Bajaj General Insurance Limited
(Formerly known as Bajaj Allianz General Insurance Co. Ltd.)
Bajaj Insurance House, Airport Road, Yerawada, Pune - 411006. IRDAI Reg No.: 113.
CIN: U66010PN2000PLC015329 | UIN: BAJHLIP27079V012627
Email: careforyou@bajajgeneral.com | Website: www.bajajgeneralinsurance.com
Sales - 1800 209 0144 / Service - 1800 209 5858 (Toll Free No.)

CARINGLY YOURS

POLICY WORDINGS

MY HEALTH COMPANION

SECTION A) PREAMBLE

Whereas the Insured has made a Proposal to Bajaj General Insurance Limited (Formerly known as Bajaj Allianz General Insurance Company Limited) together with all information and documents submitted in connection therewith which is hereby agreed to be the basis of this Policy and are deemed to be incorporated herein, and in consideration of payment of Premium, as specified in the Schedule, by You and realized by Us, the Company agrees, subject to the following terms, conditions, exclusions, definitions, and limitations of the Policy, to indemnify Insured Person(s)/make payment, in excess of the amount of the Deductible and subject to the Sum Insured and/or Limit of Indemnity, in the manner and to the extent as provided herein.

SECTION B) DEFINITIONS-

I. STANDARD DEFINITIONS

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

2. AYUSH Hospital
   An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a. Central or State Government AYUSH Hospital; or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i. Having at least 5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out
      iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

4. Cashless facility
   Cashless facility means a facility extended by the Insurer to the Insured where the payments, of the costs of Medical 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 of pre-authorization is approved.

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

6. 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.

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

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

9. Day Care Treatment
   Day care treatment means Medical Treatment, and/or Surgical Procedure which is:
   i. undertaken under General or Local Anaesthesia 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. Medical Treatment normally taken on an outpatient basis is not included in the scope of this definition.

10. Deductible
    Deductible means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified amount (in INR) in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the Insurer. A deductible does not reduce the Sum Insured.
    Deductible will be applicable either per year (Aggregate Deductible) or per claim, as specified in the Policy Schedule.

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

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

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

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

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

i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii. has qualified Medical Practitioner(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
v. Maintains daily records of patients and makes these accessible to the ICompany's authorized personnel.

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

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

a. Acute condition - Acute condition is a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
b. Chronic condition – A chronic condition is defined as a disease, Illness, or Injury that has one or more of the following characteristics:
    i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
    ii. it needs ongoing or long-term control for relief of symptoms
    iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
    iv. it continues indefinitely
    v. it recurs or is likely to recur.

18. 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.

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

20. Intensive Care Unit (ICU)
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.

21. 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.

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

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

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

25. Medical Practitioner/Doctor/ Physician
Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license and acceptable to Us.

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

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

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

29. Network Provider
Network Provider means Hospitals or health care providers enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a Cashless facility.

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

31. Non-Network Provider means any Hospital, Day Care Centre or other provider that is not part of the network.

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

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

34. Pre-Existing Disease:
Pre-existing disease means any condition, ailment or Injury or disease
a. That is/are diagnosed by a Physician within 36 months prior to the effective date of the Policy issued by the Insurer or its reinstatement Or
b. For which medical advice or treatment was recommended by, or received from, a Physician/Medical Practitioner within 36 months prior to the effective date of the Policy issued by the Insurer or its reinstatement.

35. 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.

36. 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.

37. 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.

38. Specific waiting period
Specific waiting period means a period up to 24 months from the commencement of Policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

39. Surgery or Surgical Procedure
Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

40. 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.

II. SPECIFIC DEFINITIONS

1. Act of Terrorism
Means an act or thing by any person or group(s) of persons, whether acting alone or on behalf of or in connection with or in connivance with or at the instance or instigation of any person or group(s) or organisation(s) or associations(s), who are committed or proclaimed to be committed for political, religious or ideological purposes, whether such person or group(s) of persons or organisation(s) or association(s) are or are not banned any law, in such a manner or 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 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, with intend to cause, or likely to cause, death or, 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 defence of India or in connection with any other purposes of the Government of India, any State Government or an 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. Provided further that for the above acts appropriate criminal prosecution has been initiated by police and charge sheet has been filed in competent court of criminal jurisdiction, either under special law or under general law.

2. Aggregate Deductible
Aggregate Deductible means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified amount (in INR) in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits/claims are payable by the Insurer. A deductible does not reduce the Sum Insured. The deductible is applicable in aggregate towards Hospitalisation expenses incurred during the Policy Period.

3. AYUSH Consultation
AYUSH Consultation refers to consultation provided by a qualified and registered practitioner of Ayurveda, Yoga & Naturopathy, Unani, Siddha or Homeopathy, recognized by the respective statutory council in India.

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

5. Dependent child
A child is considered a dependent for insurance purposes provided he is financially dependent, on the proposer/Insured.

6. Disappearance
Disappearance means the event of the disappearance of the Insured Person, following a forced landing, stranding, sinking or wrecking of a conveyance in which such Insured Person was known to have been

travelling as an occupant, it shall be deemed after twelve (12) months, subject to all other terms and conditions of this Policy, that such Insured Person shall have died as the result of an Accident.

7. Endorsement
Means any writing on a Policy Schedule or Policy, in addition to its normal wording which supplements or modifies its terms. It may be added when Policy is prepared, or subsequently. Provided however any Service Level Agreement [SLA] or Agreement/MOU laying down various service levels shall not be treated as Endorsement.

8. Family or Family Members
For the purpose of Individual Sum Insured Policy- includes the Insured; his/her lawfully wedded spouse, dependent children, dependent parents, dependent parents-in-law.
For the purpose of Family Floater policy- includes the Insured; his/her lawfully wedded spouse and dependent children.
For Parents/ Parents in law separate floater Policy can be taken.

