tonics
4. **Investigation & Evaluation**

- Diagnostic procedures unrelated to treatment
- General health evaluations

5. **War & Nuclear Risks**
   - War-related injuries
   - Nuclear radiation
   - Chemical weapons
6. **Sports & Adventure Activities**
   - Professional sports injuries
   - Hazardous activities
   - Extreme sports

Co-payment & Deductibles

- Certain plans may have co-payment clauses
- Deductible amounts vary by plan
- Zone-wise variations may apply

CLAIM PROCESS

CASHLESS CLAIMS (Preferred Method)

Step-by-Step Process:

1. **Pre-authorization Request**
   - Contact network hospital
   - Submit health card
   - Hospital sends pre-auth request to insurer
2. **Document Submission**
   - Filled claim form
   - Doctor's prescription
   - Medical reports
   - ID proof
3. **Approval Process**
   - Medical team reviews case
   - Pre-authorization granted/denied
   - Treatment proceeds if approved
4. **Settlement**

- Hospital bills directly settled
- Only pay non-covered expenses

REIMBURSEMENT CLAIMS

Process:

1. **Treatment & Payment**
   - Pay hospital bills upfront
   - Collect all medical documents
2. **Claim Submission** (Within 30 days)
   - Filled claim form
   - Original medical bills
   - Discharge summary
   - Investigation reports
3. **Claim Processing**
   - Document verification
   - Medical assessment
   - Settlement within 30 days

Required Documents for Claims

1. Duly filled claim form
2. Original medical bills & receipts
3. Discharge summary
4. Investigation reports
5. Doctor's prescription
6. Police FIR (if accident)
7. ID proof & policy copy

Claim Settlement Time

- **Cashless:** Real-time processing
- **Reimbursement:** 15-30 days
- **Complex cases:** Up to 45 days

PREMIUM CALCULATION

Factors Affecting Premium

Personal Factors

1. **Age:** Higher age = Higher premium
2. **Gender:** Slight variations may apply
3. **Location:** Zone-wise pricing
4. **Occupation:** Risk-based pricing
5. **Lifestyle:** Smoking, drinking habits

Policy Factors

1. **Sum Insured:** Higher coverage = Higher premium
2. **Plan Type:** Individual vs Family floater
3. **Add-on Covers:** Each rider increases premium
4. **Deductible:** Higher deductible = Lower premium
5. **Co-payment:** Higher co-pay = Lower premium

Premium Range Estimates

- **Individual (25-35 years):** ₹5,000 - ₹15,000 annually
- **Family Floater (2+2):** ₹8,000 - ₹25,000 annually
- **Senior Citizen:** ₹15,000 - ₹50,000 annually

Discounts Available

1. **Online Purchase:** Up to 10%
2. **Family Discount:** Multiple members
3. **No Claim Bonus:** Up to 50%
4. **Wellness Discount:** Health check-ups
5. **Long-term Policy:** 2-3 year discounts

NETWORK HOSPITALS

Coverage

- **Total Hospitals:** 18,400+ across India
- **Coverage:** All major cities and towns
- **Specializations:** Multi-specialty, cardiac, cancer, orthopedic

Hospital Locator

- Available on company website

- Mobile app integration
- 24/7 helpline assistance

Cashless Facility

- Pre-authorization required
- Valid health card mandatory
- Network hospital treatment only

WAITING PERIODS

Detailed Waiting Period Structure

30 Days Initial Waiting

- Applies to all illnesses
- Accidents excluded
- Emergency conditions covered

Pre-existing Diseases

- **12 Months:** Diabetes, Hypertension
- **24 Months:** Heart conditions, Kidney problems
- **36 Months:** Complex chronic conditions

Specific Disease Waiting

- **Cataract:** 12 months
- **Hernia:** 24 months
- **Kidney Stones:** 12 months
- **Gallbladder:** 12 months

Maternity Benefits

- **Normal Delivery:** 36 months
- **Cesarean:** 36 months
- **Complications:** 36 months

Waiting Period Waiver

- Port from another insurer
- Continuous coverage credit
- No gap in insurance

TAX BENEFITS

Section 80D Deductions

For Individuals Under 60

- Self, Spouse, Children: Up to ₹25,000
- Parents (Under 60): Up to ₹25,000
- **Total Maximum:** ₹50,000

For Senior Citizens (60+)

- Self & Spouse: Up to ₹50,000
- Parents (60+): Up to ₹50,000
- **Total Maximum:** ₹1,00,000

Additional Benefits

- Preventive health check-up: ₹5,000
- Included within the above limits
- Both cashless and reimbursement eligible

REQUIRED DOCUMENTS

For Policy Purchase

Identity Proof (Any One)

- Aadhaar Card
- PAN Card
- Passport
- Voter ID
- Driving License

Address Proof (Any One)

- Aadhaar Card
- Utility Bills
- Passport
- Ration Card
- Bank Statement

Age Proof (Any One)

- Birth Certificate
- 10th Class Certificate
- Passport
- Aadhaar Card

Additional Documents

- Recent passport-size photographs
- Proposal form (duly filled)
- Medical certificates (if required)
- Income proof (for high sum insured)

For Claims

- Policy copy
- Claim form
- Medical reports
- Bills and receipts
- Discharge summary
- ID proof

RENEWAL PROCESS

Online Renewal

1. Login to official website/app
2. Enter policy details
3. Review coverage
4. Make payment
5. Download renewed policy

Offline Renewal

1. Contact agent/branch
2. Submit renewal documents
3. Pay premium
4. Collect policy documents

Grace Period

- **Standard:** 30 days
- **Senior Citizens:** 30 days
- No coverage during grace period

Renewal Benefits

- No-claim bonus
- Continuous coverage benefit
- Loyalty discounts
- Coverage enhancements

COVID-19 COVERAGE

Comprehensive COVID Coverage

Hospitalization Coverage

- ICU charges
- Room rent
- Doctor fees
- Medicines
- Oxygen support
- Ventilator charges

Home Treatment

- Doctor consultations
- Medicines
- Oxygen concentrator
- Nursing charges

Additional Benefits

- Mental health support
- Teleconsultation
- Quarantine expenses
- Contact tracing support

TRICKY QUESTIONS & HIDDEN DETAILS

🚨 CRITICAL QUESTIONS TO ASK

1. Waiting Period Tricks

Q: "Can I claim for diabetes treatment immediately after buying the policy?" **A:** NO! Pre-existing conditions like diabetes have 12-36 months waiting period. Don't let agents mislead you about "immediate coverage."

2. Room Rent Capping

Q: "Is there a limit on room rent I can claim?" **A:** YES! Many plans have room rent capping (1-2% of sum insured). A ₹5 lakh policy might limit room rent to ₹5,000-₹10,000 per day.

3. Network Hospital Limitations

Q: "Can I get treatment at any hospital?" **A:** For CASHLESS treatment, ONLY network hospitals. For reimbursement, any hospital is fine, but you pay upfront.

4. Co-payment Clauses

Q: "Will the insurance pay 100% of my medical bills?" **A:** Not always! Some plans have co-payment (you pay 10-20% of bills). Check your policy document carefully.

5. Geographic Limitations

Q: "Am I covered if I fall sick in another state/country?" **A:** Domestic coverage is usually nationwide, but international coverage needs specific add-ons and has limitations.

🎯 HIDDEN EXCLUSIONS TO WATCH OUT FOR

6. Alternative Treatment Exclusions

Q: "Does AYUSH coverage include all alternative treatments?" **A:** Limited coverage! Only specific AYUSH treatments in recognized hospitals. Homeopathic medicines from local doctors often excluded.

7. Maternity Complications

Q: "Are all pregnancy-related expenses covered under maternity?" **A:** NO! Pre-pregnancy complications, fertility treatments, IVF procedures often excluded or have separate waiting periods.

8. Mental Health Coverage

Q: "Is psychiatrist consultation covered?" **A:** Limited coverage. Inpatient psychiatric treatment might be covered, but outpatient consultations often excluded.

9. Dental & Vision Exclusions

Q: "Are dental treatments covered?" **A:** Usually excluded unless due to accident. Routine dental work, root canals, cosmetic dentistry typically not covered.

