Bajaj Allianz General Insurance Company Limited
Bajaj Allianz House, Airport Road, Yerawada, Pune - 411 006. Reg. No.: 113
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call at : **Sales - 1800 209 0144 / Service - 1800 209 5858** (Toll Free No.)
Issuing Office :

HEALTH GUARD (GROUP) GOLD PLAN

Policy Wordings

Preamble

Whereas the Policy Holder has made to Bajaj Allianz General Insurance Company Ltd (hereinafter called the "Company"), a proposal which is hereby agreed to be the basis of this Master Policy/Certificate of Insurance and has paid the premium specified in the Schedule, now the Company agrees, subject always to the following terms, conditions, exclusions and limitations, to indemnify the Insured Person and subject always up to the Sum Assured specified in the Certificate of Insurance.

Eligibility

a. All members forming part of the Group can be covered with Individual Sum Insured for each Insured Person

b. All Families forming part of the Group can be covered with Floater Sum Insured for each family

Policy Period under Certificate of Insurance:

- 1 Year

Scope of cover

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

A. COVERAGE

1. In-patient Hospitalisation Treatment

If the Insured Person is hospitalized on the advice of a Doctor as defined under policy because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then the Company will pay the Insured Person, Reasonable and Customary Medical Expenses incurred subject to

i. Room, Boarding and Nursing Expenses as provided by the Hospital/ Nursing Home without any sublimit.

ii. If admitted in ICU, the Company will pay up to actual expenses provided by Hospital.

iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees.

iv. Anesthesia, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like Pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents, relevant laboratory diagnostic tests, X-ray and such similar expenses that are medically necessary.

Note- The Company's obligation to make payment in respect of surgeries for cataracts (after the expiry of the 24 months period), shall be restricted to 20% of the Sum insured for each eye, subject to maximum of Rs 1,00,000/-.

2. Pre-Hospitalisation

The Medical Expenses incurred during the 60 days immediately before the Insured Person was Hospitalised, provided that: Such Medical Expenses were incurred for the same illness/injury for which subsequent Hospitalisation was required, and the Company has accepted an inpatient Hospitalisation claim under "Inpatient Hospitalisation Treatment" (Section A1).

3. Post-Hospitalisation

The Medical Expenses incurred during the 90 days immediately after the Insured Person was discharged post Hospitalisation provided that: Such costs are incurred in respect of the same illness/injury for which the earlier Hospitalisation was required, and the Company has accepted an inpatient Hospitalisation claim under Inpatient Hospitalisation Treatment (Section A1).

4. Road Ambulance

The Company will pay the reasonable cost upto a maximum of Rs 20000/- per Policy Period incurred on an ambulance offered by a healthcare or ambulance service provider for transferring the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of health services following an Emergency.

The Company will also reimburse the expenses incurred on an ambulance offered by a healthcare or ambulance service provider for transferring the Insured Person from the Hospital where he/ she was admitted initially to another hospital with higher medical facilities.

Claim under this section shall be payable by the Company only when:

i. Such life threatening emergency condition is certified by the Medical Practitioner, and

ii. The Company has accepted Insured Person's Claim under "In-patient Hospitalisation Treatment" or "Day Care Procedures" section of the Policy.

Subject otherwise to the terms, conditions and exclusions of the Policy.

5. Day Care Procedures

The Company will pay the Insured Person the medical expenses as listed above under Section A1 "In-patient Hospitalisation Treatment" for Day care procedures / Surgeries taken as an inpatient in a hospital or day care centre but not in the outpatient department.

List of Day Care Procedures is given in the annexure I of Policy wordings.

6. Organ Donor Expenses:

The Company will pay expenses towards organ donor's treatment for harvesting of the donated organ, provided that,

i. The organ donor is any person whose organ has been made available in accordance and in compliance with THE TRANSPLANTATION OF HUMAN ORGANS (AMENDMENT) BILL, 2011 and the organ donated is for the use of the Insured Person, and

ii. The Company has accepted an inpatient Hospitalisation claim for the Insured Person under In Patient Hospitalisation Treatment (section A1).

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7. Convalescence Benefit:

In the event of Insured Person hospitalised for a disease/illness/injury for a continuous period exceeding 10 days, the Company will pay benefit amount of Rs. 5,000 for Sum Insured up to Rs. 5lacs and Rs. 7500 for Sum Insured 7.5lacs and above per Policy Period.

This benefit will be triggered provided that the hospitalization claim is accepted under Section A1- In Patient Hospitalisation Treatment.

8. Daily Cash Benefit for Accompanying an Insured Child

The Company will pay Daily Cash Benefit of Rs. 500 per day maximum up to 10 days during each Policy Period for reasonable accommodation expenses in respect of one parent/legal guardian, to stay with any minor Insured Person (under the Age of 12 years), provided the hospitalization claim is paid under Section A1 Inpatient Hospitalisation Treatment.

9. Sum Insured Reinstatement Benefit:

If Section A1 Inpatient Hospitalization Treatment Sum Insured and Cumulative Bonus (if any) is exhausted due to claims lodged during the Policy Period, then it is agreed that 100% of the Sum Insured specified under Inpatient Hospitalization Treatment be reinstated for the particular Policy Period provided that:

1. The reinstated Sum Insured will be triggered only after the Inpatient Hospitalization Treatment Sum Insured inclusive of the Cumulative Bonus(If applicable) has been completely exhausted during the Policy Period;
2. The reinstated Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Inpatient Hospitalization Treatment.
3. If the claimed amount is higher than the Balance Sum Insured inclusive of the Cumulative Bonus(If applicable) under the policy, then this benefit will not be triggered for such claims
4. The reinstated Sum Insured would be triggered only for subsequent claims made by the Insured Person. In case of relapse within 45 days, this benefit will not trigger
5. This benefit is applicable only once during each policy period & will not be carried forward to the subsequent Policy Period/ renewals if the benefit is not utilized.
6. This benefit is applicable only once in life time of Insured Person covered under this policy for claims regarding CANCER OF SPECIFIED SEVERITY and KIDNEY FAILURE REQUIRING REGULAR DIALYSIS as defined under the policy.
7. Additional premium would not be charged for reinstatement of the Sum Insured.
8. Incase Policy having sum insured on Family Floater basis, Reinstatement of Sum Insured will be available for all Insured Persons in the Policy.

10. Preventive Health Check Up

At the end of block of every continuous period of 3 years during which the Insured Person has held Our Health Guard (Group) policy, the Insured Person is eligible for a free Preventive Health checkup. The Company will reimburse the amount equal to 1% of the sum insured max up to Rs. 5000/- for each member in the policy having Individual sum insured during the block of 3 years.

For Policy having Sum Insured on Floater Basis: This benefit can be availed by proposer & spouse only and the Company will reimburse the amount equal to 1% of the sum insured max up to Rs. 5000/- for proposer and spouse individually. The Insured Person may approach the Company for the arrangement of the Health Check up. For the avoidance of doubt, the Company shall not be liable for any other ancillary or peripheral costs or expenses (including but not limited to those for transportation, accommodation or sustenance).

11. Ayurvedic / Homeopathic Hospitalisation Expenses

If the Insured Person is Hospitalised for not less than 24 hrs, in an Ayurvedic / Homeopathic Hospital which is a government hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health and/or Teaching hospitals of AYUSH colleges recognized by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH) and/or AYUSH Hospitals on the advice of a Doctor because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period then the Company will pay the Insured Person:

In-patient Treatment- Medical Expenses for Ayurvedic and Homeopathic treatment:

- Room rent, boarding expenses
- Nursing care
- Consultation fees
- Medicines, drugs and consumables,
- Ayurvedic and Homeopathic treatment procedures

The Company's maximum liability is up to Rs. 20000 per Policy Period.

The claim will be admissible under the policy provided that,

i. The illness/injury requires inpatient admission and the procedure performed on the Insured Person cannot be carried out on out-patient basis

12. Maternity Expenses

The Company will pay the Medical Expenses for the delivery of a baby (including caesarean section) and/or expenses related to medically recommended and lawful termination of pregnancy, limited to maximum 2 deliveries or termination(s) or either, during the lifetime of the Insured Person, provided that,

i. The Company's maximum liability per delivery or termination shall be limited to the amount specified in the policy Schedule as per Sum Insured opted.
ii. From Sum insured Rs. 3lacs to Rs. 7.5 lacs is restricted to Rs. 15000 for normal delivery and Rs. 25000 for caesarean section and from Sum insured Rs. 10 lacs to Rs. 50lacs is restricted to Rs. 25000 for normal delivery and Rs. 35000 for caesarean section.
iii. The Company will pay the Medical Expenses of pre-natal and post-natal hospitalization per delivery or termination upto the amount stated in the policy Schedule.
iv. Waiting period of 72 months from the date of issuance of the first policy with the Company, provided that the policy has been renewed continuously renewed with the Company without break for the Insured Person. Fresh waiting period of 72 months would apply for all the policies which are issued with continuity under portability guidelines either from the Company's existing Health Product or any other Non-Health or Standalone Health Insurance Company.
v. The Company will not cover Ectopic pregnancy and Miscarriage due to accident under this benefit (although it shall be covered under section A1 In patient Hospitalisation Treatment)

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vi. Any complications arising out of or as a consequence of maternity/child birth will be covered within the limit of Sum Insured available under this benefit.

13. New Born Baby Cover

Coverage for new born baby will be considered subject to a valid claim being accepted under Maternity Expenses (section A12). The Company will pay the following expenses within the limit of the Sum Insured available under the Maternity Expenses section.

The Company will pay for,

i. Medical Expenses towards treatment of The Insured Person's new born baby while he/ she is hospitalised as an inpatient for delivery for the hospitalisation,

ii. Hospitalisation charges incurred on the new born baby during post birth including any complications shall be covered up to a period of 90 days from the date of birth and within limit of the Sum Insured under Maternity Expenses without payment of any additional premium

iii. Mandatory Vaccinations of the new born baby up to 90 days, as recommended by the Indian Pediatric Association will be covered under the Maternity Expenses Sum Insured.