9. First Aid
First aid refers to medical attention that is usually administered immediately after the Injury occurs and at the location where it occurred before the arrival of an ambulance, the arrival of a qualified paramedical or medical person or before arriving at a facility that can provide professional medical care.
It often consists of a one-time, short-term treatment and requires little technology or training to administer. First aid can include (but not limited to) cleaning minor cuts, scrapes, or scratches; treating a minor burn; applying bandages and dressings; the use of non-prescription medicine; draining blisters; removing debris from the eyes; massage; and drinking fluids to relieve heat stress.
The aims of first aid are:
- to preserve life,
- to prevent the worsening of one's medical condition,
- to promote recovery, and
- to help to ensure safe transportation to the nearest healthcare facility

10. General Practitioner
General practitioner is a Medical Practitioner 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.

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

12. Medical Consumable
Medical consumables and equipment include syringes, needles, sutures, staples, packaging, tubing, catheters, medical gloves, gowns, masks, adhesives and sealants for wound dressing and a whole host of other devices and tools used with a hospital or surgical environment.

13. Medical Practitioner / Doctor / Physician
Registered Medical Practitioner (RMP) means a medical practitioner holding a valid registration with the National Medical Commission (NMC) or the relevant State Medical Council and licensed to practice in India, acting within the scope of their qualification. Retain recognition of AYUSH statutory councils for AYUSH consultations.

14. Insured
Insured means the proposer, policyholder, or Insured Person (s) named in the schedule.

15. Insured Person
Insured Persons means the person(s) named in the Schedule and who are covered under the Policy.

16. Nominee
Nominee means a person designated by You to receive the proceeds of this Policy upon Your/Insured Persons death.

17. Obesity
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

18. Pregnancy-related complications mean medically necessary outpatient consultation and prescribed diagnostics for the diagnosis or treatment of complications arising during pregnancy, where such treatment is required to manage an abnormal medical condition and is not part of routine antenatal care.

19. Proposal
Proposal means the proposal form (in physical form or digital form) and other information and documentation supplied to us in any other mode of communication in considering whether and on what terms to offer this insurance.

20. Policy or Contract
Policy or Contract means the Proposal, the Policy Schedule, along with these Policy Wordings /Terms and Conditions issued to the Insured and any annexures and/or Endorsements attaching to and / or forming part thereof either at the commencement of Policy Period or during the Policy Period.

21. Policy Period
Policy Period means period from risk inception date [RID] to risk end date [RED], as mentioned in the Policy Schedule.

22. Policy Schedule or Schedule
Policy Schedule or Schedule means the policy schedule attached to and forming part of this Policy specifying the details of the Insured Persons, the Sum Insured, the Policy Period etc. and the Sub-limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then latest in time.

23. Policy Year
Policy Year means the period of 12 months.

24. Service Provider/s
Service Provider means an entity engaged or named by the Company by Us for facilitating or arranging one or more benefits or services under this Policy, including access to eligible healthcare or wellness providers, in accordance with the terms of this Policy.

25. Specialist
Specialist Consultant means a person who holds a medical post graduate or higher degree in the specific line of treatment under Allopathic medicine.

26. Sum Insured
    Sum Insured means the amount specified in the Schedule which is Our maximum, total and cumulative liability under this Policy for any and all claims arising under this Policy in a Policy Year in respect of the Insured Person(s)

27. "You", "Your", "Yourself"
    You, Your, Yourself named in the Policy Schedule means the Insured or Insured's Family Members who are beneficiaries that We insure as set out in the Schedule.

28. We, Us, Our, Ours, Insurer, Company
    We, Us, Our, Ours, Insurer, Company means the Bajaj General Insurance Limited.

SECTION C) SCOPE OF COVER

Subject to the terms, conditions, exclusions, waiting periods and limits specified in this Policy and the Policy Schedule, Insured Person shall be entitled to receive the benefits specified below during the Policy Year.

The details as to nature of each benefit together with the applicable monetary limit, number of consultations/sessions/vouchers, frequency or other utilisation limit, shall be as per the plan opted by Insured Person and specified in the under respective cover and Policy Schedule. The benefits available under this Policy, to the extent opted for and specified in the Policy Schedule, are:

1. In-Clinic Doctor Consultation
2. Prescribed Diagnostics- Pathology & Radiology
3. Dental OPD
4. Annual Health Check-up
5. Tele Consultation
6. Accidental OPD
7. Diet & Nutrition Sessions
8. Emotional Wellness Sessions
9. Value Added Services

Benefit	Start (₹5,000 OPD Wallet)	Smart (₹10,000 OPD Wallet)	Prime (₹15,000 OPD Wallet)	Elite (₹25,000 OPD Wallet)
In-clinic Doctor Consultation	₹ 2,500	₹ 5,000	₹ 7,500	₹ 10,000
Prescribed Diagnostics	₹ 2,500	₹ 5,000	₹ 7,500	₹ 10,000
Dental OPD	-	-	-	₹ 5,000
Annual Health Check-up (1 Voucher for Individual Policy 2 vouchers for Floater Policy)	Essential Package	Classic Package	Silver Package	Smart Plus Package
Tele Consultation	Unlimited GP	Unlimited GP + 5 Specialities	Unlimited GP + 10 Specialities	Unlimited All 20+ Specialities
Accidental OPD	₹ 5,000	₹ 10,000	₹ 15,000	₹ 25,000
Diet & Nutrition Sessions	4 Sessions	8 Sessions	12 Sessions	Unlimited
Emotional Wellness Sessions	2 Sessions	4 Sessions	6 Sessions	10 Sessions
Smart Face Scan	2 Scans	4 Scans	8 Scans	12 Scans
Value Added Services	✓	✓	✓	✓

A benefit shall be available only where it is expressly shown as covered in the Policy Schedule. Benefit under this Policy will be facilitated through a Network Provider or Service Provider appointed or engaged by Us and the Insured Person may avail such benefit through the applicable service delivery process communicated by Us. Availability of a particular Network Provider, healthcare professional, facility, appointment slot or mode of service shall be subject to the applicable network and operational availability.

1. In-clinic Doctor Consultation

Coverage:

If the Insured Person is requires medical consultation for any Illness or Injury during the Policy Period, Insured Person may avail an in-person consultation with an Medical Practitioner/ Physician/Doctor/AYUSH practitioner from prescribed network centres of concerned Service Provider up to the limit as specified under this Policy.