10. Age-related Premium Increases

Q: "Will my premium remain the same throughout?" **A:** NO! Premiums increase significantly with age. A ₹10,000 premium at 30 can become ₹50,000+ at 60.

💰 PREMIUM & CLAIM TRICKS

11. No-Claim Bonus Conditions

Q: "If I don't claim, do I get bonus every year?" **A:** Yes, but with conditions! Small claims might still affect your NCB. Some insurers have claim-free criteria of minimum claim amount.

12. Pre-authorization Rejection

Q: "What if cashless pre-authorization is denied?" **A:** You can still get treatment and claim reimbursement, but you pay upfront. Pre-auth denial doesn't mean claim rejection.

13. Claim Settlement Time Variations

Q: "Will all claims be settled in 30 days?" **A:** Simple claims yes, but complex cases, fraud investigations, or document issues can extend to 45-90 days.

14. Family Floater Limitations

Q: "In family floater, can each member use the full sum insured?" **A:** NO! The entire family shares ONE sum insured. If one member uses ₹3 lakhs from a ₹5 lakh policy, only ₹2 lakhs remains for others.

📋 POLICY TERMS CONFUSION

15. Restoration vs. Recharge

Q: "What's the difference between sum insured restoration and recharge?" **A:**

- **Restoration:** Automatic renewal of sum insured after it's exhausted
- **Recharge:** You pay extra premium to restore sum insured mid-year

16. Deductible vs. Co-payment

Q: "Are deductible and co-payment the same?" **A:** NO!

- **Deductible:** Fixed amount you pay first (₹25,000 deductible means you pay first ₹25,000)
- **Co-payment:** Percentage of every claim you pay (10% co-pay means you pay 10% of every bill)

17. Chronic vs. Pre-existing

Q: "Is there a difference between chronic and pre-existing conditions?" **A:** YES! Pre-existing conditions existed before policy purchase. Chronic conditions can develop after purchase but need ongoing treatment.

🔍 FINE PRINT DETAILS

18. OPD Coverage Limitations

Q: "Does the policy cover doctor consultations?" **A:** Basic policies usually DON'T cover OPD. You need specific OPD riders, which have daily/annual limits and sub-limits for different services.

19. Emergency vs. Planned Treatment

Q: "Is emergency treatment covered immediately?" **A:** Yes for accidents, but medical emergencies for illnesses still subject to 30-day waiting period unless specifically excluded.

20. Second Opinion Coverage

Q: "Can I get a second opinion covered?" **A:** Usually not covered unless specifically mentioned. International second opinions definitely not covered in standard policies.

🚨 RED FLAG QUESTIONS FOR AGENTS

21. "This policy covers everything!"

Q: Ask for specific exclusion list. No policy covers "everything."

22. "Premium will never increase!"

Q: False! Premiums increase with age, medical inflation, and claim experience.

23. "You can claim unlimited times!"

Q: While number of claims might be unlimited, sum insured is limited. Multiple claims exhaust your coverage.

24. "All hospitals accept this policy!"

Q: Only network hospitals provide cashless facility. Check network hospital list in your area.

25. "Pre-existing conditions covered from day one!"

Q: Impossible! IRDAI mandates waiting periods for pre-existing conditions.

COMPREHENSIVE Q&A SECTION

COMPREHENSIVE 500+ QUESTIONS DATABASE

SECTION 1: BAJAJ ALLIANZ HEALTH INSURANCE PLANS & PRICING

Q1: What are all the health insurance plans offered by Bajaj Allianz? A: "Bajaj Allianz offers multiple health insurance plans: My Health Care Plan (₹3 lakh to ₹5 crore coverage), Health Guard (Silver/Gold/Platinum variants, ₹1.5 lakh to ₹1 crore), Health Care Supreme (₹5 lakh to ₹50 lakh), Extra Care Plus, Global Health Care, AapKe Liye, and Senior Citizen specific plans."

Q2: What is the premium cost for My Health Care Plan for a 30-year-old individual? A: "For a 30-year-old individual, My Health Care Plan premium starts from approximately ₹8,000-₹12,000 annually for ₹5 lakh coverage, ₹15,000-₹25,000 for ₹10 lakh coverage, and ₹35,000-₹50,000 for ₹25 lakh coverage, depending on zone and optional covers selected."

Q3: What is the cost difference between individual and family floater policies? A: "Family floater policies are typically 30-40% more cost-effective than individual policies. For example, individual policies for 2 adults might cost ₹25,000 each (₹50,000 total), while a family floater for the same coverage could cost ₹30,000-₹35,000 with 10-15% family discount."

Q4: What are the zone-wise premium variations for Bajaj Allianz health insurance? A: "Zone A (metros like Delhi, Mumbai, Hyderabad) has highest premiums. Zone B gets 15% discount on Zone A rates, Zone C (states like Bihar, Goa, Punjab) gets 25% discount. For ₹10 lakh coverage: Zone A ₹20,000, Zone B ₹17,000, Zone C ₹15,000 approximately."

Q5: What is the premium for Health Guard Gold plan? A: "Health Guard Gold plan premium ranges from ₹6,000-₹8,000 annually for ₹3 lakh coverage for a 30-year-old, ₹12,000-₹18,000 for ₹5 lakh coverage, and ₹25,000-₹35,000 for ₹10 lakh coverage, varying by zone and age."

Q6: How much does Health Care Supreme plan cost? A: "Health Care Supreme plan premium starts from ₹15,000-₹20,000 annually for ₹5 lakh coverage for a 30-year-old individual, ₹25,000-₹35,000 for ₹10 lakh coverage, and ₹45,000-₹65,000 for ₹25 lakh coverage."

Q7: What is the cost for senior citizen health insurance? A: "Senior citizen health insurance (60+ years) premium ranges from ₹25,000-₹40,000 for ₹5 lakh coverage, ₹45,000-₹70,000 for ₹10 lakh coverage, and ₹80,000-₹1,20,000 for ₹25 lakh coverage, depending on pre-existing conditions and plan chosen."

Q8: What are the premium installment options and additional charges? A: "Premium can be paid annually (no extra charge), half-yearly (+2% of annual premium), quarterly (+3% of annual premium), or monthly (+5% of annual premium). For ₹20,000 annual premium: half-yearly ₹10,400, quarterly ₹5,150, monthly ₹1,750."

Q9: What discounts are available on Bajaj Allianz health insurance premiums? A: "Available discounts include: Online purchase (5%), Family discount (10% for 2 members, 15% for 3+), Long-term (4% for 2 years, 8% for 3 years), Wellness (5-10%), Early entry (5% under 35 years), Employee (20%), Loyalty (5%), Fitness (5%)."

Q10: What is the cost comparison between different sum insured amounts? A: "For 30-year-old: ₹3 lakh coverage ≈ ₹6,000, ₹5 lakh ≈ ₹9,000, ₹10 lakh ≈ ₹16,000, ₹25 lakh ≈ ₹35,000, ₹50 lakh ≈ ₹65,000, ₹1

crore ≈ ₹1,20,000 annually. Premium increases exponentially with higher coverage."

SECTION 2: PLAN FEATURES & BENEFITS

Q11: What is the maximum sum insured available in My Health Care Plan? A: "My Health Care Plan offers sum insured ranging from ₹3 lakh to ₹5 crore, making it one of the highest coverage plans available in the market. The plan can be customized based on individual needs and budget."

Q12: What are the key features of Health Guard Platinum plan? A: "Health Guard Platinum features include: Coverage up to ₹1 crore, 399 day-care procedures, AYUSH treatment, daily cash allowance ₹500/day, cumulative bonus up to 100%, room rent up to 1% of SI, ambulance cover, and pre/post hospitalization expenses."

Q13: What maternity benefits are available across different plans? A: "Maternity benefits vary by plan: My Health Care Plan offers ₹50,000 (₹5-10 lakh SI), ₹75,000 (₹15-20 lakh SI), ₹1,00,000 (above ₹20 lakh SI). Health Care Supreme offers comprehensive maternity coverage. 36-month waiting period applies for all plans."