14. Bariatric Surgery Cover

If the Insured Person is hospitalized on the advice of a Doctor because of Conditions mentioned below which required the Insured Person to undergo Bariatric Surgery during the Policy Period, then the Company will pay the Insured Person, Reasonable and Customary Expenses related to Bariatric Surgery.

Eligibility:

For adults aged 18 years or older, presence of severe obesity documented in contemporaneous clinical records, defined as any of the following:

BMI greater than and equal to 40in conjunctions with any of the following severe comorbidities:

1. Coronary heart disease; or
2. Medically refractory hypertension (blood pressure greater than 140 mm Hg systolic and/or 90 mm Hg diastolic despite concurrent use of 3 anti-hypertensive agents of different classes); or
3. Type 2 diabetes mellitus

Special Conditions applicable to Bariatric Surgery Cover

- This benefit is subject to a waiting period of 36 months from the date of first commencement of this policy and continuous renewal thereof with the Company. Fresh waiting period of 36 months would apply for all the policies which are issued with continuity under portability guidelines either from the Company's existing Health Product or any other Non-Health or Standalone Health Insurance Company.
- Policies which are issued with continuity under portability guidelines either from the Company's existing Health Product or any other Non-Health or Standalone Health Insurance Company will have to wait for 36 months from issuance of Health Guard (Group) policy to avail this benefit.
- The Company's maximum liability will be restricted to 50% of Sum insured maximum up to Rs. 5lac.
- Bariatric surgery performed for Cosmetic reasons is excluded.
- The indication for the procedure should be found appropriate by two qualified surgeons and the Insured Person shall obtain prior approval for cashless treatment from the Company.

15. Preventive and Wellness Benefits

A. Preventive and Wellness Benefits (Individual Sum Insured Policy)

The Insured Person is eligible for preventive and wellness benefits which he/ she can earn as reward points known as Healthkarats by:

a. Registering in the Bajaj Allianz General Insurance Company Ltd's (BAGIC) Preventive and Wellness Benefit Portal insurance wallet/pro-fit.bjaz.in and

b. Participating in any or all the activities mentioned in the Activity Chart shown below.

Healthkarats Benefits

The earned Healthkarats can be utilized in the following manner

I. Claim Free Policy Period

The Insured Person is eligible for increase in Sum Insured at the time of renewal by an amount equivalent to the value of the Healthkarats.

The value of the Healthkarats will be computed in the following manner.

i. Each Healthkarats will be equivalent to INR 1.00
ii. The total healthkarats earned during the policy period shall be multiplied by INR 1.00 to arrive at the value of the Healthkarats by which the Sum Insured at the time of renewal shall be increased.
iii. Sum Insured at the time of renewal will be increased by the value of Healthkarats arrived at as per Point (ii) above.

II. Claim during the Policy Period

In the event of a claim during the policy period the Insured Person can utilize the earned Healthkarats up to the date of claim in the following manner.

i. For payment of Non-medical expenses or
ii. For payment of co-pay.

The earned Healthkarats shall be computed in the following manner

i. Each Healthkarats will be equivalent to INR 0.50
ii. The total healthkarats earned up to the date of claim during the policy period shall be multiplied by INR 0.50 to arrive at the value of the Healthkarats.
iii. The value of the Healthkarats so arrived at can be utilized at the time of claim during the policy period either for the payment of Non-medical expenses or for the payment of co-pay.

B. Preventive and Wellness Benefits (Floater Sum Insured Policies)

The Insured Persons under floater policy are eligible for preventive and wellness benefits which he/ she can earn as reward points known as Healthkarats by:

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a. Registering in the Bajaj Allianz General Insurance Company Ltd's (BAGIC) Preventive and Wellness Benefit Portal- insurance wallet/pro-fit.bjaz.in and

b. Participating in any or all the activities mentioned in the Activity Chart shown below.

c. Total sum of the Healthkarats of all the Insured Persons covered under the floater Policy (who have exceeded the threshold of 2000 Healthkarats) will be considered for utilization by any of the Insured Persons covered under the floater Policy

Healthkarats Benefits

The earned Healthkarats can be utilized in the following manner

I. Claim Free Policy Period

The floater Sum Insured shall be increased at the time of renewal by an amount equivalent to the value of the Healthkarats.

The value of the Healthkarats will be computed in the following manner.

i. Each Healthkarats will be equivalent to INR 1.00

ii. The total healthkarats earned during the policy period shall be multiplied by INR 1.00 to arrive at the value of the Healthkarats by which the Sum Insured at the time of renewal shall be increased.

iii. Sum Insured at the time of renewal will be increased by the value of Healthkarats arrived at as per Point (ii) above.

II. Claim during the Policy Period

In the event of a claim during the floater policy period the Insured Person(s) can utilize the earned Healthkarats up to the date of claim in the following manner.

i. For payment of Non-medical expenses or

ii. For payment of co-pay.

The earned Healthkarats shall be computed in the following manner

i. Each Healthkarats will be equivalent to INR 0.50

ii. The total healthkarats earned up to the date of claim during the policy period shall be multiplied by INR 0.50 to arrive at the value of the Healthkarats.

iii. The value of the Healthkarats so arrived at can be utilized at the time of claim during the policy period either for the payment of Non-medical expenses or for the payment of co-pay.

Conditions (for Preventive and Wellness Benefits- Individual and Floater Sum Insured Policies)

The Insured Person can utilize the healthkarats anytime throughout a year subject to below conditions:

1. The Healthkarats Benefit Amount can be redeemed only if the health karats exceeds 2000 points.
2. The Healthkarats Benefit Amount can be redeemed in the event of a claim during the current Policy Period in which the health points are earned.
3. The cost of the health check-up (Basic, executive and comprehensive). Diabetes disease management, Hypertension/CVA disease management, Dyslipidaemia management, Obesity Management will have to be borne by the Insured Person. The tests can be done at any of the Company's Network Providers mentioned on the Company's website www.general.bajajallianz.com. Reward points will also be available in case the Insured Person undertakes the specified tests at other than our Network providers.
4. The Health Checkup done as a part of Coverage "**Section A 10.Preventive Health Check Up**" at the end of block of every continuous period of 3 years during which the Insured Person has held Our Health Guard (Group) will be considered for giving credit of the Healthkarats Benefit.
5. The Annual subscription for fitness activities such as swimming/ /gym/Yoga and participation in marathon will have to be borne by the Insured Person.

Validity of Reward Points:

In Case of renewal of a claim free policy, the Insured Person has to redeem the reward points within next 30 days from expiry date of the Policy.

Please refer annexure III for the details on healthkarats, its utilization and illustration.

Activity Chart:

(For Preventive and Wellness Benefits- Individual and Floater Sum Insured Policies)

The Activities Identified against which Healthkarat will be allotted are as follows

Activity Description	Reward Healthkarats	Maximum Healthkarats that can be earned in a year	Healthkarats breakup with Frequency
Registration and addition of your policy			
On signing up	250	250	One time activity
Addition of Health insurance policy Card/policy Details	25	100	25 Healthkarats per policy and a maximum of 100 Healthkarats can be accrued. Only one card can be added per login.
Health Risk Assessment			
Attempt	100		Frequency- once in 6 months
Completed in multiple sessions	50	250	Maximum only 2 times will be considered- one at the beginning of policy and 2nd one after the 6 months.
Completed in single session (Attempt and Completed)	250		
Wellness score- 0-40	0	200 (Maximum healthkarats that can be earned based on outcome if taken 2 times a year)	
Wellness score- 41-60	50		
Wellness score- 61-80	75		
Wellness score- Above 80	100		
Improvement by one slab	50		
Fall by one slab	-50		

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Health Check-up**- Basic	250	500	Once in year - 250 and twice a year- 500
Health Check-up**- Executive	500	1000	Once in year - 500 and twice a year- 1000
Health Check-up**- Comprehensive	1000	2000	Once in year - 1000 and twice a year- 2000
HbA1c- For Diabetes	50	200	Can be done once in a quarter, max four times a year. Per investigation 50 Healthkarats, max 200 Healthkarats in a year
2D Echo	100	200	Can be done once in a half year, max two times a year. Per investigation 100 Healthkarats, max 200 Healthkarats in a year
C TMT	100	200	Can be done once in a half year, max two times a year. Per investigation 100 Healthkarats, max 200 Healthkarats in a year
Chest X ray/USG	100	200	Can be done once in a half year, max two times a year. Per investigation 100 Healthkarats, max 200 Healthkarats in a year
PAP Smear/PSA for above 40yrs	200	200	Can be done once in a year, max once a year. Per investigation 200 Healthkarats, max 200 Healthkarats in a year
Mammography above 35yrs	200	200	Can be done once in a year, max once a year. Per investigation 200 Healthkarats, max 200 Healthkarats in a year
Additional test suggested by Medical Expert that is not included in any of the health check-up packages	100	200	Can be done once in a half year, max two times a year. Per investigation 100 Healthkarats, max 200 Healthkarats in a year
Disease management program			
Diabetes Disease management having minimum below parameters	1000	1000	Purchase-1000
HbA1c			
Blood Sugar- Fasting and PP			
Urine Analysis- Protein and Sugar			
Thyroid Function			
Diet plan			
Health Coach			
Hypertension/ CV Disease management having minimum below parameters			
ECG			
Blood Pressure Readings- three consecutive readings			
2D Echo			
Stress test			
Lipid Profile			
Kidney Profile			
Diet plan			
Health Coach			
Dyslipidaemia Management having minimum below parameters			
Lipid Profile			
ECG			
Diet plan			
Health Coach			
Obesity Management having minimum below parameters			
BMI			
Hip-waist ratio- 3 consecutive readings			
Diet plan			
Health Coach			

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Count your steps			
6000- 8000 steps/day	5 per day		
8001-10000 steps/day	7.5 per day	3650	max 3650 in a Policy Period
above 10000	10 per day		
Health Challenges- at least 4 challenges in a year	10	40	10 Per Challenge, max 40 Healthkarats in a Policy Period
Fitness Subscription			
Annual Subscription of Swimming/ /Gym/Yoga / Any other Similar Fitness Activity	1000	1000	(Sign up-750+ Weekly log- 5 (5*50=250))
Marathon Participation	500	1000	500 Per participation, max 1000 Healthkarats in a Policy Period
** As per annexure attached			