The consultation may be availed on a Cashless basis through the Service Provider in accordance with the process defined under Service Delivery Process.

Exclusions for "In-Clinic Doctor Consultation":

The following shall not be covered under this benefit:

1. Other expenses of investigations, medicines, surgical or non-surgical procedures or any medical, non-medical items are not covered under this cover/section.
2. If the In-clinic Doctor consultation cover is not availed in the Policy Year, the benefit cannot be carried forward to the subsequent Policy Year.
3. Claims related to Routine antenatal check-ups, pregnancy screening tests, delivery expenses, postnatal care, medicines and fertility treatment shall not be covered. However, consultations for Pregnancy Related Complications would be covered.
4. Dietician/nutritionist consultations/sessions will not be covered under this cover/benefit.
5. Panchakarma or any therapeutic AYUSH procedures.
6. Wellness, preventive or rejuvenation therapies, yoga classes, meditation programs, naturopathy retreats or wellness packages.
7. 30-day Waiting Period (Code-Excl03)
    a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
    b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
    c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.
8. Pre-Existing Diseases Waiting Period (Code- Excl02)
    a. Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first My Health Companion Policy with Us.
    b. The PED waiting period would be as specified on the Policy Schedule.
    c. If the Insured Person is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations, then Waiting Period for the same would be reduced to the extent of prior coverage.
    d. Coverage under the My Health Companion Policy after the expiry of the waiting period as specified in the Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.
9. Dental consultations are not covered under this benefit. They are covered only under the Dental OPD benefit, available in the ELITE plan.
10. Physiotherapist — Only the consultation fee of a physiotherapist is covered. Physiotherapy sessions / therapy charges are not covered.

11. Ophthalmologist — Consultation is covered. Eye testing for spectacles, refraction, spectacles, contact lenses and vision-correction procedures are not covered.

Please refer below table for inclusions & exclusions of doctor specialties.

Speciality	Doctor Specialization	Covered/Excluded
General Physician	General Physician	Covered
	Ayurveda	Covered
	Homeopath	Covered
	Physiotherapist	Covered
	Unani	Covered
Specialist	Paediatrician	Covered
	Dentist	Covered
	Dermatologist	Covered
	Orthopaedic	Covered
	Psychologist	Excluded
	Ophthalmologist	Covered
	Gynaecologist & Obstetrician	Covered
	ENT	Covered
	Psychiatrist	Covered
	General Surgeon	Covered
	Dietitian/Nutritionist	Excluded
	Audiologist	Excluded
	Anaesthesiologist	Covered
	Radiologist	Covered
	Pathologist	Covered
	Sexologist	Covered
	Cosmetologist*	Excluded
	Cosmetic & Plastic Surgeon*	Excluded
	Electropathy	Excluded
	Dermatologist	Covered
	ENT Surgeon	Covered
	Speech Therapist	Excluded
	Embryologist	Excluded
	Haematologist	Covered
	Preventive medicine specialist	Covered
Super specialist	Paediatric surgeon	Covered
	Dental Surgeon	Covered
	Cardiologist	Covered
	Pulmonologist	Covered
	Diabetologist	Covered
	Oncologist	Covered
	Neurologist	Covered
	Gastroenterologist	Covered
	Nephrologist	Covered
	Urologist	Covered
	Orthodontic	Covered
	Orthopaedics & Joint Replacement	Covered
	Rheumatologist	Covered
	Endocrinologist	Covered
	Laparoscopic Surgeon	Covered
	General Surgeon	Covered
	Vascular Surgeon	Covered
	Infectious disease specialist	Covered

* Expenses for consultations with Cosmetologist or Cosmetic & Plastic Surgeon are excluded, unless following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the Insured/ Insured Member. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

2. Prescribed Diagnostics- Pathology & Radiology Expenses

Coverage:

Where an eligible Medical Practitioner prescribes a pathology or radiology investigation to diagnose, monitor or evaluate an Illness or Injury of an Insured Person, We shall cover the cost of such prescribed investigation, subject to the applicable limit specified in the Policy Schedule.

The investigation may be availed on a Cashless basis from prescribed network centres of a Service Provider in accordance with the Service Delivery Process.

If the Prescribed Diagnostics-Pathology or radiology lab is not available in the prescribed network of the Service Provider, Insured Person can take a prior-approval of the Insurer to undertake the prescribed investigations at another eligible diagnostic facility. Upon such authorisation, We shall reimburse the admissible expenses actually incurred, subject to submission of the required documents and up to the applicable Benefit limit specified in the Policy Schedule as per reimbursement process as defined under Service Delivery Process. The investigation expenses would be payable up to the limit specified on the Policy Schedule. The Insured Person should undergo the prescribed investigation within 30 days from the date of the Doctor prescription.

Exclusions for "Prescribed Diagnostics – Pathology & Radiology Expenses"

The following shall not be covered under this benefit:

1. If the cover is not availed in the respective Policy Year, the benefit cannot be carried forward to the subsequent Policy Year.
2. Claims related to Routine antenatal check-ups, pregnancy screening tests, delivery expenses, postnatal care, medicines and fertility treatment shall not be covered. However, investigations for Pregnancy Related Complications would be covered.
3. Any preventive/ screening health tests shall not be covered under this benefit.
4. Invasive tests shall not be covered. Please refer Annexure I for the list of Invasive tests.
5. 30-day Waiting Period (Code-Excl03)
    a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
    b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
    c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.
6. Pre-Existing Diseases Waiting Period (Code- Excl02)
    a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry 12 months of continuous coverage after the date of inception of the first My Health Companion Policy with Us.
    b) The PED waiting period would be as specified on the Policy Schedule.
    c) If the Insured Person is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations then Waiting Period for the same would be reduced to the extent of prior coverage.
    d) Coverage under the Policy after the expiry of the waiting period as specified in Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

3. Dental OPD

Coverage:

If an Insured Person requires dental consultation or treatment due to any dental ailment during the Policy Period, We shall cover the eligible Dental OPD services specified under this benefit, up to the applicable limit specified in the Policy Schedule. The Insured Person may avail the dental consultation or treatment from a dentist who is appropriately qualified and registered in accordance with applicable law ("Dentist") from prescribed network centres of the Service Provider.