Q14: What is the difference between room rent actual and capped coverage? A: "Room rent actual means no limit on room charges, available in higher SI plans. Capped coverage limits room rent to 1-2% of SI per day. For ₹10 lakh SI with 1% cap, room rent is limited to ₹10,000/day. Exceeding this reduces all other expenses proportionately."

Q15: What modern treatment methods are covered? A: "Covered modern treatments include: Uterine Artery Embolization, HIFU, Balloon Sinuplasty, Deep Brain Stimulation, Oral Chemotherapy, Immunotherapy (Monoclonal Antibody injections), Robotic surgeries, Stereotactic radio surgeries, Bronchial Thermoplasty, and Stem cell therapy for bone marrow transplant."

Q16: How does the cumulative bonus work across different plans? A: "Cumulative bonus increases sum insured by 25-50% annually for claim-free years. My Health Care Plan: 25% for ₹3-4 lakh SI, 50% for ₹5 lakh+ SI. Maximum bonus can be 100% of base SI. For ₹10 lakh SI with 50% annual bonus, it becomes ₹15 lakh after 1 claim-free year."

Q17: What is the sum insured reinstatement benefit? A: "Sum insured reinstatement restores exhausted coverage during the same policy year. For SI below ₹5 lakh: once per year. For SI ≥₹5 lakh: unlimited reinstatement. Available after 15-day gap from previous discharge (except for different family members in floater policies)."

Q18: What is the recharge benefit and when is it applicable? A: "Recharge benefit is available for SI ≥₹5 lakh. It provides additional 20% of SI (max ₹25 lakh) when SI is exhausted in same claim. For ₹10 lakh SI, recharge provides additional ₹2 lakh. Available once per policy year per person/family."

Q19: What OPD benefits are available? A: "OPD benefits include: Tele-consultation (unlimited during subscription), Doctor consultation (₹500 GP, ₹1,200 specialist per visit, max 5/day, 15/month), Prescribed

investigations (pathology & radiology), Annual preventive health check-up. Limits vary by plan and SI chosen."

Q20: What is covered under international emergency care? A: "International emergency care covers: Hospitalization expenses overseas, room rent as per policy limits, ICU charges at actuals, surgeon/doctor fees, medicines, medical consumables, diagnostic tests. 10% mandatory co-payment applies. Coverage limited to 45 days per trip, 180 days annually."

SECTION 3: WAITING PERIODS & EXCLUSIONS

Q21: What are the different types of waiting periods? A: "Waiting periods include: Initial 30-day waiting period (except accidents), Pre-existing diseases 12-36 months (varies by plan), Specific diseases 12-24 months (cataracts, hernia, etc.), Maternity 36 months, Mental illness varies by plan, Organ transplant no waiting post PED period."

Q22: Which diseases have 24-month waiting period? A: "24-month waiting diseases include: All types of cataracts, Hernia (all types), Benign prostatic hypertrophy, All types of sinuses, Hemorrhoids/piles, Hydrocele, Fibromyoma, Endometriosis, Hysterectomy, Stones in urinary/biliary systems, Surgery on ears/tonsils/adenoids, Joint replacement surgery, Varicose veins surgery."

Q23: What pre-existing diseases have shorter waiting periods? A: "Some insurers offer reduced PED waiting: Diabetes, Hypertension (12 months in some plans), Thyroid disorders (12 months), Asthma (12 months if controlled), High cholesterol (12 months). However, Bajaj Allianz standard PED waiting is 24-36 months depending on plan chosen."

Q24: What is excluded from coverage permanently? A: "Permanent exclusions include: Cosmetic/plastic surgery (unless accident/cancer), Fertility treatments (IVF, ICSI), Change of gender treatments, Self-inflicted injuries, Drug/alcohol abuse, War/nuclear risks, Experimental treatments, Congenital external anomalies, Growth hormone therapy."

Q25: Are genetic disorders covered? A: "Genetic disorders coverage varies: Hereditary conditions manifesting after policy inception are covered post waiting periods. Congenital internal anomalies may be covered after 30-month waiting. Genetic testing for predisposition (without symptoms) is excluded. Treatment for manifested genetic conditions covered."

Q26: What dental treatments are covered? A: "Dental coverage is limited to: Accident-related dental injuries requiring hospitalization, Oral surgery as part of covered medical procedures, Oral cancer treatment, Jaw fracture treatment. Excluded: Routine dental care, cosmetic dentistry, orthodontics, dentures, implants, periodontal treatments."

Q27: Are psychiatric treatments covered? A: "Psychiatric treatments covered for: Inpatient hospitalization only, Subject to sub-limits (₹50,000-₹1,00,000 annually), Conditions listed in ICD-10 mental health codes, Excludes: OPD psychiatric consultations, counseling sessions, substance abuse treatment, behavioral therapy."

Q28: What eye treatments are excluded? A: "Eye treatment exclusions include: Refractive error correction (LASIK) unless >7.5 diopters for medical reasons, Contact lenses, Spectacles, Routine eye examinations, Cosmetic eye procedures. Covered: Cataract surgery (after waiting period), Retinal treatments, Glaucoma surgery, Eye injuries."

Q29: Are alternative medicine treatments covered? A: "AYUSH treatments covered for: Inpatient hospitalization in recognized AYUSH hospitals/government facilities, Ayurveda, Yoga, Naturopathy, Unani, Siddha, Homeopathy systems, Must be prescribed by qualified AYUSH practitioners. Excluded: OPD AYUSH consultations, medicines without hospitalization."

Q30: What obesity-related treatments are covered? A: "Bariatric surgery covered when: BMI ≥40 OR BMI ≥35 with severe co-morbidities (obesity-related cardiomyopathy, coronary heart disease, severe sleep apnea, uncontrolled Type 2 diabetes), Age ≥18 years, Failure of conservative weight loss methods, Surgery recommended by qualified physician."

SECTION 4: CLAIM PROCEDURES & SETTLEMENT

Q31: What is the cashless claim procedure? A: "Cashless procedure: Contact network hospital with health card and ID, Hospital sends pre-authorization request, Submit required documents (ID, medical reports, prescription), Insurance team reviews and approves/rejects within 2-6 hours, Treatment proceeds if approved, Settlement directly with hospital."

Q32: What documents are required for reimbursement claims? A: "Required documents: Claim form with NEFT details, Original discharge summary, Indoor case papers, Original final hospital bill with breakup, Original paid receipts, Investigation reports and bills, First consultation letter, Ambulance bills, Implant invoices/stickers if applicable."

Q33: What is the time limit for claim intimation? A: "Claim intimation timeframes: Cashless claims - 48 hours before planned hospitalization, Emergency cashless - within 24 hours of admission, Reimbursement claims - within 30 days of discharge, Waiver may be considered in extreme hardship cases with proper justification."

Q34: How long does claim settlement take? A: "Claim settlement timelines: Simple claims - within 30 days of complete documentation, Investigation cases - within 45 days, Payment within 7 days of settlement approval, Delay beyond timeline attracts 2% above bank rate interest, Complex cases may take longer with proper intimation."

Q35: What is the claim settlement ratio of Bajaj Allianz? A: "Bajaj Allianz maintains a claim settlement ratio of 98%, meaning 98 out of 100 eligible claims are settled. This is among the highest in the industry, indicating reliable claim processing and customer-friendly approach to settlements."

Q36: What reasons can lead to claim rejection? A: "Common rejection reasons: Non-disclosure of pre-existing conditions, Treatment during waiting periods, Excluded treatments/conditions, Incomplete

documentation, Late intimation without valid reason, Fraudulent claims, Treatment at non-network hospital without emergency justification, Policy lapse due to non-payment."

Q37: What is the procedure for claim appeals? A: "Claim appeal process: Submit written appeal within 30 days of rejection, Provide additional supporting documents, Company reviews appeal within 30 days, If unsatisfied, approach Insurance Ombudsman, Final recourse through Consumer Court or IRDAI, Maintain all correspondence and medical records."

Q38: How are emergency claims handled? A: "Emergency claim handling: Immediate treatment allowed at any hospital, Intimate within 24 hours of admission, Submit pre-authorization request if in network hospital, Emergency care covered until stabilization even in non-network hospitals, Full claim processing as per standard procedure post-stabilization."