Health Check-up		
BASIC (Vital)-	EXECUTIVE (MALE/FEMALE)-	COMPREHENSIVE(MALE/FEMALE)-
CBC	CBC	CBC
FMR	ESR	ESR
Urine Routine	Blood Group	Blood Group
	Urine Routine	Urine Routine
	VIT D3	VIT D3
	VIT B12	VIT B12
	TSH	T3
		T4
		TSH
FBS	FBS	FBS
	PPBS	PPBS
		Fasting Insulin
HbA1c		HB1Ac
	BUN	BUN
S.Creatinine	S.Creatinine	S.Creatinine
	S. Electrolytes	S. Electrolytes
	S.Uric Acid	S. Calicum
		S.Uric Acid
	Billirubin	Billirubin
	Total Protein	Total Protein
	Albumin	Albumin
	Globulin	Globulin
SGOT	SGOT	SGOT
SGPT	SGPT	SGPT
	Alkaline Phosphatase	Alkaline Phosphatase
GGTP	GGTP	GGTP
	Chest X-Ray	Chest X-Ray
		USG Abdomen & Pelvis
		BMD
		Mammography*
ECG	ECG	ECG
	Stress Test	Stress Test
		2D Echo
Total Cholesterol	Total Cholesterol	Total Cholesterol
Triglycerides	Triglycerides	Triglycerides
HDL	HDl	HDl

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	LDL	LDL
	VLDL	VLDL
		Lipoprotein(Lp(a))
		Apolipoprotein A1
		Apolipoprotein B
		Apo A1/Apo B Ratio
Physician	Physician	Physician
	Ophthalmologist	Ophthalmologist
	Gynaecologist*	Gynaecologist*
	Dentist	Dentist
	ENT	ENT
		Dietician
	Pap Smear*	Pap Smear*
	PSA**	PSA**
		CEA
		CA - 125*
	Pulmonary Function Test	Pulmonary Fuction Test
	Audiometry	Audiometry
		HBsAg (ELISA)
		HIV I & II (ELISA)

*- Tests to be conducted only for female

**- Tests to be conducted only for Male

B. Definitions

1. **Accident**

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

2. **Act of Terrorism:-**

Whoever

a. With intent to threaten the unity, integrity, security or sovereignty of India or to strike terror in the people or any section of the people does any act or thing by using bombs, dynamite or other explosive substances or inflammable substances or firearms or other lethal weapons or poisons or noxious gases or other chemicals or by any other substances (whether biological or otherwise) of a hazardous nature or by any other means whatsoever, in such a manner as to cause or likely to cause, death of or injuries to any person or persons or loss of or damage to or destruction of property or disruption of any supplies or services essential to the life of the community or causes damage or destruction of any property or equipment used or intended to be used for the defense of India or in connection with any other purposes of the Government of India, any state government or any of their agencies or detains any person and threatens to kill or injure such person in order to compel the Government or any other person to do or abstain from doing any act

b. Is or continues to be a member of an association declared unlawful under the Unlawful Activities (Prevention) Act 1967, (37 of 1967), or voluntarily does an act aiding or promoting in any manner the objects of such association and in either case is in possession of any unlicensed firearms, ammunition, explosives or other instrument or substances capable of causing mass destruction and commits any act resulting in loss of human life or grievous injury to any person or causes significant damage to any property, commits a terrorist act

3. **Any one illness**

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

4. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

5. **Ayurvedic / Homeopathic Hospitals**- means the hospitals having registration with a Government authority under appropriate Act in the State/UT and complies with the following as minimum criteria

a. has at least 15 inpatient beds

b. has minimum five qualified and registered AYUSH doctors

c. has qualified paramedical staff under its employment round the clock

d. has dedicated Ayurvedic / Homeopathic therapy sections

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

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6. **Bajaj Allianz Network Hospitals / Network Hospitals**

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

7. **Bajaj Allianz Diagnostic Centre**

   Bajaj Allianz Diagnostic Centre means the diagnostic centers which have been empanelled by us as per the latest version of the schedule of diagnostic centers maintained by Us, which is available to You on request.

8. **Bariatric surgery:**

   Bariatric Surgery means Surgery on the stomach and/or intestines to help a person with extreme obesity to lose weight. Bariatric surgery is an option for people who have a body mass index (BMI) above 40. Surgery is also an option for people with a body mass index between 35 and 40 who have health problems like type 2 diabetes or heart disease.

9. **Cancer of Specified Severity**

   A malignant tumor characterized by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy The term cancer includes leukemia, lymphoma and sarcoma.

   The following are excluded –

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

10. **Cashless facility**

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

11. **Certificate of Insurance** means the document issued by the Company to the Insured as per these terms and conditions detailing the commencement date and expiry date of the cover, Insured Person(s) name, address, age, coverage, sums insured, condition(s), exclusions and or endorsement(s).

12. **Co-Payment**

    Co-payment means a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

13. **Condition Precedent**

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

14. **Congenital Anomaly**

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

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

15. **Cumulative Bonus**

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

16. **Day care centre**

    A day care centre means any institution established for day care treatment of illness and / or injuries or a medical set -up 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:-

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

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17. Day Care Treatment

Day care treatment means to medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and

ii. Which would have otherwise required a hospitalization of more than 24 hours.

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

18. Dental Treatment

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

19. Disclosure to information norm

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

20. 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 Person's health.

21. Family

For the purpose of Individual Sum Insured policy- includes the insured; his/her lawfully wedded spouse and dependent children and dependent parents,

For the purpose of Floater Sum Insured Policy- includes the insured; his/her lawfully wedded spouse and dependent children.

22. Grace Period

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

23. 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 015/IRDA/Life/Circular/GI Guidelines/2005 dated 14th July 2005, as amended/modified/further guidelines issued, from time to time

24. Hospital

A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

--has qualified nursing staff under its employment round the clock;

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

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

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

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

25. Hospitalisation

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

26. Illness

Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

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

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

— it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests

—it needs ongoing or long-term control or relief of symptoms

— it requires rehabilitation or for the patient to be specially trained to cope with it

—it continues indefinitely

—it recurs or is likely to recur..

27. Inpatient Care

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

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28. Injury/ Bodily Injury

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

29. **Insured** mean the Policy Holder who has taken the Group Insurance Policy as Group Manager of a homogeneous group of person who assemble together for a community of purpose and there is a clarity evident relationship between the member of group and group manager for services other than insurance.

30. **Insured Person or Insured Beneficiary or member of Group** means the person(s) named in the Certificate of Insurance who shall be the beneficiary under the Policy.

31. Intensive Care Unit

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

32. ICU Charges

    ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

33. Kidney Failure Requiring Regular Dialysis

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

34. Limit of Indemnity

    Limit of Indemnity represents Our maximum liability to make payment for each and every claim per person and collectively for all persons mentioned in the Certificate of Insurance during the Policy Period and in the aggregate for the person(s) named in the Certificate of Insurance during the Policy Period, and means the amount stated in the Certificate of Insurance against each Cover.

35. **Master Policy** shall mean the group Policy issued to the Insured containing the terms and conditions of the insurance coverage and under which Certificates of Insurance shall be issued to the Insured Person/Insured Beneficiary. The validity of the Master Policy shall be for a period of twelve months as mentioned in the Group Policy Schedule

36. Maternity expense / treatment shall include the following Medical treatment Expenses:

    Maternity expenses means;

a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

b. expenses towards lawful medical termination of pregnancy during the Policy Period.

37. Medical Advise

    Medical advise means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription

38. Medical expenses

    Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

39. Medical Practitioner

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

40. Medically Necessary Treatment

    Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

    - is required for the medical management of the illness or injury suffered by the insured;
    - must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    - must have been prescribed by a medical practitioner,
    - must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

41. Network Provider

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

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42. New Born Baby

    Newborn baby means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

43. Non- Network Provider

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

44. Notification of Claim

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

45. OPD treatment

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

46. **Obesity** means abnormal or excessive fat accumulation that may impair health. Obesity is measured in Body Mass Index.

    Body mass index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m2).

    The WHO definition is:

- BMI greater than or equal to 25 is overweight
- BMI greater than or equal to 30 is obesity

47. **Policy** means the proposal, the certificate of insurance, the Master Policy/Health Guard (Group) Policy Schedule, the Policy documents, these Terms and Conditions and any endorsements attaching to or forming part hereof either on the commencement date or during the Policy Period.

48. **Policyholder** is the Organization or Entity which has taken the policy on behalf of all Insured Persons/Insured Beneficiary.

49. **Policy Period:** means period for which the Insured Person/Insured Beneficiary is covered under the Certificate of Insurance.

50. **Master Policy Period:** means period for which the Master Policy is valid in the name of Insured.

51. Portability

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

52. Pre-Existing Disease

    Pre-Existing Disease means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.

53. Pre-hospitalization Medical Expenses

    Pre-hospitalization Medical Expenses means Medical Expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person , provided that:

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

54. Post-hospitalization Medical Expenses

    Post-hospitalization Medical Expenses means Medical Expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the hospital, provided that:

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

55. Qualified Nurse

    Qualified nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

56. Reasonable and Customary Charges

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

57. Room rent

    Roome rent means the amount charged by a hospital towards Room and Boarding expenses and shall include associated medical expenses.

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58. Renewal

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

59. Surgery or Surgical Procedure

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

60. **Schedule** means the Health Guard (Group) Policy schedule and any annexure to it read with respective Certificate of Insurance.

61. **Sum Assured** means the amount stated in the Certificate of Insurance against each relevant Section, which shall be the Company's maximum liability under this Policy.

62. Unproven/Experimental treatment

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

63. **You, Your, Yourself, Your Family** the Insured Person/Insured Beneficiary, family members of Insured Person [in floater Policy] as set out in the Certificate of Insurance.

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

C. EXCLUSIONS UNDER THE POLICY

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

I. Waiting Period

1. Benefits will not be available for Any Pre-existing condition, ailment or injury, until 36 months of continuous coverage have elapsed, after the date of inception of the first Health Guard (Group) policy, provided the preexisting disease / ailment / injury is disclosed on the proposal form.

The above exclusion 1 shall cease to apply if the Insured person has maintained a Health Guard (Group) policy with the Company for a continuous period of a full 36 months without break from the date of his/ her first Health Guard (Group) policy.