This benefit shall ordinarily be available on a Cashless basis through dentists/dental facilities forming part of the prescribed network of the Service Provider and in accordance with the procedure specified under the Service Delivery Process. The availability of a particular Dentist or dental facility shall be subject to the applicable network and appointment availability.

If the required Dentist is not available in the prescribed network of the Service Provider, Insured Person can take a prior-approval of the Insurer to avail the covered dental service from an appropriately qualified and registered Dentist outside such network. Upon such authorisation, We shall reimburse the admissible expenses actually incurred, subject to submission of the required documents up to the applicable benefit limit and as per reimbursement process as defined under Service Delivery Process. Such reimbursements will be capped for respective services as per the table below. However, this capping will apply only for reimbursement claims.

The following dental services shall be covered under this benefit, subject to the applicable limits, sub-limits, frequency limits and other conditions specified in the Policy Schedule

Procedure	Capping amount
Consultation charges	500
IOPA/X-ray	
IOPA	250
Digital X ray	400
Root canal treatment	
RCT with GIC /Miracle /SF POR	5000
RCT with composite POR	5000
Third molar RCT	5000
Repeat RCT	5000
Post and core	4000
Restoration /Filling	
GIC	1000
Silver filling	2000
Composite	3000
Diastema Closure	3500
Anterior Fracture Repair	3000
Extraction	
Mobile tooth	700
Firm tooth	1000
Badly carious/Surgical/Erupted wisdom	2500
Disimpassion	5000
Extraction – wisdom tooth – upper jaw	3000
Extraction – wisdom tooth – lower jaw	5000
Extraction – Impacted/Surgical removal	5000
Extraction – Root canal treated teeth -Nonsurgical	3000
Extraction – Root canal treated teeth -surgical	5000
Crown	
Ni-Cr Metal crown	3000
Co-Cr Metal crown	4500

RFM (Ceramic)	5000
CAD CAM PFM	5000
Zirconia	5000
Brux zir	5000
Lava / Porcera / E-max	5000
Paediatric dentistry	
Extraction of primary teeth	750
Pulpectomy	4000

Exclusions for "Dental OPD":
The following shall not be covered under this benefit:

1. Other expenses of investigations, medicines, surgical or non-surgical procedures or any medical, non-medical items not mentioned under this coverage are excluded.
2. Any cosmetic level scaling/polishing, bleaching, cap of teeth, braces, aligner, and tooth replacement, any other cosmetic and aesthetic treatment.
3. This benefit cannot be availed outside the prescribed network of dentists and hospitals.
4. If the benefit under this cover is not availed in the Policy Year, the benefit cannot be carried forward to the subsequent Policy Year.
5. 30-day Waiting Period (Code-Excl03)
    a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
    b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
    c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.
6. Pre-Existing Diseases Waiting Period (Code- Excl02)
    a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first My Health Companion Policy with Us.
    b) The PED waiting period would be as specified on the Policy Schedule.
    c) If the Insured Person is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations, then Waiting Period for the same would be reduced to the extent of prior coverage.
    d) Coverage under the Policy after the expiry of the waiting period as specified in Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

4. Annual Preventive Health Check-up cover

Coverage:

1. The Insured Person /s, as per the plan opted, can avail the Preventive health check-up once in every Policy Year as per the list given below in the network centres of the Service Provider.

Essential

Test	Component
Complete Blood Count	Absolute Basophils Count, Absolute Eosinophil Count, Absolute Lymphocyte Count, Absolute Monocyte Count, Absolute Neutrophil Count, Basophils, Eosinophils, Hemoglobin (Hb), Lymphocytes, MCH, MCHC, MCV, Mentzer Index (MCV/RCC), Monocytes, MPV (Mean Platelet Volume), Neutrophils, PCV (Haematocrit), Platelet Count (Thrombocyte Count), RBC Count, RDW-CV, RDW (Red Cell Distribution Width), WBC - Total Counts (Leucocytes)

Diabetic Profile	Fasting Blood Sugar
Lipid Profile	Serum Cholesterol
Kidney Function Tests	Serum Creatinine

Classic

Test	Component
Hemogram	Monocytes - Absolute Count, Lymphocyte Percentage, Nucleated Red Blood Cells, Neutrophils, Basophils, MCHC, Eosinophils, Haemoglobin, Platelet Count, Mean Corpuscular Volume (MCV), Immature Granulocytes (IG), Eosinophils - Absolute Count, Lymphocytes - Absolute Count, Basophils - Absolute Count, Neutrophils - Absolute Count, Immature Granulocyte Percentage (IG%), Nucleated Red Blood Cells %, Haematocrit (PCV), RDW-SD, RDW-CV, Total RBC, Total Leucocytes Count, Mean Corpuscular Haemoglobin (MCH), Monocytes
Diabetic Profile	Fasting Blood Sugar, HbA1C
Liver Function Test	Albumin Serum, Bilirubin - Indirect Serum, Globulin, SGOT/SGPT Ratio, GGTP (Gamma GT), Alkaline Phosphatase Serum, SGOT/AST, A/G Ratio, SGPT/ALT, Bilirubin Direct Serum, Proteins Serum, Bilirubin Total Serum
Urine Routine	Colour, Urinary Leucocytes, Epithelial Cells, Crystals, Urine Ketone, Urobilinogen, Urinary Glucose, Urinary Protein, Urine Blood
Lipid Profile	VLDL, HDL/LDL Cholesterol Ratio, HDL Cholesterol Direct, LDL Cholesterol - Calculated, Non-HDL Cholesterol Serum, LDL/HDL Ratio, CHOL/HDL Ratio, Cholesterol - Total Serum, Triglycerides Serum
Bone Health	Calcium
Thyroid Profile	T3 - Total Tri Iodothyronine, TSH Ultra-sensitive, T4 - Total Thyroxine
Kidney Function Tests	Blood Urea Nitrogen (BUN), Creatinine - Serum
ESR	ESR