Q39: What is the procedure for claims involving multiple policies? A: "Multiple policy claims: Choose primary insurer for claim processing, Primary insurer settles as per their policy terms, Remaining amount can be claimed from secondary insurer, Provide settlement letter from primary insurer, Both insurers coordinate to avoid duplicate payments."

Q40: How are international claims processed? A: "International claims processing: Must have International Emergency Care cover, Intimate within 24 hours of overseas treatment, Submit claims within 30 days with translated documents if required, Currency conversion at RBI rates on date of treatment, 10% co-payment automatically deducted."

SECTION 5: NETWORK HOSPITALS & CASHLESS FACILITY

Q41: How many network hospitals does Bajaj Allianz have? A: "Bajaj Allianz has 18,400+ network hospitals across India, covering all major cities and tier-2/tier-3 towns. The network includes multi-specialty hospitals, cardiac centers, cancer institutes, and specialty clinics, ensuring comprehensive healthcare access."

Q42: How to find network hospitals in my area? A: "Network hospital locator methods: Visit bajajallianz.com and use hospital locator tool, Download Caringly Yours mobile app, Call customer service 1800-103-2529, Check policy documents for hospital list, Visit nearest Bajaj Allianz branch office for printed list."

Q43: What services are available at network hospitals? A: "Network hospital services: Cashless pre-authorization, Direct billing settlement, 24x7 helpdesk support, Dedicated insurance desk, Faster claim processing, Quality healthcare assurance, Standardized billing practices, Emergency treatment facilities."

Q44: Can I get treatment at non-network hospitals? A: "Non-network hospital treatment: Allowed with reimbursement facility, Pay upfront and submit bills for reimbursement, Same coverage terms apply, May require additional documentation, Emergency treatment covered until stabilization, Pre-authorization not applicable for non-network hospitals."

Q45: What happens if network hospital denies cashless facility? A: "If cashless denied: Request reason in writing, Pay for treatment and apply for reimbursement, Submit all bills with cashless denial letter, Company processes reimbursement as per policy terms, Denial doesn't affect reimbursement eligibility if treatment is covered."

Q46: Are specialized hospitals like cancer centers included in network? A: "Specialized hospitals included: Cancer institutes (Tata Memorial, AIIMS Oncology), Cardiac centers (Fortis, Apollo), Orthopedic hospitals (Hinduja, Manipal), Eye hospitals (Sankara Nethralaya), Fertility clinics, Mental health facilities, Rehabilitation centers."

Q47: How is quality maintained in network hospitals? A: "Quality maintenance measures: Regular hospital audits, NABH/JCI accreditation preferences, Patient feedback monitoring, Billing practice reviews, Medical outcome assessments, Compliance with insurance guidelines, Continuous quality improvement programs."

Q48: What is the procedure for pre-authorization? A: "Pre-authorization procedure: Visit network hospital with health card, Hospital submits authorization request online, Insurance desk reviews medical necessity, Approval/rejection communicated within 2-6 hours, Treatment proceeds based on authorized amount, Any excess amount paid by patient."

Q49: Can I change hospitals during treatment? A: "Hospital change during treatment: Allowed for medical reasons with doctor's recommendation, New hospital must be in network for continued cashless facility, Medical records transferred to new hospital, Additional pre-authorization may be required, Coverage continues seamlessly if medically justified."

Q50: What facilities are available for outstation treatment? A: "Outstation treatment facilities: Network hospitals available in all major cities, Family visit benefit for attendant travel, Accommodation assistance through hospital or TPA, Local transport arrangements, 24x7 helpline support, Medical escort facility if required."

SECTION 6: PREMIUM CALCULATIONS & TAX BENEFITS

Q51: How is health insurance premium calculated? A: "Premium calculation factors: Age (primary factor), Sum insured amount, Plan type chosen, Geographic location (zone), Family size, Optional covers selected, Deductible opted, Co-payment percentage, Previous claim history, Medical examination results if required."

Q52: What tax benefits are available under Section 80D? A: "Section 80D tax benefits: Individual/Family under 60 - ₹25,000 deduction, Senior citizens 60+ - ₹50,000 deduction, Parents under 60 - additional ₹25,000, Senior citizen parents - additional ₹50,000, Maximum total deduction ₹1,00,000, Preventive health checkup ₹5,000 within limits."

Q53: How do age slabs affect premium calculation? A: "Age-based premium multipliers: 18-25 years (base rate), 26-35 years (1.2x), 36-45 years (1.8x), 46-55 years (2.5x), 56-65 years (4x), Above 65 years (6-

8x). Premium increases significantly with age due to higher health risks."

Q54: What is the impact of pre-existing diseases on premium? A: "PED impact on premium: Standard loading of 25-100% on base premium, Specific conditions may have higher loading, Diabetes/Hypertension typically 25-50% extra, Cardiac conditions 50-100% extra, Cancer survivors 100-200% extra, Some conditions may be excluded permanently."

Q55: How do optional covers affect premium cost? A: "Optional cover premiums: Maternity cover adds 15-25% to base premium, Critical illness cover adds 20-30%, Personal accident cover adds 10-15%, International emergency care adds 5-10%, OPD cover adds 25-40%, Each optional cover increases total premium cost."

Q56: What is the GST applicable on health insurance premiums? A: "GST on health insurance: 18% GST applicable on all health insurance premiums, Includes both base premium and optional covers, GST calculated on final premium after all discounts, For ₹20,000 annual premium, total payment including GST is ₹23,600."

Q57: How do family discounts work in premium calculation? A: "Family discount structure: 2 family members - 10% discount on total premium, 3+ family members - 15% discount, Discount applied after calculating individual premiums, Additional discounts may be available for large families, Floater policies inherently more economical than individual policies."

Q58: What is the impact of claim history on renewal premium? A: "Claim history impact: No-claim years earn cumulative bonus (reduces effective premium), Claim years reduce accumulated bonus, Multiple claims may increase renewal premium by 10-25%, Fraud history leads to policy cancellation, Portability protects accumulated benefits."

Q59: How do long-term policies affect premium cost? A: "Long-term policy benefits: 2-year policies get 4% discount, 3-year policies get 8% discount, Protection against premium increases during term, Locked-in benefits and coverage, One-time documentation, Reduced renewal hassles, Better long-term financial planning."

Q60: What is the premium difference between zones? A: "Zone-wise premium variations: Zone A (metros) - Base premium rate, Zone B (other cities) - 15% lower than Zone A, Zone C (smaller towns/rural) - 25% lower than Zone A, Based on healthcare costs and risk assessment in different regions."

SECTION 7: SENIOR CITIZEN HEALTH INSURANCE

Q61: What are the age limits for senior citizen health insurance? A: "Senior citizen age limits: Entry age 60+ years, Maximum entry age varies by plan (typically 65-75 years), Renewal possible lifelong without upper age limit, Some plans allow entry up to 80 years, Coverage continues for life if renewed without break."

Q62: What is the premium cost for senior citizens? A: "Senior citizen premium costs: 60-65 years - ₹25,000-₹45,000 for ₹5 lakh coverage, 66-70 years - ₹35,000-₹65,000, 71-75 years - ₹50,000-₹90,000,

Above 75 years - ₹70,000-₹1,25,000, Varies significantly based on health conditions."

Q63: What pre-existing diseases are commonly covered for seniors? A: "Common PED coverage for seniors: Diabetes, Hypertension, Arthritis, Thyroid disorders, High cholesterol, Osteoporosis, Benign prostate enlargement, Cataract (after waiting period), Heart conditions (with loading), Kidney diseases (stable cases)."

Q64: What special benefits are available for senior citizens? A: "Senior citizen special benefits: Extended coverage for age-related conditions, Domiciliary hospitalization, Ayurvedic treatment coverage, Reduced waiting periods in some cases, Daily cash allowance during hospitalization, Home nursing benefits, Ambulance coverage, Family visit benefits."