In case of enhancement of Sum Insured, this exclusion shall apply afresh only to the extent of the amount by which the limit of indemnity has been increased (i.e. enhanced Sum Insured) and if the policy is a renewal of Health Guard (Group) policy with the Company without break in cover.

2. The Company will also not pay for claims arising out of or howsoever connected to the following for the first 24 months of Health Guard (Group) policy,

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

This exclusion shall apply for a continuous period of 36 months from the date of Insured Person's first Health Guard (Group) policy, if the above referred illness were present at the time of commencement of the policy and if the Insured Person had declared such illness at the time of proposing the policy for the first time.

In case of enhancement of Sum Insured, the waiting periods shall apply afresh only to the extent of the amount by which the limit of indemnity has been increased (i.e. enhanced Sum Insured) and if the policy is a renewal of Health Guard (Group) policy with the Company without break in cover.

3. Any Medical Expenses incurred during the first 36 months during which the Insured Person has the benefit of a Health Guard (Group) Policy with the Company in connection with:

- Joint replacement surgery,
- Surgery for prolapsed inter vertebral disc (unless necessitated due to an accident)
- Surgery to correct deviated nasal septum
- Hypertrophied turbinate
- Congenital internal diseases or anomalies
- Treatment for correction of eye sight due to refractive error recommended by Ophthalmologist for medical reasons.
- Bariatric Surgery

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4. Any disease contracted and /or medical expenses incurred in respect of any disease /illness by the Insured Person during the first 30 days from the commencement of the policy, except for accidental injuries.

II General Exclusions

5. Any treatment arising from or traceable to pregnancy, child birth including cesarean section and/or any treatment related to pre and postnatal care and complications arising out of Pregnancy and Childbirth until 72 months continuous period has elapsed since the inception of the first Health Guard (Group) Policy with the Company. However this exclusion will not apply to:

i. Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending medical practitioner.

ii. Miscarriage due to accident, if the proximate cause of such miscarriage is accident.

6. Any dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for the temporomandibular (jaw) joint, or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer and also requiring Hospitalisation

7. Medical expenses where Inpatient care is not warranted and does not require supervision of qualified nursing staff and qualified medical practitioner round the clock

8. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not) [], civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority.

   Any Medical expenses incurred due to Acts of Terrorism will be covered under the policy.

9. Act of terrorism where the Insured person is directly involved in the Perpetration or Commission of any act of terrorism.

10. Circumcision unless required for the treatment of Illness or Accidental bodily injury,

11. Cosmetic or aesthetic treatments of any description, treatment or surgery for change of life/gender.

12. Any form of plastic surgery unless necessary for the treatment of cancer, burns or accidental Bodily Injury

13. The cost of spectacles, contact lenses, hearing aids, crutches, dentures, artificial teeth and all other external appliances and/or devices whether for diagnosis or treatment except for intrinsic fixtures used for orthopedic treatments such as plates and K-wires.

14. External medical equipment of any kind used at home as post hospitalisation care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition.

15. Convalescence, general debility, rest cure, congenital external diseases or defects or anomalies, stem cell implantation or surgery, or growth hormone therapy.

16. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol)

17. Ailments requiring treatment due to use or abuse of any substance, drug or alcohol and treatment for de-addiction.

18. Any condition directly or indirectly caused by or associated with Human Immunodeficiency Virus or Variant/mutant viruses and or any syndrome or condition of a similar kind commonly referred to as AIDS.

19. Medical Expenses relating to any hospitalisation primarily and specifically for diagnostic, X-ray or laboratory examinations and investigations

20. Vaccination or inoculation unless forming a part of post bite treatment or if medically necessary and forming a part of treatment recommended by the treating doctor.

21. Any fertility, sub fertility, Infertility, sterility, erectile dysfunction, impotence, assisted conception operation or sterilization procedure.

22. Vitamins, tonics, nutritional supplements unless forming part of the treatment for injury or disease as certified by the attending Doctor

23. Experimental or unproven treatment

24. Weight management services and treatment related to weight reduction programmes including treatment of obesity

25. Treatment for any mental illness or psychiatric illness, Parkinson's Disease.

26. All non-medical Items as per Annexure II

27. Any treatment received outside India is not covered under this policy.

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D. Conditions

I. Conditions precedent to the contract

1. Conditions Precedent

Where this Policy requires the Insured Person to do or not to do something, then the complete satisfaction of that requirement by the Insured Person or someone claiming on his/ her behalf is a precondition to any obligation the Company has under this Policy. If the Insured Person or someone claiming on his/ her behalf fails to completely satisfy that requirement, then the Company may refuse to consider his/ her claim.

2. Entry Age and Renewal Age

Cover	Member	Eligible Entry Age	Renewal
"Health Guard (Group)"	Self, Spouse, Parents	18 years to 65 years	lifetime renewals**
	Dependent Children	3 months to 30 years	35 Years*

** Subject to policy is renewed annually with the Company within the Grace period of 30 days from date of Expiry

Eligibility:

- Indian nationals residing in India would be considered for this policy.
- Sum Insured for Self cannot be less than any of his/her family members.

II. Conditions when a claim arises

1. Claims Procedure

All Claims will be settled by In house claims settlement team of the company and no TPA is engaged.

If the Insured Person meet with any Accidental Bodily Injury or suffer an Illness that may result in a claim, then as a condition precedent to the Company's liability, the Insured Person must comply with the following:

A. Cashless Claims Procedure:

Cashless treatment is only available at Network Hospitals. In order to avail of cashless treatment, the following procedure must be followed by the Insured Person:

i. Prior to taking treatment and/or incurring Medical Expenses at a Network Hospital, the Insured Person/ his or her representative must call the Company and request pre-authorisation by way of the written form.

ii. In case of Planned hospitalization, the Insured Person/Insured Person's representative shall intimate such admission 48 hours prior to such hospitalization.

iii. In case of Emergency hospitalization, the Insured Person/Insured Person's representative shall intimate such admission within 24 hours of such hospitalisation

iv. On receipt of Insured Person's pre-authorization form duly filled and signed by the Insured Person/ his or her representative, the Company's representative then within 2 hours will respond with Approval, Rejection or an more information

v. After considering the Insured Person's request and after obtaining any further information or documentation the Company has sought, the Company may, if satisfied, send the Insured Person or the Network Hospital, an authorisation letter. The authorisation letter, the ID card issued to the Insured Person along with this Policy and any other information or documentation that the Company has specified must be produced to the Network Hospital identified in the pre-authorization letter at the time of Insured Person's admission to the same.

vi. If the procedure above is followed, the Insured Person will not be required to directly pay for the bill amount in the Network Hospital that the Company is liable under Section A1 In-Patient Hospitalisation Treatment above and the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital. Pre-authorisation does not guarantee that all costs and expenses will be covered. The Company reserve the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy.

B. Reimbursement Claims Procedure:

If Pre-authorisation as per Cashless Claims Procedure above is denied by the Company or if treatment is taken in a Hospital other than a Network Hospital or if the Insured Person do not wish to avail cashless facility, then:

i. The Insured Person or someone claiming on his/ her behalf must inform the Company in writing immediately within 48 hours of hospitalization in case of emergency hospitalization and 48 hours prior to hospitalization in case of planned hospitalization

ii. The Insured Person must immediately consult a Doctor and follow the advice and treatment that he recommends.

iii. The Insured Person must take reasonable steps or measures to minimize the quantum of any claim that may be made under this Policy.

iv. The Insured Person must have himself / herself examined by the Company's medical advisors if the Company ask for this, and as often as the Company consider this to be necessary at the Company's cost.

v. The Insured Person or someone claiming on his/ her behalf must promptly and in any event within 30 days of discharge from a Hospital give the Company documentation as listed out in greater detail below and other information the Company ask for to investigate the claim or the Company's obligation to make payment for it.

vi. In the event of the death of the Insured Person, someone claiming on his behalf must inform the Company in writing immediately and send the Company a copy of the post mortem report (if any) within 30 days*

vii. If the original documents are submitted with the co-insurer, the Xerox copies attested by the co-insurer should be submitted

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*Note: In case the Insured Person is claiming for the same event under an indemnity based policy of another insurer and is required to submit the original documents related to his/ her treatment with that particular insurer, then the Insured Person may provide the Company with the attested Xerox copies of such documents along with a declaration from the particular insurer specifying the availability of the original copies of the specified treatment documents with it.

**Note: Waiver of conditions (i) and (vi) may be considered in extreme cases of hardship where it is proved to the Company's satisfaction that under the circumstances in which the Insured Person was placed, it was not possible for the Insured Person or any other person to give notice or file claim within the prescribed time limit.

List of Claim documents:

- Claim form with NEFT details & cancelled cheque duly signed by Insured
- Original/Attested copies of Discharge Summary / Discharge Certificate / Death Summary with Surgical & anesthetics notes
- Attested copies of Indoor case papers (Optional)
- Original/Attested copies Final Hospital Bill with break up of surgical charges, surgeon's fees, OT charges etc
- Original Paid Receipt against the final Hospital Bill.
- Original bills towards Investigations done / Laboratory Bills.
- Original/Attested copies of Investigation Reports against Investigations done.
- Original bills and receipts paid for the transportation from Registered Ambulance Service Provider. Treating Doctor certificate to transfer the Injured person to a higher medical centre for further treatment (if Applicable).
- Cashless settlement letter or other company settlement letter
- First consultation letter for the current ailment.
- In case of implant surgery, invoice & sticker.
- In cases where a fraud is suspected, we may call for any additional document(s) in addition to the documents listed above

Please send the documents on below address
Bajaj Allianz General Insurance Company
2nd Floor, Bajaj Finserv Building,
Behind Weikfield IT park,
Off Nagar Road, Viman Nagar
Pune 411014| Toll free: 1800-103-2529, 1800-22-5858

2. Paying a Claim

i. The Insured Person agree that the Company need only make payment when the Insured Person or someone claiming on his/ her behalf has provided the Company with necessary documentation and information.

ii. The Company will make payment to the Insured Person or his/ her Nominee. If there is no Nominee and the Insured Person is incapacitated or deceased, the Company will pay the Insured Person's heir, executor or validly appointed legal representative and any payment the Company make in this way will be a complete and final discharge of the Company's liability to make payment.

iii. On receipt of all the documents and on being satisfied with regard to the admissibility of the claim as per Policy terms and conditions, the Company shall offer a settlement of the claim to the Insured Person. Upon acceptance of an offer of settlement by the Insured Person, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured Person. The Company will settle the claim within 30 (thirty) days of the receipt of the last necessary document. In the cases of delay in the payment, the Company shall be liable to pay interest at a rate which is 2% above the bank rate (prevalent at the beginning of the financial year in which the claim is reviewed by it) from the date of receipt of last necessary document to the date of payment of claim.

iv. However, where the circumstances of a claim warrant an investigation, the Company will 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 will settle the claim within 45 days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days, the Company will be liable to pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

v. If the Company, for any reasons decides to reject the claim under the policy the reasons regarding the rejection shall be communicated to the Insured Person in writing within 30 days of the receipt of documents. The Insured Person may take recourse to the Grievance Redressal procedure stated under policy.