Silver

Test	Component
Hemogram	Monocytes - Absolute Count, Lymphocyte Percentage, Nucleated Red Blood Cells, Neutrophils, Basophils, MCHC, Eosinophils, Haemoglobin, Platelet Count, Mean Corpuscular Volume (MCV), Immature Granulocytes (IG), Eosinophils - Absolute Count, Lymphocytes - Absolute Count, Basophils - Absolute Count, Neutrophils - Absolute Count, Immature Granulocyte Percentage (IG%), Nucleated Red Blood Cells %, Haematocrit (PCV), RDW-SD, RDW-CV, Total RBC, Total Leucocytes Count, Mean Corpuscular Haemoglobin (MCH), Monocytes
Diabetic Profile	Fasting Blood Sugar, HbA1C
Liver Function Test	Bilirubin - Total, Serum Alb/Globulin Ratio, Serum Globulin, Gamma Glutamyl Transferase (GGT), Alanine Transaminase (SGPT), Alkaline Phosphatase, Aspartate Aminotransferase

	(SGOT), Albumin - Serum, Bilirubin (Indirect), Protein - Total, Bilirubin - Direct
Complete Urine Routine	Crystals, Urinary Leucocytes, Urobilinogen, Colour, Epithelial Cells, Urinary Protein, Urine Ketone, Urine Blood, Urinary Glucose
Lipid Profile	VLDL, HDL/LDL Cholesterol Ratio, HDL Cholesterol Direct, LDL Cholesterol - Calculated, Non-HDL Cholesterol Serum, LDL/HDL Ratio, CHOL/HDL Ratio, Cholesterol - Total Serum, Triglycerides Serum
Iron Deficiency	Total Iron Binding Capacity (TIBC), % Transferrin Saturation, Iron
Thyroid Profile	Thyroid Stimulating Hormone (TSH), Total Triiodothyronine (T3), Total Thyroxine (T4)
Kidney Function Tests	Calcium, Uric Acid, Creatinine - Serum, BUN / Sr. Creatinine Ratio, Blood Urea Nitrogen (BUN)
Stool Routine & Microscopic Examination	Colour, Consistency, Mucus, Blood, Pus Cells, RBC, Cysts, Parasites, OVA, Others
Hs-CRP	High-Sensitivity C-Reactive Protein
VITAMIN B	Vitamin B12 (Cyanocobalamin)
VITAMIN D	Vitamin D Total - 25 Hydroxy
ESR	ESR

Smart Plus

Test	Component
Infection Screening [Hemogram + Esr]	Absolute Basophils Count, Absolute Eosinophil Count, Absolute Lymphocyte Count, Absolute Monocyte Count, Absolute Neutrophil Count, ESR (Automated), Hemoglobin (Hb), MCH, MCHC, MCV, MPV (Mean Platelet Volume), PCV (Haematocrit), Platelet Count, WBC – Total Counts, RDW (Red Cell Distribution Width), Neutrophils, Eosinophils, Lymphocytes, Monocytes, Basophils, RDW-CV, Mentzer Index (MCV/RCC), Red Blood Cells, RDWI, PDW, P-LCR, P-LCC
Blood Group & Rh Typing	Blood Group ABO & Rh Typing
Lipid Profile	Total Cholesterol, HDL Cholesterol (Direct), LDL Cholesterol (Direct), Triglycerides, Non-HDL Cholesterol, VLDL, LDL/HDL Ratio, Chol/HDL Ratio, HDL/LDL Ratio, Apolipoprotein A1, Apolipoprotein B, Apo Ratio A1/B, hs-CRP
Liver Health	Albumin, Alkaline Phosphatase, Bilirubin (Direct), Bilirubin (Total), Bilirubin (Indirect), GGTP (Gamma GT), Total Proteins, SGOT/AST, SGPT/ALT, Globulin, A/G Ratio, SGOT/SGPT Ratio
Urine Routine & Microscopy	Volume, Colour, Transparency, Deposit, pH, Specific Gravity, Sugar, Protein/Albumin, Ketones/Acetone, Blood, Leucocyte Esterase, Bilirubin, Nitrite, Urobilinogen, Pus/WBC Cells, Epithelial Cells, RBC Cells, Casts, Crystals, Yeast Cells, Amorphous Deposits, Bacteria, Protozoa
Kidney Health	Urea (Serum), Blood Urea Nitrogen, Creatinine, Uric Acid, BUN/Creatinine Ratio, Urea/Creatinine Ratio
Diabetes Profile	Glucose Fasting (BSF), Average Blood Glucose, HbA1C (Glycosylated Haemoglobin)
Anaemia Profile [Iron]	Iron (Serum), TIBC, UIBC (Serum), Transferrin Saturation, Serum Ferritin

Allergy Profile	C-Reactive Protein, Lactate Dehydrogenase (LDH) Serum
Bone Health	Calcium, Phosphorus, RA Factor (Rheumatoid)
Electrolyte Profile	Sodium, Potassium, Chloride
Vitamins Profile	T3, T4, TSH (Thyroid Stimulating Hormone)
Thyroid Profile	ESR
Cancer Marker	Alpha-Fetoprotein (AFP)

2. The health check-up can be availed on a cashless basis in the prescribed list of hospitals or diagnostic centers, which can be accessed from the Insurer's website or digital application of the Insurer/Service Provider.
3. The list of tests listed above cannot be changed.

Exclusions for "Annual Preventive Health Check-up Cover"

The following shall not be covered under this benefit:

1. Preventive health check-up cannot be availed outside the prescribed list of Hospitals or diagnostic centers.
2. Home collection facility will be available only at selected locations. For locations where home sample collection is not available, the customer will have to physically go and take the tests.
3. The complete list of tests as given above has to be completed in a single appointment.
4. If the health check-up is not availed in the Policy Year during the Policy Period, the benefit cannot be carried forward to the subsequent Policy Year.
5. Reimbursement of preventive health check-up expenses is excluded from the scope of this Policy.
6. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
   c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

5. Tele Consultation

Coverage:

During the Policy Period, If an Insured Person is suffering from any Illness or Injury, he/she may avail teleconsultation from the Medical Practitioner/AYUSH practitioner listed on the digital platform/application made available by Us or the Service Provider, subject to the applicable number of consultations, limits and conditions as per opted plan specified in the Policy Schedule.