Q65: Are there any specific exclusions for senior citizens? A: "Senior-specific exclusions may include: Alzheimer's/Dementia (varies by insurer), Advanced stage cancers, End-stage renal/liver disease, Major organ transplants (some cases), Complications from age-related wear and tear, Some experimental treatments, High-risk surgeries."

Q66: What medical tests are required for senior citizen policies? A: "Medical tests for seniors: Blood sugar (fasting & PP), Blood pressure monitoring, Lipid profile, Kidney function tests, Liver function tests, ECG, Chest X-ray, Urine analysis, BMI assessment, Additional tests based on health history and sum insured."

Q67: How does the claim process differ for senior citizens? A: "Senior citizen claim process: Same as standard process but with additional support, Dedicated senior citizen helpline, Family member can handle claims, Simplified documentation process, Priority processing for emergency claims, Regular follow-up for chronic conditions."

Q68: Can senior citizens port their existing policies? A: "Senior citizen portability: Allowed as per IRDAI guidelines, All accumulated benefits transferred, Waiting period credits maintained, No-claim bonus protected, Medical underwriting may be required, 45-60 days window before renewal for porting application."

Q69: What is the renewal process for senior citizen policies? A: "Senior renewal process: Automatic renewal facility available, 30-day grace period for premium payment, Medical check-up may be required annually, Premium adjustment based on age and claims, Family members can handle renewal process, Digital renewal options available."

Q70: Are there any specific riders available for senior citizens? A: "Senior citizen riders: Critical illness rider, Hospital cash rider, Personal accident rider, Home nursing rider, Ambulance rider, Daily allowance rider, Outpatient treatment rider, International emergency care rider, Some riders have age restrictions."

SECTION 8: MATERNITY & CHILD HEALTH COVERAGE

Q71: What is the waiting period for maternity coverage? A: "Maternity waiting period: Standard 36 months from first policy inception, Reduced to 24 months if 2-year premium paid upfront, 12 months if

3-year premium paid upfront, Waiting period applies to delivery, cesarean, pregnancy complications, No waiting for ectopic pregnancy if life-threatening."

Q72: What expenses are covered under maternity benefits? A: "Maternity coverage includes: Normal delivery expenses, Cesarean section costs, Pre-natal expenses (complete pre-natal period), Post-natal expenses (up to 90 days), Pregnancy complications, Medical termination of pregnancy (if lawful), Room rent as per policy terms, Doctor's fees and hospital charges."

Q73: What are the maternity benefit limits across different plans? A: "Maternity limits by sum insured: ₹3-4 lakh SI - Not covered, ₹5-10 lakh SI - ₹50,000, ₹15-20 lakh SI - ₹75,000, Above ₹20 lakh SI - ₹1,00,000, Maximum 2 deliveries during policy lifetime, Includes surrogacy expenses under same limits."

Q74: Is newborn baby care covered? A: "Newborn coverage: Baby care covered from day one of birth, Coverage for 90 days post-delivery, Sum insured: ₹1 lakh (up to ₹4 lakh SI), ₹5 lakh (₹5-10 lakh SI), ₹10 lakh (₹15-50 lakh SI), ₹15 lakh (above ₹50 lakh SI), Includes congenital anomalies treatment."

Q75: Are fertility treatments covered? A: "Fertility treatment exclusions: IVF, IUI, ICSI procedures excluded, Assisted reproductive technology excluded, Fertility drugs not covered, Gestational surrogacy excluded, However, complications arising from ART procedures may be covered under maternity benefits if hospitalization required."

Q76: What complications during pregnancy are covered? A: "Covered pregnancy complications: Gestational diabetes, Pre-eclampsia/eclampsia, Placenta previa, Premature labor, Postpartum hemorrhage, Infections during pregnancy, Ectopic pregnancy (emergency), Miscarriage due to medical reasons, C-section complications."

Q77: Is maternity coverage available for single women? A: "Single women maternity coverage: Available for unmarried women, Same waiting periods apply, All maternity benefits included, Adoption expenses not covered, Medical termination covered if lawful, Age limit typically up to 45 years for maternity benefits."

Q78: What is covered under baby care benefits? A: "Baby care benefits include: Hospitalization expenses for newborn, Congenital disease treatment, Birth complications, NICU charges, Vaccination costs, Pediatric consultations during admission, Medical equipment for baby, Treatment for birth defects, Coverage continues in subsequent renewals."

Q79: Are there any exclusions in maternity coverage? A: "Maternity exclusions: Multiple births beyond twins in some plans, Cosmetic procedures post-delivery, Non-medical expenses during delivery, Fertility preservation treatments, Sex determination tests, Abortion for non-medical reasons, Treatment outside network without emergency."

Q80: How does maternity coverage work in family floater policies? A: "Maternity in family floater: Female members covered for maternity, Shared sum insured for all family members, Maternity expenses

utilize family floater limit, Other family members can use remaining sum insured, Cumulative bonus applies to entire family, Waiting periods same as individual policies."

SECTION 9: CRITICAL ILLNESS & SPECIALIZED COVERAGE

Q81: What critical illnesses are covered? A: "Critical illnesses covered: Cancer (all stages), Heart attack, Stroke, Kidney failure requiring dialysis, Major organ transplants, Coronary artery bypass surgery, Multiple sclerosis, Paralysis of limbs, End-stage liver disease, Bone marrow transplant, Brain surgery, Coma, Burns covering 20% body surface."

Q82: Is cancer treatment fully covered? A: "Cancer treatment coverage: Hospitalization expenses covered up to sum insured, Chemotherapy, radiotherapy included, Surgery and post-operative care, Targeted therapy and immunotherapy, Oral chemotherapy medicines, Bone marrow transplant, Stem cell therapy, Follow-up treatments, Palliative care."

Q83: What cardiac treatments are covered? A: "Cardiac treatment coverage: Heart attack treatment, Coronary angioplasty, Bypass surgery, Heart valve replacement, Pacemaker implantation, Stent procedures, Cardiac catheterization, Emergency cardiac care, Post-cardiac rehabilitation, Cardiac medications during hospitalization."

Q84: Are organ transplants covered? A: "Organ transplant coverage: Kidney transplant, Liver transplant, Heart transplant, Lung transplant, Bone marrow transplant, Corneal transplant, Pre-transplant evaluation, Surgery and hospitalization, Post-transplant medications, Donor expenses covered, Immunosuppressive therapy."

Q85: What neurological conditions are covered? A: "Neurological coverage: Stroke treatment, Brain surgery, Spinal cord injuries, Multiple sclerosis, Parkinson's disease treatment, Epilepsy management, Brain tumor treatment, Neurosurgery procedures, Rehabilitation therapy, Diagnostic procedures like MRI, CT scans."

Q86: Is mental health treatment covered? **

POLICY-SPECIFIC QUESTIONS & ANSWERS

Grace Period & Payment Terms

Q1: What is the grace period for premium payment under Bajaj Allianz Health Insurance policies?
A: "A grace period of thirty (30) days is provided for premium payment after the due date to renew or continue the policy without losing continuity benefits. During this grace period, no coverage is provided."

Q2: What happens if premium is not paid within the grace period?
A: "If the premium is not paid within the grace period, the policy lapses and all benefits including waiting period credits are forfeited. The policy can be revived within two years with fresh medical underwriting."

Q3: Can premium be paid in installments?
A: "Yes, premium can be paid annually, half-yearly, quarterly, or monthly. However, installment payments attract additional charges ranging from 2-5% depending on the frequency chosen."

Waiting Period Queries

Q4: What is the waiting period for pre-existing diseases (PED) to be covered?
A: "There is a waiting period of twenty-four (24) to thirty-six (36) months of continuous coverage from the first policy inception for pre-existing diseases and their direct complications to be covered, depending on the specific plan chosen."

Q5: What is the waiting period for cataract surgery?
A: "The policy has a specific waiting period of twenty-four (24) months for cataract surgery from the date of policy inception or enhancement of sum insured."

Q6: What is the waiting period for hernia treatment?
A: "Hernia treatment has a specific disease waiting period of twenty-four (24) months from the policy inception date, unless caused by an accident."