3. Basis of Claims Payment

i. If the Insured Person suffer a relapse within 45 days of the date when he/ she last obtained medical treatment or consulted a Doctor and for which a claim has been made, then such relapse shall be deemed to be part of the same claim.

ii. If opted voluntarily by the Policyholder, the Insured Person shall bear 10% / 20% of co-payment for each and every claim payable under the Inpatient Hospitalization Treatment section and the Company's liability, if any, shall only be in excess of that sum.

iii. The day care procedures listed are subject to the exclusions, terms and conditions of the policy and will not be treated as independent coverage under the policy.

iv. The Company's obligation to make payment in respect of surgeries for cataracts (after the expiry of the 24 months period referred to in Exclusion C2) above, shall be restricted to 20% of the Sum insured for each eye, subject to maximum of Rs 1,00,000/-.

v. The Company's obligation to make payment in respect of Bariatric Surgery (after the expiry of the 36 months period referred to in Exclusion C3) above, shall be restricted to 50% of the Sum insured, subject to maximum of Rs 5lac.

The Company shall make payment in Indian Rupees only.

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4. Multiple Policies

i. In case of multiple policies which provide fixed benefits, on the occurrence of the covered event/s in accordance with the terms and conditions of the Policy, each Insurer shall make the claim payments independent of payments received under other similar polices.

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

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

b. Claims under other Policy/ies may be made after exhaustion of Sum Insured in the earlier chosen Policy / Policies.

c. If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.

d. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

e. If Insured Person has multiple Policies, he/ she has the right to prefer claims from other Policy/Policies for the amounts disallowed under the earlier chosen Policy/ Policies, even if the sum insured is not exhausted. The Company shall settle the claim subject to the terms and conditions of the Policy.

5. Arbitration and Reconciliation

i. If any dispute or difference shall arise as to the quantum to be paid under the Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to decision of a sole arbitrator in writing by the parties or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of the arbitrators comprising of two arbitrators, one appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996. The law of the arbitration will be Indian law, and the seat of the arbitration and venue for all hearings shall be within India.

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

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

iv. If these arbitration provisions are held to be invalid, then all such disputes or differences shall be referred to the exclusive jurisdiction of the Indian Courts.

III. Conditions for renewal of the contract.

1. Renewal

i. Under normal circumstances, renewal will not be refused except on the grounds of moral hazard, misrepresentation, fraud, or your non-cooperation of the Insured Person/ Policyholder. (Subject to policy is renewed annually with us within the Grace period of 30 days from date of Expiry)

ii. Premium payable on renewal and on subsequent continuation of cover are subject to change with prior approval from IRDAI

2. Cumulative Bonus:

If the Insured Person's Health Guard (Group) Policy with the Company is renewed without any break and there has been no claim in the preceding year, the Company will increase the Limit of Indemnity by 10% of base sum insured per annum, but:

i. The maximum cumulative increase in the Limit of Indemnity will be limited to 100% of base sum insured of the Insured Person's first "Health Guard (Group) Policy" with the Company.

ii. This clause does not alter the annual character of this insurance

iii. If a claim is made in any year where a cumulative increase has been applied, then the increased Limit of Indemnity in the Policy Period of the subsequent "Health Guard (Group) Policy" shall be reduced by 10%, save that the limit of indemnity applicable to the Insured Person's first "Health Guard (Group) Policy" with the Company shall be preserved.

3. Sum Insured Enhancement:

i. The Insured Person can apply for enhancement of Sum Insured at the time of renewal. Insured Person can apply for enhancement of Sum Insured by submitting a fresh proposal form to the company.

ii. The acceptance of enhancement of Sum Insured would be at the discretion of the company, based on the health condition of the Insured Person & claim history of the Policy.

iii. All waiting periods as defined in the Policy shall apply for this enhanced Sum Insured limit from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

4. Revision/ Modification of the policy:

There is a possibility of revision/ modification of terms, conditions, coverages and/or premiums of this product at any time in future, with appropriate approval from IRDAI. In such an event of revision/modification of the product, intimation shall be set out to all the existing Insured Persons at least 3 months prior to the date of such revision/modification comes into the effect

5. Migration of policy:

- The Insured Person can opt for migration of policy to our other similar or closely similar products at the time of renewal
- The premium will be charged as per Our Underwriting Policy for such chosen new product, and all the guidelines, terms and condition of the chosen product shall be applicable.
- Suitable credit of continuity/waiting periods for all the previous policy years would be extended in the new policy, provided the policy has been maintained without a break

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6. Withdrawal of Policy

   There is possibility of withdrawal of this product at any time in future with appropriate approval from IRDAI, as the Company reserve right to do so with a intimation of 3 months to all the existing Insured Persons. In such an event of withdrawal of this product, at the time of Insured seeking renewal of the Master Policy, Insured can choose, among the Company's available similar and closely similar Health insurance products subject to underwriting policy of the Company. Upon Insured so choosing the Company's new product, Insured and the Insured Persons will be charged the Premium as per the Company's Underwriting Policy for such chosen new product, as approved by IRDAI.

   Provided however, if Insurer Person do not respond to the Company's intimation regarding the withdrawal of the product under which this Policy is issued, then this Policy shall be withdrawn and shall not be available to Insurer person for renewal on the renewal date and accordingly upon Insured seeking renewal of the Master Policy, Insured shall have to take a Master Policy under available new products of the Company subject to Insured paying the Premium as per the Company's Underwriting Policy for such available new product chosen by the Insured and also subject to Portability condition.

IV. Conditions applicable during the contract

1. Insured

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

2. Communications

   Any communication meant for the Company must be in writing and be delivered to the Company's address shown in the Schedule. Any communication meant for the Insured Person will be sent by the Company to Insured Person's address shown in the Certificate of Insurance.

3. Fraud

   If the Insured Person make or progress any claim knowing it to be false or fraudulent in any way, then this Policy will be void and all claims or payments due under it shall be lost and the premium paid shall become forfeited.

4. Free Look Period

   You have a period of 15 days from the date of receipt of the first policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You have the option of canceling the Policy stating the reasons for cancellation.

   If you have not made any claim during the Free look period, you shall be entitled to refund of premium subject to,

- a deduction of the expenses incurred by Us on Your medical examination, stamp duty charges, if the risk has not commenced,
- a deduction of the stamp duty charges, medical examination charges & proportionate risk premium for period on cover, If the risk has commenced
- a deduction of such proportionate risk premium commensurating with the risk covered during such period ,where only a part of risk has commenced

   Free look period is not applicable for renewal policies.

5. Cancellation of Master Policy/ Certificate of Insurance

i. The Master Policy/Certificate of Insurance may be cancelled by or on behalf of the Company by giving the Insured at least 15 days of written notice and if no claim has been made then the Company shall refund a pro-rata premium for the unexpired Policy Period. Under normal circumstances, Policy will not be cancelled except for reasons of mis-representation, fraud, non-disclosure of material facts or non-cooperation.

ii. The Master Policy may be cancelled by the Insured at any time before the expiry of the Master Policy Period by giving at least 15 days written notice to the Company.

iii. The Certificate of Insurance may be cancelled by the Insured Person at any time before the expiry of the Policy Period by giving at least 15 days written notice to the Company and if no claim has been made then the Company will refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Period in Risk	Premium Refund
Within 15 Days	Pro Rata Refund
Exceeding 15 days but less than 3 months	65.00%
Exceeding 3 months but less than 6 months	45.00%
Exceeding 6 months to 12 months	0.00%

iv. For the avoidance of doubt, the Company shall remain liable for any claim that was made prior to the date upon which this Master Policy/ Certificate of Insurance is cancelled except in cases such cancellation is on account of Fraud, mis-representation or non-disclosure of material facts or non-co-operation by the Insured/Insured person.

6. Portability Conditions

   Group Policies: As per the Portability Guidelines issued by IRDAI, applicable benefits shall be passed on to Insured Persons who were insured under Our Group Health Policy and are availing the Company's individual Health Policy.

7. Endorsements

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

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8. Discounts:

i. Co-pay Discount:

If opted voluntarily and mentioned on the Master Policy Schedule read with Certificate of Insurance that a Co-payment is effective by the Group then Group and Insured Persons will be eligible of additional 10% or 20% discount respectively on the policy premium.

If a claim has been admitted under Section A 1) In-patient Hospitalisation Treatment then, the Insured Person shall bear 10% or 20% of the eligible claim amount payable under this section and the Company's liability, if any, shall only be in excess of that sum and would be subject to the Sum Insured.

ii. Discount offered in lieu of Group size

Non Floater Policies		Floater Policies	
Group Size band	Implied Group Discount	Group Size band	Implied Group Discount
7 to 100	10%	7 to 100	8%
101 to 250	14%	101 to 250	12%
251 to 500	16%	251 to 500	13%
501 to 750	17%	501 to 750	15%
751 to 1000	18%	751 to 1000	16%
1001 to 5000	19%	1001 to 5000	17%
5001 and above	20%	5001 and above	18%

9. Premium payment Zone:

Zone A

"Following cities has been clubbed in Zone A:-

Delhi / NCR, Mumbai including (Navi Mumbai, Thane and Kalyan), Hyderabad and Secunderabad, Bangalore, Kolkata, Ahmedabad, Vadodara and Surat.