Teleconsultation may be provided through video, audio, or chat channel. The Insured Person may select from the specialties and Medical Practitioners available on the digital platform/application at the relevant time.

This cover shall be provided in compliance with applicable law, including Telemedicine Practice Guidelines dated 25th of March 2020 as amended from time to time. This is a cashless benefit and shall be available only through the digital platform/application specified by Us or the Service Provider.

Conditions/Exclusions for "Tele Consultation"
The following shall not be covered under this benefit:

1. Tele consultation outside the digital platform/application of Insurer or concerned Service Provider, in-clinic/physical consultation is not covered under this cover of Policy.
2. Teleconsultation benefit is not transferrable to any other person/member unless such person/member is covered under this Policy.
3. If the Tele Consultation is not availed in the Policy Year, the benefit cannot be carried forward to the subsequent Policy Year.
4. Wellness, preventive or rejuvenation therapies, yoga classes, meditation programs, naturopathy retreats or wellness packages.
5. Each Insured Beneficiary may book or utilize a maximum of 10 consultations per month.
6. Each Insured Beneficiary may utilize a maximum of 2 consultations per day.
7. Only 1 consultation per day with the same doctor is permitted for an Insured Beneficiary.
8. The maximum consultation fee covered shall be ₹2,000 per consultation.
9. Reimbursement of expenses incurred for teleconsultation benefit is excluded.
10. 30-day Waiting Period (Code-Excl03)
    a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
    b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
    c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

6. Accidental OPD

Coverage:
Where an Insured Person sustains an Injury solely and directly as a result of an Accident occurring during the Policy Period, We shall cover the eligible outpatient medical expenses reasonably and necessarily incurred for below listed consultations/treatment of such Injury, up to the limit as per plan specified in the Policy Schedule.

The below listed consultations/treatment may be availed from a Medical Practitioner /AYUSH practitioner in person either through the prescribed network centres of concerned Service Provider or any Clinic/ Hospital of Your choice up to the limit as specified under this Policy.

1. Emergency medical consultations and First Aid treatment.
2. Wound management, including suturing, dressing, splinting, plaster/cast application and removal.
3. Joint stabilization, reduction of minor dislocations, and removal of superficial foreign bodies.
4. Medically Necessary intramuscular or intravenous injections, including tetanus prophylaxis and anti-rabies prophylaxis following an accident.
5. Diagnostic investigations directly related to the accidental injury, including X-rays and other medically indicated diagnostic tests.
6. Medically Necessary follow-up outpatient consultations for the treatment of the same accidental injury, subject to the limits and conditions of this Policy.

Exclusions for "Accidental OPD":
The following shall not be covered under this benefit:

1. Treatment for injuries that did not arise from an Accident occurring during the Policy Period.

2. Chronic orthopedic conditions, degenerative diseases and arthritis.
3. Rehabilitation and long-term physiotherapy.
4. Cosmetic or reconstructive procedures.
5. Sports overuse injuries.
6. Prosthetic devices and implants.
7. Supplements & vitamins, Medicines

7. Diet & Nutrition Consultation Sessions

Coverage:

During each Policy Year, to maintain a balance between good nutrition and diet, an Insured Person shall be entitled to avail the consultation from a Dietician or Nutritionist listed on the digital platform/application made available by Us or the Service Provider, via video, audio, or chat channel, up to the limit as per opted plan specified in the Policy Schedule.

This is a cashless service and can only be availed through the prescribed network of Service Provider.

Conditions/Exclusions for "Diet & Nutrition Consultation Sessions":

1. Consultation with the dietician is strictly limited to in-app/website video/audio/chat consultation, no in-clinic/physical consultation is allowed.
2. Dietician & Nutritionist consultation benefit is not transferrable.
3. If the benefit is not availed in the Policy Year the benefit cannot be carried forward to the subsequent Policy Year.
4. Reimbursement of dietician & nutritionist consultation expenses is excluded from the scope of the Policy.
5. 30-day Waiting Period (Code-Excl03)
   a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
   b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
   c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

8. Emotional Wellness Sessions

Coverage:

During each Policy Year, an Insured Person shall be entitled to avail the emotional wellbeing services wherein an Insured Person can consult an emotional health coach/psychologist listed on the digital platform/application made available by Us or the Service Provider, via video, audio, or chat channel, up to the limit as per opted plan specified in the Policy Schedule.

This is a cashless service and can only be availed through the prescribed network of Service Provider.

Conditions and Exclusions for "Emotional Wellness Sessions":

1. Consultation with the emotional health coach/psychologist is strictly limited to in-app/website video/audio/chat consultation, no in-clinic/physical consultation is allowed.
2. Emotional wellbeing benefit is not transferrable.
3. If the benefit is not availed in the Policy Year the benefit cannot be carried forward to the subsequent Policy Year.
4. Reimbursement of emotional health coach/psychologist consultation expenses is excluded from the scope of this product.
5. 30-day Waiting Period (Code-Excl03)

a) Expenses related to the treatment of any Illness within 30 days as per the option specified in the Policy Schedule from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.
b) This exclusion shall not, however apply if the Insured Person has continuous coverage for more than twelve months.
c) The within referred Waiting Period is made applicable to extent of the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

9. Value Added Services

The Insured Person may access the following Value Added Services through the digital platform/application made available by the Service Provider. Unless expressly stated otherwise in the Policy Schedule, these services are facilitation/wellness services and do not constitute an indemnity, reimbursement or monetary benefit payable under the Policy.

Smart Face Scan:

The Insured Person may voluntarily access Smart Face Scan, a technology-enabled wellness assessment feature through the Service Provider's application, which may use the camera of the Insured Person's compatible device to generate certain wellness-related indicators or insights.

Emergency Ambulance Assistance:

At the request of an Insured Person, the Service Provider will assist in locating, booking and/or coordinating an ambulance service, subject to availability of ambulance service providers at the relevant location and time. The actual ambulance charges shall be borne by the Insured Person.