Q7: What is the waiting period for kidney stones treatment?
A: "Treatment for kidney stones has a waiting period of twelve (12) months from the policy inception date, except when caused by an accidental injury."

Q8: Is there any waiting period for accidental injuries?
A: "No, there is no waiting period for treatment of accidental injuries. Coverage is available from the policy inception date for all accident-related medical expenses."

Maternity & Family Benefits

Q9: Does this policy cover maternity expenses, and what are the conditions?
A: "Yes, the policy covers maternity expenses including normal delivery, cesarean section, and lawful medical termination of pregnancy. To be eligible, the female insured person must have been continuously covered for at least thirty-six (36) months. The benefit is limited to specific amounts as per the plan and covers up to two deliveries

during the policy period."

Q10: Are newborn baby expenses covered?
A: "Yes, medical expenses for newborn babies are covered from day one of birth for a period of ninety (90) days, provided the delivery is covered under the policy. Coverage includes congenital anomalies and birth complications."

Q11: Are fertility treatments covered?
A: "No, fertility treatments including IVF, IUI, ICSI, and other assisted reproductive techniques are specifically excluded from coverage under all health insurance plans."

Organ Donation & Advanced Treatments

Q12: Are the medical expenses for an organ donor covered under this policy?
A: "Yes, the policy indemnifies the medical expenses for the organ donor's hospitalization for the purpose of harvesting the organ, provided the organ is for an insured person covered under the policy and the donation complies with the Transplantation of Human Organs Act, 1994."

Q13: Does the policy cover organ transplant expenses?
A: "Yes, organ transplant expenses are covered subject to the sum insured limit, including pre and post-transplant care, provided it is medically necessary and performed at a recognized medical facility."

Q14: Are experimental or investigational treatments covered?
A: "No, experimental, investigational, or unproven treatments are excluded from coverage. Only established medical procedures recognized by the medical community are covered."

Discount & Bonus Structure

Q15: What is the No Claim Discount (NCD) offered in this policy?
A: "A No Claim Discount of five percent (5%) to twenty percent (20%) on the renewal premium is offered if no claims were made in the preceding policy year. The NCD increases cumulatively each claim-free year up to a maximum of fifty percent (50%) of the base premium."

Q16: What is cumulative bonus and how does it work?
A: "Cumulative bonus increases the sum insured by five percent (5%) for every claim-free year, up to a maximum of fifty percent (50%) of the original sum insured. This bonus is available without any additional premium payment."

Q17: Can No Claim Bonus be transferred when porting the policy?
A: "Yes, accumulated No Claim Bonus and waiting period credits can be transferred when porting from another insurer, provided there is no break in coverage and proper documentation is submitted."

Health Check-up Benefits

Q18: Is there a benefit for preventive health check-ups?
A: "Yes, the policy reimburses expenses for preventive health check-ups annually after completion of two continuous policy years without claims. The amount varies from Rs. 2,000 to Rs. 10,000 depending on the sum insured and plan chosen."

Q19: What is included in the preventive health check-up benefit?
A: "The preventive health check-up covers basic diagnostic tests including blood tests, urine analysis, ECG, chest X-ray, and consultation charges as specified in the policy schedule."

Q20: Can health check-up benefit be availed at any diagnostic center?
A: "Health check-up benefits can be availed at any NABL-accredited diagnostic center or network hospital. Reimbursement requires submission of original bills and reports."

Hospital & Treatment Definitions

Q21: How does the policy define a 'Hospital'?
A: "A hospital is defined as an institution with at least ten (10) inpatient beds in towns with population below ten lakhs or fifteen (15) beds in all other places, with qualified nursing staff under a resident qualified doctor available 24x7, a fully equipped operation theatre, and which maintains daily records of patients and is registered with local authorities."

Q22: What constitutes 'Hospitalization' under the policy?
A: "Hospitalization means admission as an inpatient in a hospital for a minimum period of twenty-four (24) consecutive hours for medically necessary treatment, except for specified day-care procedures which require less than 24 hours."

Q23: Are day-care procedures covered?
A: "Yes, the policy covers specified day-care procedures that require less than twenty-four (24) hours of hospitalization. The policy schedule lists over 300 approved day-care procedures including cataract surgery, dialysis, and chemotherapy."

AYUSH & Alternative Medicine

Q24: What is the extent of coverage for AYUSH treatments?
A: "The policy covers medical expenses for inpatient treatment under Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy systems up to the Sum Insured limit, provided the treatment is taken in a government hospital or an AYUSH hospital recognized by the respective government authority."

Q25: Are consultation fees for AYUSH practitioners covered?
A: "AYUSH consultation fees are covered only when part of inpatient hospitalization. Outpatient consultation fees for AYUSH practitioners are not covered unless specifically included through an OPD rider."

Q26: Does AYUSH coverage include medicines?
A: "Yes, medicines prescribed as part of inpatient AYUSH treatment are covered up to the policy limits. However, over-the-counter AYUSH medicines without hospitalization are not covered."

Room Rent & Sub-limits

Q27: Are there any sub-limits on room rent and ICU charges?
A: "Yes, room rent is typically capped at one percent (1%) to two percent (2%) of the Sum Insured per day, and ICU charges are capped at two percent (2%) to four percent (4%) of the Sum Insured per day, depending on the plan chosen. These limits do not apply in Preferred Provider Network hospitals for covered procedures."

Q28: What happens if room rent exceeds the capping limit?
A: "If room rent exceeds the specified limit, all associated expenses including surgeon fees, anesthetist charges, and other treatment costs are proportionately reduced in the same ratio as the room rent capping."

Q29: Can room rent capping be removed?
A: "Yes, room rent capping can be removed by opting for specific riders or higher variants of the policy at additional premium. Some premium plans offer unlimited room rent coverage."

Exclusions & Limitations

Q30: Are psychiatric and mental health treatments covered?
A: "Psychiatric and mental health treatments are covered for inpatient hospitalization only, subject to a sub-limit of typically Rs. 50,000 to Rs. 1,00,000 per policy year. Outpatient psychiatric consultations are generally excluded unless covered under OPD benefits."

Q31: Are dental treatments covered under the policy?
A: "Dental treatments are covered only when necessitated due to accidental injuries or as part of a covered surgical procedure. Routine dental treatments, cosmetic dentistry, and orthodontic treatments are excluded from coverage."

Q32: Does the policy cover treatment outside India?
A: "International treatment coverage is available only under specific global health plans or as an add-on rider. Emergency treatment during overseas travel may be covered up to specified limits with prior approval."

Claims & Settlement

Q33: What is the time limit for intimating a claim?
A: "Claims must be intimated to the insurer within forty-eight (48) hours of hospitalization for cashless claims and within thirty (30) days of discharge for reimbursement claims. Delay may result in claim rejection."

Q34: What is the maximum time for claim settlement?
A: "Claims are settled within thirty (30) days of receipt of all necessary documents. In case of investigation or additional information requirement, the settlement may extend up to sixty (60) days with proper intimation to the insured."

Q35: Can claims be made for multiple hospitalizations in a year?
A: "Yes, multiple claims can be made during the policy year until the sum insured is exhausted. Each hospitalization is treated as a separate claim subject to policy terms and conditions."

Policy Renewal & Continuity

Q36: Is there a maximum age limit for policy renewal?
A: "Most policies can be renewed lifelong without any upper age limit, provided premiums are paid on time and there is no fraud or misrepresentation. However, premiums increase significantly with advancing age."

Q37: Can the sum insured be increased during renewal?

A: "Yes, sum insured can be increased during renewal without medical underwriting up to specified limits. Increases beyond certain thresholds may require medical tests and have separate waiting periods for the enhanced amount."

Q38: What happens to waiting periods upon renewal?
A: "Waiting periods completed under the previous policy year are carried forward upon renewal without break. However, if there is a gap in renewal beyond the grace period, waiting periods restart."

Family Coverage & Floater Benefits

Q39: How does family floater sum insured work?
A: "In a family floater policy, the entire sum insured is shared among all covered family members. Any member can utilize the full sum insured, but once exhausted, no coverage remains for other family members until renewal."