Zone B

Rest of India apart from Zone A cities are classified as Zone B.

Note:-

- Insured Person can avail treatment allover India without any co-payment, if Zone A premium rates is paid.
- Insured Person for whom premium rate of Zone B is paid and avail treatment in Zone A city will have to pay 20% co-payment on admissible claim amount. This Co – payment will not be applicable for Accidental Hospitalization cases."
- Insured Person residing in Zone B and for whom Zone A premium is paid can avail treatment all over India without any co-payment.

10. Territorial Limits & Governing Law

i. The Company cover insured events arising during the Policy Period, as well as treatment availed, within India only. The Company's liability to make any payment shall be to make payment within India and in Indian Rupees only.

ii. The Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by an endorsement on the Schedule.

iii. The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law. The section headings of this Policy are included for descriptive purposes only and do not form part of this Policy for the purpose of its construction or interpretation.

11. Special Conditions relating to Group Policy

All group policies are subject to the following conditions:

1. The insured will maintain sufficient deposit or provide a Bank Guarantee to strictly comply with the requirement of section 64VB.
2. New names can be added to the existing group policies by charging pro-rata premium for the unexpired Policy Period.
3. For deletion of names from Group Policies during the currency of the Policy, refund of pro- Rata premium can be allowed only if there is no claim in respect of the particular Insured Person at the expiry of the policy only.

12. Grievance Redressal Procedure

Level 1

In case you have any concern, you may please reach out to our Customer Experience Team through any of the following options:

- Our Website @ https://general.bajajallianz.com/Corp/aboutus/general-insurance-customer-service.jsp
- Call us on our Toll free no 1800 209 5858
- Mail us on bagichelp@bajajallianz.co.in
- Write to Bajaj Allianz General Insurance Co. Ltd.
  Bajaj Allianz House, Airport Road, Yerwada Pune- 411006

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Level 2 In case you are not satisfied with the response given to you by our team, you may write to our Grievance Redressal Officer Mr. Rakesh Sharma at ggro@bajajallianz.co.in.
Level 3 If you are still not satisfied with the solutions provided, or have some feedback for us, write to the Head of Customer experience directly at head.customerservice@bajajallianz.co.in.
Grievance Redressal Cell for Senior Citizens Bajaj Allianz introduces a dedicated team for all the senior citizens, so no more wait time, no more standing in long queue. Senior citizens can now contact us on 1800-103-2529 or write to us at seniorcitizen@bajajallianz.co.in

In case your complaint is not fully addressed by the insurer, You may use the Integrated Greivance Management System (IGMS) for escalating the complaint to IRDAI or call 155255 . Through IGMS you can register your complain online and track its status. For registration please visit IRDAI website www.irda.gov.in.

If the issue still remains unresolved, You may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of the grievance.
The contact details of the ombudsman offices are mentioned below. However, we request you to visit http://www.gbic.co.in for updated details.

Office Details	Jurisdiction of Office Union Territory, District)	Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD - Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: **bimalokpal.ahmedabad@gbic.co.in**	Gujarat, Dadra & Nagar Haveli, Daman and Diu.	JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.co.in	Rajasthan
BENGALURU 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@gbic.co.in**	Karnataka	ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: **bimalokpal.ernakulam@gbic.co.in**	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: **bimalokpal.bhopal@gbic.co.in**	Madhya Pradesh Chattisgarh.	KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: **bimalokpal.kolkata@gbic.co.in**	West Bengal, Sikkim, Andaman & Nicobar Islands.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: **bimalokpal.bhubaneswar@gbic.co.in**	Orissa	LUCKNOW - Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: **bimalokpal.lucknow@gbic.co.in**	Districts of Uttar Pradesh : Laitpur, 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.
CHANDIGARH - Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: **bimalokpal.chandigarh@gbic.co.in**	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.	MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: **bimalokpal.mumbai@gbic.co.in**	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.

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CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: **bimalokpal.chennai@gbic.co.in**	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).	NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: **bimalokpal.noida@gbic.co.in**	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: **bimalokpal.delhi@gbic.co.in**	Delhi	PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: **bimalokpal.patna@gbic.co.in**	Bihar, Jharkhand.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: **bimalokpal.guwahati@gbic.co.in**	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	PUNE 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 - 32341320 Email: **bimalokpal.pune@gbic.co.in**	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region
HYDERABAD 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 - 65504123 / 23312122 Fax: 040 - 23376599 Email: **bimalokpal.hyderabad@gbic.co.in**	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.		

Note: Address and contact number of Governing Body of Insurance Council
Secretary General - Governing Body of Insurance Council
JeevanSevaAnnexe, 3rd Floor, S.V. Road, Santacruz (W), Mumbai - 400 054
Tel No: 022-2610 6889, 26106245, Fax No. : 022-26106949, 2610 6052, E-mail ID: inscoun@vsnl.net

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Annexure I

Indicative list of Day Care Procedures:

1. Suturing - CLW -under LA or GA	66. Incision and excision of tissue in the perianal region
2. Surgical debridement of wound	67. Surgical treatment of anal fistula
3. Therapeutic Ascitic Tapping	68. Surgical treatment of hemorrhoids
4. Therapeutic Pleural Tapping	69. Sphincterotomy/Fissurectomy
5. Therapeutic Joint Aspiration	70. Laparoscopic appendicectomy
6. Aspiration of an internal abscess under ultrasound guidance	71. Laparoscopic cholecystectomy
7. Aspiration of hematoma	72. TURP (Resection prostate)
8. Incision and Drainage	73. Varicose vein stripping or ligation
9. Endoscopic Foreign Body Removal - Trachea /- pharynx-larynx/ bronchus	74. Excision of dupuytren's contracture
10. Endoscopic Foreign Body Removal -Oesophagus/stomach / rectum.	75. Carpal tunnel decompression
11. True cut Biopsy - breast/- liver/- kidney-Lymph Node/-Pleura/- lung/-Muscle biopsy/-Nerve biopsy/Synovial biopsy/-Bone trephine biopsy/-Pericardial biopsy	76. Excision of granuloma
12. Endoscopic ligation/banding	77. Arthroscopic therapy
13. Sclerotherapy	78. Surgery for ligament tear
14. Dilatation of digestive tract strictures	79. Surgery for meniscus tear

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15. Endoscopic ultrasonography and biopsy	80. Surgery for hemoarthrosis/pyoarthrosis
16. Nissen fundoplication for Hiatus Hernia /Gastro esophageal reflux disease	81. Removal of fracture pins/nails
17. Endoscopic placement/removal of stents	82. Removal of metal wire
18. Endoscopic Gastrostomy	83. Incision of bone, septic and aseptic
19. Replacement of Gastrostomy tube	84. Closed reduction on fracture, luxation or epiphyseolysis with osetosynthesis
20. Endoscopic polypectomy	85. Suture and other operations on tendons and tendon sheath
21. Endoscopic decompression of colon	86. Reduction of dislocation under GA
22. Therapeutic ERCP	87. Cataract surgery
23. Brochoscopic treatment of bleeding lesion	88. Excision of lachrymal cyst
24. Brochoscopic treatment of fistula /stenting	89. Excision of pterigium
25. Bronchoalveolar lavage & biopsy	90. Glaucoma Surgery
26. Tonsillectomy without Adenoidectomy	91. Surgery for retinal detachment
27. Tonsillectomy with Adenoidectomy	92. Chalazion removal (Eye)
28. Excision and destruction of lingual tonsil	93. Incision of lachrymal glands
29. Foreign body removal from nose	94. Incision of diseased eye lids
30. Myringotomy	95. Excision of eye lid granuloma
31. Myringotomy with Grommet insertion	96. Operation on canthus & epicanthus
32. Myringoplasty /Tympanoplasty	97. Corrective surgery for entropion&ectropion
33. Antral wash under LA	98. Corrective surgery for blepharoptosis
34. Quinsy drainage	99. Foreign body removal from conjunctiva
35. Direct Laryngoscopy with or w/o biopsy	100. Foreign body removal from cornea
36. Reduction of nasal fracture	101. Incision of cornea
37. Mastoidectomy	102. Foreign body removal from lens of the eye
38. Removal of tympanic drain	103. Foreign body removal from posterior chamber of eye
39. Reconstruction of middle ear	104. Foreign body removal from orbit and eye ball
40. Incision of mastoid process & middle ear	105. Excision of breast lump /Fibro adenoma
41. Excision of nose granuloma	106. Operations on the nipple
42. Blood transfusion for recipient	107. Incision/Drainage of breast abscess
43. Therapeutic Phlebotomy	108. Incision of pilonidal sinus
44. Haemodialysis/Peritoneal Dialysis	109. Local excision of diseased tissue of skin and subcutaneous tissue
45. Chemotherapy	110. Simple restoration of surface continuity of the skin and subcutaneous tissue
46. Radiotherapy	111. Free skin transportation, donor site
47. Coronary Angioplasty (PTCA)	112. Free skin transportation recipient site
48. Pericardiocentesis	113. Revision of skin plasty
49. Insertion of filter in inferior vena cava	114. Destruction of the diseases tissue of the skin and subcutaneous tissue
50. Insertion of gel foam in artery or vein	115. Incision, excision, destruction of the diseased tissue of the tongue
51. Carotid angioplasty	116. Glossectomy
52. Renal angioplasty	117. Reconstruction of the tongue
53. Tumor embolisation	118. Incision and lancing of the salivary gland and a salivary duct
54. TIPS procedure for portal hypertension	119. Resection of a salivary duct
55. Endoscopic Drainage of Pseudopancreatic cyst	120. Reconstruction of a salivary gland and a salivary duct
56. Lithotripsy	121. External incision and drainage in the region of the mouth, jaw and face
57. PCNS (Percutaneous nephrostomy)	122. Incision of hard and soft palate
58. PCNL (percutaneous nephrolithotomy)	123. Excision and destruction of the diseased hard and soft palate
59. Suprapubiccytostomy	124. Incision, excision and destruction in the mouth
60. Tran urethral resection of bladder tumor	125. Surgery to the floor of mouth
61. Hydrocele surgery	126. Palatoplasty
62. Epididymectomy	127. Transoral incision and drainage of pharyngeal abscess
63. Orchidectomy	128. Dilatation and curettage