Network Partner Discount:

An Insured Person may be eligible to avail discounts offered by participating network providers on Doctor Consultation, Lab test, Annual Health Check-Up & Dental Procedures, as communicated through the Service Provider's Platform from time to time.

Conditions applicable for Value Added Services cover

i. Any output generated through Smart Face Scan service is intended solely for general wellness/informational purposes and is not intended to constitute, and shall not be relied upon as, medical diagnosis, medical advice, medical screening or a substitute for consultation with an appropriately qualified healthcare professional.
ii. While availing Emergency Ambulance Assistance, neither the Insured Person nor any other person should delay seeking emergency medical assistance while attempting to access this facilitation service.
iii. The applicable discount, participating network providers and eligible services may vary, subject to the terms communicated for the service. A network partner discount does not constitute a claim payment or reimbursement by Us and shall not increase the Sum Insured or benefit limit under the Policy.

SECTION D) EXCLUSIONS

I. Standard Exclusions

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

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

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

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

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

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

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

8. Excluded Providers (Code-Excl11)
Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the Policy Holder/Insured Person are not admissible. However, in case of life-threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

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

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

12. Refractive Error (Code-Excl15)
Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

13. Unproven Treatments (Code-Excl16)
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

14. Sterility and Infertility (Code-Excl17)
Expenses related to sterility and infertility. This includes:
a) Any type of contraception, sterilization
b) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c) Gestational Surrogacy
d) Reversal of sterilization

15. Maternity: (Code Excl18)
i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the Cover Period.

II. Specific Exclusions
We shall not be liable for, and no service or benefit shall be available under this Policy in respect of or arising out of or in connection with:

1. Experimental, investigational or Unproven Treatment devices and pharmacological regimens.
2. Treatment for alopecia, baldness, wigs, or toupees, and all treatment related to the same.
3. Congenital external diseases, defects or anomalies.
4. Venereal disease, all sexually transmitted disease or Illness including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
5. Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose.
6. Treatment taken from a person not falling within the scope of definition of Medical Practitioner.
7. Treatment charges or fees charged by any Medical Practitioner acting outside the scope of license or registration granted to him by any medical council.

8. Treatments rendered by a Medical Practitioner who is a member of the Customer's family or stays with him.
9. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.
10. Naturopathy treatment, acupressure, acupuncture, magnetic and such other therapies.
11. Treatment/Service taken outside India.
12. All day-care treatments, surgical procedures, and related medical interventions are excluded from coverage.
13. Any expenses arising from inpatient hospitalization (IPD), admission charges, room rent, nursing charges, or hospitalization of any kind are excluded.
14. OTC supplements, vitamins and wellness products are excluded.
15. Expenses related to Spectacles, contact lenses and vision correction are excluded.

SECTION E) GENERAL TERMS AND CONDITIONS

I. STANDARD GENERAL TERMS AND CONDITIONS

1. Disclosure of Information
The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by Policyholder/ Insured.

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

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

4. Claim Settlement (provision for Penal Interest)
   i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
   ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest, to the Insured Person from the date of receipt of last necessary document to the date of payment of claim, at a rate 2% above the bank rate.
   iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 15 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 15 days, the Company shall be liable to pay interest, to the Insured Person, at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due).

5. Renewal of Policy

i. Your Policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by You, provided this policy is not withdrawn and also subject to conditions stated at "Moratorium Period" of this Schedule.

ii. We shall not deny the Renewal of this policy on the ground that You have made a claim or claims in the preceding Policy Years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policy.

iii. We shall condone a delay in Renewal up to the Grace Period (30 days) from the due date of Renewal without considering such condonation as a Break in Policy.

iv. For this policy, the loadings on Renewal premium shall be at portfolio and not based upon any individual policy claim experience. However, discount in premium may be provided by Us to You for good claims experience.

v. We shall not resort to fresh underwriting by calling for medical examination, fresh proposal form etc. at Renewal stage where there is no change in Sum Insured offered. Provided that where there is an improvement in the risk profile, We may endeavour to recognize that for removal of loadings at the point of renewal.

vi. In case the product is withdrawn, the Insured shall be provided with suitable alternative options for migration, as per applicable regulatory provisions.

6. Cancellation

(A) Cancellation by the Insured

The Insured can cancel this Policy by providing a written notice of 7 days. In such a case, the Company will refund the premium for the unexpired Policy Period as detailed below:

1. Cancellation of policy where full premium received at Policy inception -
   - Annual Policy: The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the Policy Year.
   - Multi-year Policy:
     - For any Policy Year where the risk date has not yet started, the premium will be refunded without any deduction.
     - For any Policy Year where the risk has started, the premium will be refunded on a pro-rata basis for that policy year, provided no claim has been made during the Policy Year and in full for future Policy Years.

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

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

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

(D) In case of any delay in refund of premium beyond stipulated 7 days, the Company shall refund such amounts along with interest, at a rate 2% above the bank rate on the refundable amount, from the date of receipt of the request for cancellation till the date of refund.

7. Portability
The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire Policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the Policy Renewal date as per IRDAI guidelines related to Portability. If such Insured Person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Portability. Insurer is free to consider proposal for portability even if the Insured has approached within 15 days from the Renewal date of the existing policy, but in all such cases acquiring insurer shall ensure that there is no break in policy.
For Detailed Guidelines on Portability, kindly refer the link:
https://irdai.gov.in/document detail? documentId=393128
(Please note referred link is of the IRDAI website and subject to change from time to time.)

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

9. Possibility of Revision of Terms
The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are affected.

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

11. Norms on Migration
The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company by applying for migration of the Policy Schedule at least 30 days before the Policy Renewal date as per IRDAI guidelines on Migration. If such Insured Person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.
For Detailed Guidelines on Portability, kindly refer the link:
https://irdai.gov.in/document detail? documentId=393128
(Please note referred link is of the IRDAI website and subject to change from time to time.)