Q40: Can individual limits be set in family floater policies?
A: "Some policies offer the option to set individual limits within the family floater structure, ensuring minimum coverage for each member while maintaining the overall shared sum insured benefit."

Q41: Who can be covered under a family floater policy?
A: "Family floater policies typically cover self, spouse, dependent children up to 25 years, and dependent parents. Some policies also allow coverage for parents-in-law and other dependents as defined in the policy terms."

COVID-19 & Pandemic Coverage

Q42: Is COVID-19 treatment covered under the policy?
A: "Yes, COVID-19 treatment is covered including hospitalization, ICU charges, ventilator costs, medicines, and related medical expenses. Home treatment and quarantine expenses may also be covered subject to policy terms."

Q43: Are COVID-19 vaccines covered?
A: "COVID-19 vaccination expenses are generally not covered as they fall under preventive care. However, treatment for adverse reactions post-vaccination may be covered as per policy terms."

Q44: Does the policy cover future pandemic-related treatments?
A: "Coverage for future pandemics depends on the specific policy terms and government guidelines. Most policies cover treatment for any communicable disease as per standard medical protocols."

Technology & Telemedicine

Q45: Are telemedicine consultations covered?
A: "Telemedicine consultations are covered under specific riders or plans that include OPD benefits. The coverage is subject to annual limits and may require consultations through approved platforms or network doctors."

Q46: Can digital health records be used for claims?
A: "Yes, digital health records, electronic prescriptions, and digital medical reports are accepted for claim processing, provided they are from recognized medical practitioners and meet the insurer's documentation requirements."

Premium & Payment Related

Q47: Are there any additional charges beyond the premium?
A: "Yes, additional charges may include service tax, policy administration charges, and installment processing fees. These are clearly mentioned in the policy document and are payable along with the premium."

Q48: Can premium be paid through insurance agents?
A: "Yes, premium can be paid through authorized insurance agents, but direct online payment often provides discounts. Agent payments should always be made through official receipt and proper documentation."

Q49: What payment modes are accepted for premium payment?
A: "Premiums can be paid through online banking, debit/credit cards, UPI, NEFT, RTGS, cheques, demand drafts, and cash (up to specified limits) at authorized collection centers."

Q50: Is there any penalty for late premium payment?
A: "Late premium payment within the grace period does not attract penalty, but no coverage is provided during this period. Payment beyond grace period requires policy revival with potential medical underwriting and additional charges."

Detailed Policy Terms & Conditions

Q51: What is the minimum and maximum age for policy coverage?
A: "Coverage is available for individuals from three (3) months of age to sixty-five (65) years at policy commencement. However, the policy can be renewed lifelong without any upper age limit."

Q52: What is the definition of 'Any One Illness' under the policy?
A: "Any one illness means continuous period of illness and includes relapse within forty-five (45) days from the date of last consultation with the hospital/nursing home where treatment was taken."

Q53: How many family members can be covered under a family floater policy?
A: "Family floater policy covers the insured, his/her lawfully wedded spouse, and dependent children. For parents/parents-in-law, separate floater policies can be taken. Individual sum insured policies can also cover dependent parents, sister, brother, parents-in-law, aunt, uncle, and grandchildren."

Q54: What is the moratorium period and how does it work?
A: "After completion of sixty (60) continuous months of coverage (including portability and migration), no look-back would be applied. This is called the moratorium period. After expiry of this period, no claim shall be contestable except for proven fraud and permanent exclusions."

Q55: Can the sum insured be enhanced during the policy term?
A: "Sum insured can be enhanced only at the time of renewal or at any time subject to underwriting by the company. For any increase in sum insured, the waiting period shall start afresh only for the enhanced portion of the sum insured."

Q56: What is the procedure for policy migration within the same company?
A: "The insured can migrate to other health insurance products/plans offered by the company by applying at least thirty (30) days before the policy renewal date. All accrued continuity benefits in waiting periods will be

protected as per IRDAI guidelines on migration."

Q57: What expenses are covered under Modern Treatment Methods?
A: "The policy covers expenses for modern treatments including Uterine Artery Embolization, HIFU, Balloon Sinuplasty, Deep Brain Stimulation, Oral Chemotherapy, Immunotherapy, Robotic Surgeries, Stereotactic Radio Surgeries, and Stem Cell Therapy for bone marrow transplant."

Q58: How does the Sum Insured Reinstatement benefit work?
A: "For sum insured less than Rs. 5 lakhs, reinstatement is available once per policy year. For sum insured Rs. 5 lakhs and above, unlimited reinstatement is available. The reinstated sum insured is available for subsequent claims after a gap of at least fifteen (15) days from date of discharge."

Q59: What is the Recharge benefit and when is it applicable?
A: "Recharge benefit is applicable only for sum insured Rs. 5 lakhs and above. The recharged limit is twenty percent (20%) of the sum insured, maximum up to Rs. 25 lakhs per policy year, and is available for utilization in the same claim."

Q60: What conditions must be met for Domiciliary Hospitalization coverage?
A: "Domiciliary hospitalization should exceed three (3) days and is covered when the patient's condition prevents movement to hospital or when treatment is taken at home due to non-availability of hospital room. However, conditions like asthma, bronchitis, diabetes, hypertension are excluded."

Q61: What is the limit for cataract surgery expenses?
A: "Cataract surgery expenses are limited to twenty percent (20%) of the sum insured for each eye, subject to maximum of Rs. 1,00,000 for each insured person. This limit can be waived by paying additional premium at policy inception."

Q62: How does the Family Visit benefit work?
A: "If the insured is hospitalized 200 kms away from residence, actual to-and-fro economy class transportation expenses for one family member/relative/friend will be reimbursed. The treating physician must certify the necessity for family member attendance."

Q63: What is covered under the Airlift Cover?
A: "Airlift cover reimburses expenses for life-threatening conditions requiring transportation from insured's location to hospital. The distance must be more than 200 kms, pre-approval is mandatory, and it's applicable only within Indian geographical limits."

Q64: What are the zone-wise discounts available?
A: "Zone B residents get fifteen percent (15%) discount on Zone A premium, Zone C residents get twenty-five percent (25%) discount. Zone A includes metros like Delhi, Mumbai, Hyderabad. Zone C includes states like Bihar, Goa, Punjab, Himachal Pradesh."

Q65: What is the wellness discount and how can it be availed?
A: "Wellness discount ranges from five percent (5%) to ten percent (10%) based on achieving 4-8 health parameters including HbA1c up to 6.5%, BMI 18-25, blood pressure up to 140/90, cholesterol up to 200mg/dl, and walking 5,000 steps daily for 20 days every month."

Q66: Can telemedicine consultations be availed unlimited times?
A: "No, each insured can utilize maximum five (5) consultations per day and maximum fifteen (15) online consultations per month. Only one active consultation is allowed at any given time."

Q67: What documents are required for International Cover claims?
A: "For international cover claims, passport and visa copy with entry stamp overseas and exit stamp from India, Release of Medical Information Form (ROMIF), and all standard claim documents are required."

Q68: What is the procedure for cashless claims?
A: "For planned treatment, intimate forty-eight (48) hours before hospitalization and request pre-authorization. For emergency, intimate within twenty-four (24) hours of hospitalization. Present authorization letter, ID card, and specified documents to network hospital."

Q69: How long does the company take to settle reimbursement claims?
A: "Claims are settled within thirty (30) days of receipt of last necessary document. If investigation is required, settlement will be within forty-five (45) days. Payment is made within seven (7) days of acceptance by the insured."

Q70: What is the procedure for adding new members to the policy?
A: "New members can be added by endorsement or at renewal. For newly added members, pre-existing disease clause, exclusions, and waiting periods will apply considering the policy year as the first year with the company."

Q71: Under what circumstances does coverage automatically terminate?
A: "Coverage terminates upon death of the insured or upon exhaustion of sum insured and cumulative bonus for the policy year. However, the policy remains subject to renewal on the due date."

Q72: What is the Early Entry Discount?
A: "Five percent (5%) discount is offered if the proposer opts for long-term policy prior to thirty-five (35) years of age. This discount applies at inception and each renewal until the insured completes forty-five (45) years of age."