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64. Herniorrhaphy	129. Myomectomies
65. Hernioplasty	130. Simple Oophorectomies

Note:

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

Annexure II:- List of Non-Medical Items

S. NO	List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy -	SUGGESTIONS	S. NO	List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy -	SUGGESTIONS
TOILETRIES/COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS			ADMINISTRATIVE OR NON-MEDICAL CHARGES		
1	HAIR REMOVAL CREAM	Not Payable	107	ADMISSION KIT	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/ INDICATED)	Not Payable	108	BIRTH CERTIFICATE	Not Payable
3	BABY FOOD	Not Payable	109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
4	BABY UTILITES CHARGES	Not Payable	110	CERTIFICATE CHARGES	Not Payable
5	BABY SET	Not Payable	111	COURIER CHARGES	Not Payable
6	BABY BOTTLES	Not Payable	112	CONVENYANCE CHARGES	Not Payable
7	BRUSH	Not Payable	113	DIABETIC CHART CHARGES	Not Payable
8	COSY TOWEL	Not Payable	114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
9	HAND WASH	Not Payable	115	DISCHARGE PROCEDURE CHARGES	Not Payable
10	M01STUR1SER PASTE BRUSH	Not Payable	116	DAILY CHART CHARGES	Not Payable
11	POWDER	Not Payable	117	ENTRANCEPASS / VISITORS PASS CHARGES	Not Payable
12	RAZOR	Payable	118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
13	SHOE COVER	Not Payable	119	FILE OPENING CHARGES	Not Payable
14	BEAUTY SERVICES	Not Payable	120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
15	BELTS/ BRACES	Essential and may be paid specifically for cases who have undergone surgery o f thoracic o r lumbar spine.	121	MEDICAL CERTIFICATE	Not Payable
16	BUDS	Not Payable	122	MAINTENANCE CHARGES	Not Payable
17	BARBER CHARGES	Not Payable	123	MEDICAL RECORDS	Not Payable
18	CAPS	Not Payable	124	PREPARATION CHARGES	Not Payable
19	COLD PACK/HOT PACK	Not Payable	125	PHOTOCOPIES CHARGES	Not Payable
20	CARRY BAGS	Not Payable	126	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
21	CRADLE CHARGES	Not Payable	127	WASHING CHARGES	Not Payable
22	COMB	Not Payable	128	MEDICINE BOX	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable	129	MORTUARY CHARGES	Payable upto 24 hrs, shifting charges not payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable	130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	
25	EYE PAD	Not Payable			
26	EYE SHEILD	Not Payable	EXTERNAL DURABLE DEVICES		
27	EMAIL / INTERNET CHARGES	Not Payable	131	WALKING AIDS CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable	132	BIPAP MACHINE	Not Payable
29	FOOT COVER	Not Payable	133	COMMODE	Not Payable
30	GOWN	Not Payable	134	CPAP/ CAPD EQUIPMENTS	Device not payable
31	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.	135	INFUSION PUMP - COST	Device not payable

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32	LAUNDRY CHARGES	Not Payable	136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
33	MINERAL WATER	Not Payable	137	PULSEOXYMETER CHARGES	Device not payable
34	OIL CHARGES	Not Payable	138	SPACER	Not Payable
35	SANITARY PAD	Not Payable	139	SPIROMETRE	Device not payable
36	SLIPPERS	Not Payable	140	S P0 2PRO B E	Not Payable
37	TELEPHONE CHARGES	Not Payable	141	NEBULIZER KIT	Not Payable
38	TISSUE PAPER	Not Payable	142	STEAM INHALER	Not Payable
39	TOOTH PASTE	Not Payable	143	ARMSLING	Not Payable
40	TOOTH BRUSH	Not Payable	144	THERMOMETER	Not Payable (paid by patient)
41	GUEST SERVICES	Not Payable	145	CERVICAL COLLAR	Not Payable
42	BED PAN	Not Payable	146	SPLINT	Not Payable
43	BED UNDER PAD CHARGES	Not Payable	147	DIABETIC FOOT WEAR	Not Payable
44	CAMERA COVER	Not Payable	148	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
45	CLINIPLAST	Not Payable	149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
46	CREPE BANDAGE	Not Payable/ Payable by the patient	150	LUMBOSACRAL BELT	Essential and should be paid specifically for cases who have undergone surgery of lumbar spine.
47	CURAPORE	Not Payable	151	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia /quadriplegia for any reason and at reasonable cost of approximately Rs 200/day
48	DIAPER OF ANY TYPE	Not Payable	152	AMBULANCE COLLAR	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insure r /T PA then payable)	153	AMBULANCE EQUIPMENT	Not Payable
50	EYELET COLLAR	Not Payable	154	MICROSHEILD	Not Payable
51	FACE MASK	Not Payable	155	ABDOMINAL BINDER	Essential and should be paid in post surgerypatients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruct ion, liver transplant etc.
52	FLEXI MASK	Not Payable			
53	GAUSE SOFT	Not Payable	ITEMS PA YABLE IF SUPPORTED BY A PRESCRIPTION		
54	GAUZE	Not Payable	156	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC	May be payable when prescribed for patient , not payable for hospital use in OT o r ward o r for dressings in hospital
55	HAND HOLDER	Not Payable	157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post hospitalization nursing charges not Payable
56	HANSAPLAST/ADHESIVE BANDAGES	Not Payable	158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES	Patient Diet provided by hospital is payable
57	INFANT FOOD	Not Payable	159	SUGAR FREE Tablets	Payable -S u g a r free variants of admissible medicines are not excluded
58	SLINGS	Reasonable costs for one sling in case o f upper arm fractures should be considered	160	CREAMS POWDERS LOTIONS (Toileteries are not payable only prescribed medical pharmaceuticals payable)	Payable when prescribed
			161	Digestion gels	Payable when prescribed
ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES			162	ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in policy unless otherwise specified	163	GLOVES	Sterilized Gloves payable /unsterilized gloves not payable
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Exclusion in policy unless otherwise specified	164	HIV KIT	Payable - payable Pre op e ra t iv e screening
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Exclusion in policy unless otherwise specified	165	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
62	HORMONE REPLACEMENT THERAPY	Exclusion in policy unless otherwise specified	166	LOZENGES	Payable when prescribed

63	HOME VISIT CHARGES	Exclusion in policy unless otherwise specified	167	MOUTH PAINT	Payable when prescribed
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in policy unless otherwise specified	168	NEBULISATION KIT	If used during hospitalization is payable reasonably
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Exclusion in policy unless otherwise specified	169	NOVARAPID	Payable when prescribed
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Exclusion in policy unless otherwise specified	170	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in policy unless otherwise specified	171	ZYTEE GEL	Payable when prescribed
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in policy unless otherwise specified	172	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
69	DONOR SCREENING CHARGES	Exclusion in policy unless otherwise specified			
70	ADMISSION/REGISTRATION CHARGES	Exclusion in policy unless otherwise specified	PART OF HOSPITAL'S OWN COSTS AND NOT PA YA BLE		
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in policy unless otherwise specified	173	AHD	Not Payable - P a r t of Hospital's internal Cost
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable - Exclusion in policy unless otherwise specified	174	ALCOHOL SWABES	Not Payable - P a r t of Hospital's internal Cost
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not payable as per HIV/AIDS exclusion	175	SCRUB SOLUTION/STERILLIUM	Not Payable - P a r t of Hospital's internal Cost
74	STEM CELL IMPLANTATION/ SURGERY and storage	Not Payable except Bone Marrow Transplantation where covered by policy			
			OTHERS		
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARA TE CONSUMABLES ARE NOT PA YABLE BUT THE SER VICE IS			176	VACCINE CHARGES FOR BABY	Not Payable
75	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges ,not payable separately	177	AESTHETIC TREATMENT / SURGERY	Not Payable
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.	178	TPA CHARGES	Not Payable
77	MICROSCOPE COVER	Payable under OT Charges , not separately	179	VISCO BELT CHARGES	Not Payable
78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges , not separately	180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
79	SURGICAL DRILL	Payable under OT Charges , not separately	181	EXAMINATION GLOVES	Not Payable
80	EYE KIT	Payable under OT Charges ,not separately	182	KIDNEY TRAY	Not Payable
81	EYE DRAPE	Payable under OT Charges ,not separately	183	MASK	Not Payable
82	X-RAY FILM	Payable under Radiology Charges, not as consumable	184	OUNCE GLASS	Not Payable
83	SPUTUM CUP	Payable under Investigation Charges, not as consumable	185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable, except for telemedicine consultations w here covered by policy
84	BOYLES APPARATUS CHARGES	Part o f OT Charges , not separately	186	OXYGEN MASK	Not Payable
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part o f Cost of Blood, not payable	187	PAPER GLOVES	Not Payable
86	Antiseptic or disinfetant lotions	Not Payable -Part of Dressing Charges	188	PELVIC TRACTION BELT	Should be payable in case o f PI VI) requiring traction as this is generally not reused
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges	189	REFERAL DOCTOR'S FEES	Not Payable
88	COTTON	Not Payable -Part of Dressing Charges	190	ACCU CHECK (Glucometery/ Strips)	Not payable pre hospitalisation or post hospitalisation / Reports and Charts required / Device not payable
89	COTTON BANDAGE	Not Payable- Part of Dressing Charges	191	PAN CAN	Not Payable

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90	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed , otherwise included as Dressing Charges	192	SOFNET	Not Payable
91	BLADE	Not Payable	193	TROLLY COVER	Not Payable
92	APRON	Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU charges	194	UROMETER, URINE JUG	Not Payable
93	TORNIQUET	Not Payable (service is charged by hospitals, consumables can not be separately charged)	195	AMBULANCE	Payable-Ambulance from home to hospital or inter hospital shifts is payable/ RTA as specific requirement is payable
94	ORTHOBUNDLE, GYNAEC BUNDLE	Part o f Dressing Charges	196	TEGADERM / VASOFIX SAFETY	Payable - maximum o f 3 in 48 hrs an d then 1 in 24 hrs
95	URINE CONTAINER	Not Payable	197	URINE BAG	Payable w here medically necessary till a reasonable cost - maximum 1 per 24hrs
			198	SOFTOVAC	Not Payable
ELEMENTS OF ROOM CHARGE			199	STOCKINGS	Essential for case like CABG etc. where it should be paid.
96	LUXURY TAX	Actual tax levied by government is payable. P a r t of room charge for sub limits			
97	HVAC	Part o f room charge not payable separately			
98	HOUSE KEEPING CHARGES	Part of room charge not payable separately			
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge notpayable separately			
100	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied			
101	SURCHARGES	Part of Room Charge , Not payable separately			
102	ATTENDANT CHARGES	Not Payable - P a r t of Room Charges			
103	M IV INJECTION CHARGES	Part of nursing charges, not payable			
104	CLEAN SHEET	Part of Laundry/ Housekeeping not payable separately			
105	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable			
106	BLANKET/WARMER BLANKET	Not Payable- part of room charges			

Annexure III - Preventive and Wellness Benefit

What is Healthkarats-

Healthkarats are reward points earned for each activity specified in activity chart.