Q73: How does the Voluntary Co-payment option work?
A: "If voluntary co-payment is opted, discount corresponding to co-payment (5%/10%/15%/20%) is applicable on premium. The insured bears the same percentage of eligible claim amount, and insurer's liability is only in excess of that sum."

Q74: What is the Free Look Period?
A: "Thirty (30) days free look period is available from date of receipt of policy document at inception only. If returned during this period without any claim, premium is refunded less medical examination expenses and stamp duty charges."

Q75: What are the contact details for claim intimation?
A: "Claims can be intimated at toll-free numbers 1800-103-2529 or 1800-22-5858. Address: Bajaj Allianz General Insurance Company Ltd, 2nd Floor, Bajaj Finserv Building, Behind Weikfield IT Park, Off Nagar Road, Viman Nagar, Pune 411014."

Specific Disease & Treatment Coverage

Q76: Which specific diseases have twenty-four (24) months waiting period?

A: "Cataracts, Hernia of all types, Benign prostatic hypertrophy, Fibromyoma, Hysterectomy, Surgery for varicose veins, Joint replacement surgery, Bariatric surgery, and thirty-two (32) other specified conditions have 24 months waiting period."

Q77: What is covered under AYUSH treatment?
A: "AYUSH treatment covers inpatient hospitalization expenses for Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy systems in government hospitals or AYUSH hospitals recognized by respective government authorities."

Q78: Are congenital diseases covered?
A: "Internal congenital anomalies have thirty (30) months waiting period. External congenital diseases, defects, or anomalies are excluded. Growth hormone therapy and stem cell implantation are excluded except hematopoietic stem cells for bone marrow transplant."

Q79: What mental health conditions are covered?
A: "Mental health treatments are covered for inpatient hospitalization only, subject to sub-limit typically ranging from Rs. 50,000 to Rs. 1,00,000 per policy year. Outpatient psychiatric consultations are generally excluded."

Q80: Are obesity-related treatments covered?
A: "Obesity-related surgical treatment is covered only if BMI is greater than or equal to 40, or greater than 35 with severe co-morbidities like obesity-related cardiomyopathy, coronary heart disease, severe sleep apnea, or uncontrolled Type 2 diabetes."

OPD & Additional Benefits

Q81: What is the sub-limit for doctor consultations under OPD cover?
A: "General physician consultation is limited to Rs. 500 per consultation and specialist consultation to Rs. 1,200 per consultation. Maximum five (5) consultations per day and fifteen (15) consultations per month are allowed."

Q82: What tests are included in the Annual Preventive Health Check-up?
A: "The check-up includes CBC, ESR, Liver function tests (SGOT, SGPT, Bilirubin), Urine routine, Sugar profile (Fasting blood sugar, HbA1c), Lipid profile, Kidney function tests, and Thyroid tests (T3, T4, TSH)."

Q83: Can the preventive health check-up be taken at home?
A: "Home collection facility is available only at selected locations. Where home sample collection is not available, the customer must physically visit the diagnostic center. The complete list of tests must be completed in a single appointment."

Q84: What is the procedure for OPD reimbursement claims?
A: "Pre-approval is required for non-network doctors and diagnostic centers. Reimbursement requests without pre-approval will not be accepted. Authorization must be taken through the Caringly Yours app before the visit."

Q85: Are physiotherapy and diet counseling covered under OPD?
A: "No, the plan does not cover yoga, naturopathy, reiki, acupuncture, acupressure, physiotherapy, psychiatric counseling, or diet counseling under the doctor consultation cover."

Claims & Settlement Details

Q86: What is the time limit for claim intimation?
A: "Claims must be intimated within forty-eight (48) hours of hospitalization for cashless claims and within thirty (30) days of discharge for reimbursement claims. Waiver may be considered in extreme hardship cases."

Q87: What happens if original documents are with co-insurer?
A: "If original documents are submitted with co-insurer, attested Xerox copies along with declaration from the particular insurer specifying availability of original copies can be submitted."

Q88: What is the penalty for delayed claim settlement?
A: "For delay in claim payment, the company is liable to pay interest at two percent (2%) above the bank rate from the date of receipt of last necessary document to the date of payment."

Q89: What additional documents are required for Renewal Premium Waiver Benefit claims?
A: "Death certificate stating the reason of death is required in addition to standard claim documents. The benefit covers renewal premium for dependent insured members for one policy year."

Q90: Can claims be made for treatment outside India?
A: "Treatment outside India is not covered under standard policy except when 'International Cover-emergency care only' optional cover is chosen. This cover has mandatory ten percent (10%) co-payment and is limited to forty-five (45) days per trip."

Non-Medical Items & Exclusions

Q91: What items are considered non-medical and excluded?
A: "Non-medical items include baby food, beauty services, email/internet charges, laundry charges, mineral water, sanitary pads, telephone charges, guest services, diapers, television charges, attendant charges, and courier charges."

Q92: What items are subsumed into room charges?
A: "Items like baby charges, hand wash, shoe cover, caps, cradle charges, comb, gown, slippers, tissue paper, toothpaste, toothbrush, bed pan, face mask, and luxury tax are included in room charges."

Q93: What expenses are covered under Consumable Expenses cover?
A: "Consumables include belts/braces, cold pack/hot pack, crepe bandage, eyelet collar, slings, oxygen cylinder for outside hospital use, nebulizer kit, thermometer, cervical collar, knee braces, and other specified medical consumables."

Q94: Are experimental treatments covered?
A: "No, unproven/experimental treatments that lack significant medical documentation to support their effectiveness are excluded. Only established medical procedures recognized by the medical community are covered."

Q95: What dental treatments are covered?
A: "Dental treatment is covered only when necessitated due to accidental injuries or as part of covered surgical procedure requiring hospitalization. Cosmetic dentistry, dentures, dental implants, and orthodontics are excluded."

Policy Administration

Q96: How can policy documents be downloaded?
A: "Policy documents can be downloaded through the company website using policy number and registered mobile number, or through the Caringly Yours mobile app after logging in with registered credentials."

Q97: What is the procedure for policy cancellation by policyholder?
A: "Policy can be cancelled by providing seven (7) days written notice. Premium refund for unexpired period is on pro-rata basis provided no claim has been made during the policy year."

Q98: Can premium be paid in installments?
A: "Yes, premium can be paid annually, half-yearly, quarterly, or monthly. Grace period of fifteen (15) days for monthly and thirty (30) days for other frequencies is available. No interest is charged for delayed installment payment within grace period."

Q99: What discounts are available for long-term policies?
A: "Four percent (4%) discount for two-year policies and eight percent (8%) discount for three-year policies are available. Long-term discount is not applicable to policies where premium is paid in installments."

Q100: What is the loyalty discount?
A: "Five percent (5%) discount is offered if the insured has any active Bajaj Allianz retail policy (Motor, Health, Home, Cyber, Pet Insurance) with minimum premium of Rs. 2,500."

CONTACT INFORMATION

Customer Service
- **Toll-Free:** 1800-210-1030
- **Email:** bagichelp@bajajallianz.co.in
- **Website:** www.bajajallianz.com

Corporate Address
Bajaj Allianz House
Airport Road, Yerawada
Pune - 411006
Maharashtra, India

Online Services
- **Mobile App:** Caringly Yours
- **Policy Management:** Online portal
- **Claim Status:** Real-time tracking

Branch Network
- **Regional Offices:** 100+
- **Service Centers:** 1,000+
- **Agents:** 50,000+

IMPORTANT DISCLAIMERS

1. **Policy Terms:** This guide is for general information. Actual policy terms and conditions available in policy document.

2. **Premium Rates:** Premiums mentioned are indicative. Actual rates depend on various factors and are subject to change.

3. **Coverage Details:** Coverage details may vary by plan and state regulations. Always read policy wordings carefully.

4. **Regulatory Compliance:** All policies subject to IRDAI regulations and guidelines.

5. **Medical Underwriting:** High sum insured policies may require medical tests and underwriting.

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Document prepared based on information available from official Bajaj Allianz sources and regulatory filings

Remember: Insurance is a contract of utmost good faith. Disclose all material facts honestly to avoid claim rejections.