Healthkarats can be earned by complying with various activities listed below under step 2 activities.

How to earn Healthkarats-

Step 1- Portal registration

- Download the android and iOS based mobile application "Insurance Wallet" from Play Store Or register in the Bajaj Allianz General Insurance Company's (BAGIC) Preventive and Wellness Benefit Portal insurance wallet / pro-fit.bjaz.in
- Fill up essentials mentioned for registration
- Create Log in id and Password
- Post registration, log in to your account by using the USER ID and PASSWORD
- The Insured Person can also earn Healthkarats for the Registration and addition of your policy details

Step 2- Activities

- Prevention and Identification
- Care Management

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- Connected Health
- Fitness Subscription

I. **Prevention and Identification-**

Early prevention of any medical condition helps for early and uncomplicated recovery resulting in healthy and longer life.

This can be achieved by doing a regular "Health Check-up" and Investigations (Tests).

During The Insured Person's regular "Health Check-up" if he/she is identified for any disease/illness, he/she is expected to take disease specific tests.

Healthkarats can be earned by performing regular "Health Check-up", "Investigations" (Tests) and "Disease specific tests" as indicated in the table provided in policy wording.

II. Care Management

The Insured Person can avail healthkarats by uploading the receipt of Disease management program as advised by the treating consultant.

The healthkarats for Care Management can be availed once in a year.

III. Connected Health

The Company ensures the Insured Person's participation for good health with his/her everyday activity.

Helathkarats can be earned for the Insured Person's daily exercise i.e calculating steps and or completed health challenges which can be tracked and calculated by mobile app informed earlier in Step 1 i.e. Portal registration by the Company

IV. Fitness Subscription

The Insured Person can earn Healthkarats by enrolling himself/herself in any of the following registered activity:

a. Annual Subscription of Swimming
b. Annual Subscription of Gym
c. Annual Subscription of Yoga
d. Participation in marathon event
e. Any other annual subscription of similar fitness activity

How to redeem Healthkarats-

Eligibility for redemption of Healthkarats :-

- Healthkarats redemption benefit can be availed only if the healthkarats exceeds 2000 points.

Process of Redemptions of healthkarats

1. Portal registration and self-enrolment is mandatory.
2. The Insured Person can participate in any or all the activities mentioned in activity chart.
3. The cost of Medical Risk Assessment, Preventive disease specific check-up, chronic disease management program, and Fitness subscription specified in the Activity chart will be borne by the Insured Person.
4. Medical tests can also be done at any of the Company's Network Providers*.
5. The reward Healthkarats earned/ redeemed and the reward amount will be updated as per the scheduler on the Portal during the Policy Period and at the end of the Policy Period. Reward amount if any shall be intimated to the Insured Person via SMS, EMAIL or can be checked on our portal as well i.e insurance wallet/pro-fit.bjaz.in.
6. In cases of family floater policy, total sum of the Healthkarats of all the Family Members covered under the Policy (who have exceeded the threshold of 2000 Healthkarats) will be considered for utilization by any of the Family Member covered under the Policy.
7. All of these Healthkarats will be accrued and can be used for one of the below-
   - For Payment of Non Medical Expenses or
   - For Payment of Co pay
   - Sum Insured at the time of renewal will be increased by the value of Healthkarats
8. The Healthkarats Benefit Amount earned during the Policy Period shall be updated real-time during the current Policy Period and shown on the portal and also intimated to the Insured Person via SMS/ email..

Illustration of Healthkarats Redemption

Scenario I: - Individual Policy

- Ram is enrolled under Group Health Guard for INR 5lacs Sum Insured.
- He has undergone pre-Policy medical examination due to his Age and is found to have diabetes.
- He opt for a Chronic Management Program to keep his diabetes condition in control.

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Let's understand how he can earn Healthkarats under the Policy under different circumstances.

Activity Description	Earned Healthkarats
Step 1- Portal registration	
Signed up and added the Policy details	275
Step 2- Activities Prevention and Identification	
Taken Health Risk Assessment	
Completed in single session (Attempt and Completed)	250
Achieved Wellness score- 41-60	50
Taken HRA again after 6 months where wellness score came at 61-80	75
Improvement by one slab	50
Health Check-up- Basic taken twice in a year	500
*HbA1c- For Diabetes done 4 times in a year	200
Done PSA for males above 40yrs	200
Care Management	
Purchased the Diabetes Disease management program which includes below activities	1000
HbA1c	
Blood Sugar- Fasting and PP	
Urine Analysis- Protein and Sugar	
Thyroid Function	
Diet plan	
Health Coach	
Connected Health	
Average Steps taken every day was 6000- 8000 steps/day	5 per day for 365 days = 1825
Fitness Subscription	
Subscribe to annual Yoga classes, entered the log thought the year	1000
Total Points Earned	5425

I. **In case of Claim**

Based on the total points earned in a year Ram will be entitled to redeem his points against claims.

- Total points earned- 5425

5425 points x INR 0.50 (1 point = INR 0.50) = INR 2713/-

- o INR 2713/- can be redeemed against the Non-medical expenses as defined under Annexure II of policy wordings.
- o If the non-medical expenses are INR. 2000/- i.e. 4000 reward points
  - 4000 points would be redeemed
  - Remaining 1425 points would be updated to the portal.

II. **In case of No Claim**

i) If Ram has Health Guard (Group) policy of INR 300,000 Sum Insured.

- Total points earned= 5425

5425 points x INR 1 (1 point = INR 1) = INR 5425/-

- o Sum Insured will be increased INR 5425/- over and above basic Sum Insured i.e INR 300,000.
- o INR 5425 + INR 300,000 = INR 305,425

Scenario II: - Floater Policy

- Mr Abhijit, his wife Mrs Kapila and their son Mr. Sam are enrolled under Group Health Guard for INR 3 lacs Floater Sum Insured
- All are living healthy life and not diagnosed or having treatment for any chronic Management programme.

HEALTH GUARD (GROUP) GOLD PLAN

Let's understand how he can earn Healthkarats under the Policy under different circumstances.

Activity Description	Earned Health-karats	Activity Description	Earned Health-karats	Activity Description	Earned Health-karats
	Mr Abhijit		Mrs Kapila		Mr. Sam
Step 1- Portal registration	Step 1- Portal registration			Step 1- Portal registration	
Signed up and added the Policy details	275	Signed up and added the Policy details	275	Signed up and added the Policy details	275
Step 2- Activities Prevention and Identification	Step 2- Activities Prevention and Identification				
Taken Health Risk Assessment		Taken Health Risk Assessment		Taken Health Risk Assessment	
Completed in single session (Attempt and Completed)	250	Completed in single session (Attempt and Completed)	250	Completed in single session (Attempt and Completed)	250
Achieved Wellness score- 41-60	50	Achieved Wellness score- 41-60	50	Achieved Wellness score- 41-60	50
Taken HRA again after 6 months where wellness score came at 61-80	75	Taken HRA again after 6 months where wellness score remain same at 41-60	50	Taken HRA again after 6 months where wellness score remain same at 41-60	-
Improvement by one slab	50	Improvement by one slab	-	Improvement by one slab	-
Done PSA for males above 40yrs	200	No additional Tests done	-	No additional Tests done	-
Connected Health	Connected Health			Connected Health	
Average Steps taken every day was 6000- 8000 steps/day	5 per day for 365 days = 1825	Average Steps taken every day was 8001- 10000 steps/day	7.5 per day for 365 days = 2738	Average Steps taken every day was 4001- 5000 steps/day	Nil
Fitness Subscription	Fitness Subscription			Fitness Subscription	
Subscribe to Yoga classes	750	Subscribe to Gym	750	Subscribe to Swimming	750
Total Points Earned	3475	Total Points Earned	4113	Total Points Earned	1325

I. **In case of Claim**

- Under floater policy you will be entitled for the benefit by taking total sum of Healthkarats points earned by all members covered under the policy.
  - o Mr Abhijit had earned 3475 points
  - o Mrs Kapila had earned 4113 points,
  - o Mr. Sam had earned 1325 points
  - o Total points earned 7588 (3475+4113)
- Total Point earned by all members covered under the policy will be considered for utilization by any of the family member covered under the policy.

Mr. Abhijeet or Mrs. Kapila or Mr. Sam will be entitled to redeem their points against claims.

7588 points x INR 0.50 (1 point = INR 0. 50) = INR 3794/- can be redeemed against the Non-medical expenses as defined under Annexure II of policy wordings.

II. **In case of No Claim**

i) If Mr. Abhijit, his wife Mrs Kapila and their son Sam have Health Guard (Group) policy of INR 300,000 Floater Sum Insured.

- o Mr Abhijit had earned 3475 points
- o Mrs Kapila had earned 4113 points,
- o Mr. Sam had earned 1325 points
- o Total points earned 7588 (3475+4113)

7588 points x INR 1 (1 point = INR 1) = INR 7,588/-

- o Sum Insured of the Floater Policy will be increased INR 7,588/- over and above basic Sum Insured i.e INR 300,000.
- o INR 7,588+ INR 300,000 = INR 3,07,588