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

13. Fraud
    i. If any claim made by the Insured, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured or anyone acting on his/her behalf to obtain any benefit under the Policy, all benefits under the Policy and the premium paid shall be forfeited.
    ii. Any amount already paid against claims which are found fraudulent later under the Policy shall be repaid by all Insured Person(s) named in Policy Schedule, who shall be jointly and severally liable for such repayment.
    iii. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured or by his agent, with intent to deceive the Insurer or to induce the Insurer to issue Policy:
        a. the suggestion, as a fact of that which is not true and which the Insured does not believe to be true;
        b. the active concealment of a fact by the Insured having knowledge or belief of the fact;
        c. any other act fitted to deceive; and
        d. any such act or omission as the law specially declares to be fraudulent
    iv. The Company shall not repudiate the claim under Policy on the ground of Fraud, if the Insured can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer. Onus of disproving is upon the Insured, if alive, or beneficiaries.

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

15. Redressal of Grievance
    Bajaj General Insurance Limited (Formerly known as Bajaj Allianz General Insurance Company Limited) has always been known as a forward-looking customer centric organization. We take immense pride in the spirit of service and the culture of keeping customer first in our scheme of things. In order to provide you with top-notch service on all fronts, we have provided you with multiple platforms via which you can always reach one of our representatives.

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 www.bajajgeneralinsurance.com • Call us on our Toll free no 1800 209 5858 • Mail us on careforyou@bajajgeneral.com • Write to Bajaj General Insurance Limited Bajaj Insurance House, Airport Road, Yerwada Pune- 411006
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 at ggro@bajajgeneral.com
Level 3 If in case, your grievance is not resolved and you wish to talk to our care specialist, please Give a missed on +91 80809 45060 OR SMS to 575758 and our care specialist will call you back
If you are still not satisfied with the solutions provided, write to Head of Customer experience directly at head.customerservice@bajajgeneral.com
Grievance Redressal Cell for Senior Citizens Bajaj General 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@bajajgeneral.com
If you are still not satisfied with the decision of the Insurance Company, you may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. Detailed process along with list of Ombudsman offices are available at https://www.cioins.co.in/ombudsman. Note: Address and contact number of Governing Body of Insurance Council: Council for Insurance Ombudsmen,3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. E-mail: inscoun@cioins.co.in, Tel: 022 -69038800/69038812, Website: https://www.cioins.co.in
The contact details of the Ombudsman offices are mentioned in, https://www.bajajgeneralinsurance.com/download-documents/health-insurance/OMBUDSMAN-ADDRESS.pdf

16. Free Look Period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of Porting the Policy.

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

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

i. A refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charges; or
ii. where the risk has already commenced and the option of return of the Policy Schedule is exercised by the Insured Person, a deduction towards the proportionate risk premium for Cover Period; or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such Cover Period.

II. SPECIFIC GENERAL TERMS AND CONDITIONS

1. Conditions Precedent

Where this Policy requires You to do or not to do something, then the complete satisfaction of that requirement by You or someone claiming on Your behalf is a precondition to any obligation We have under this Policy. If You or someone claiming on Your behalf fails to completely satisfy that requirement, then We may refuse to consider Your claim.

2. Insured Person

Only those persons named as the Insured Beneficiary(s) in the Policy Schedule shall be covered under the Policy. Cover under the Policy shall be withdrawn from any Insured Beneficiary upon such Insured Beneficiary
giving 7 days written notice to be received by Us.

3. Additional Norms on Migration

Insured Person shall apply for migration of the Policy at least 30 days before the Policy Renewal due date. All revised guidelines of IRDAI from time to time as to Migration shall apply.

4. Notice & Communication
   i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
   ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
   iii. The Company will communicate to the Insured at the address or through any other electronic mode mentioned in the Policy Schedule.

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

6. Terms and conditions of the Policy
   The terms and conditions contained herein and, in the Policy, Schedule shall be deemed to form part of the Policy and shall be read together as one document.

7. Automatic change in Coverage under the Policy
   The coverage for the Insured Person(s) shall automatically terminate:
   i. In the case of his/ her (Insured Person) demise. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other Insured Persons may also apply to renew the Policy Schedule. In case, the other Insured Person is minor, the Policy Schedule shall be renewed only through any one of his/her natural guardian or guardians appointed by court. All relevant particulars in respect of such person (including his/her relationship with the Insured Person) must be submitted to the Company along with the application. Provided no claim has been made, and termination takes place on account of death of the Insured Person, pro-rata refund of premium of the deceased Insured Person for the balance period of the Policy Schedule will be effective.
   ii. Upon exhaustion of Sum Insured and cumulative bonus, for the Policy Year. However, the Policy is subject to Renewal on the due date as per the applicable terms and conditions.

8. Territorial Jurisdiction and Territorial Limit
   i. All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy/Policy Schedule shall be determined by the Indian courts and according to Indian law.
   ii. All medical treatment for the purpose of the Policy Schedule will have to be taken in India only.
   iii. Our liability to make any payment shall be to make payment within India and in Indian Rupees only.
   iv. 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.

9. Arbitration
   Arbitration Clause shall not be applicable.

10. Sum Insured Enhancement
   i. The Insured Person can apply for enhancement of Sum Insured at the time of renewal. You 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(s) & 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.

11. Inclusion of members under the Policy

Where an Insured Person is added to this Policy, either by way of Endorsement or at the time of renewal, the pre-existing disease clause, exclusions and waiting periods will be applicable considering such Policy Year as the first year of Policy with the Company for that newly added Insured Person.

12. Paying a Claim

i. You agree that We will only make payment when You or someone claiming on Your behalf has provided Us with necessary documentation and information.

ii. We will make payment to You or Your Nominee. If there is no Nominee and You are incapacitated or deceased, We will pay Your heir, executor or validly appointed legal representative and any payment We make in this way will be a complete and final discharge of Our liability to make payment.

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 will settle the claim within 30 (thirty) days of the receipt of the last necessary document. 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.

iv. If the Insurer, 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 last receipt of necessary documents. The Insured Person may take recourse to the Grievance Redressal procedure stated under Policy.

13. Conditions for Benefits Facilitated/Provided through Service Providers

i. Where any assistance, service or other non-indemnity benefit specified under this Policy ("Benefit") is arranged, facilitated or made available by Us through a Service Provider, such Benefit shall be subject to the terms, conditions, limitations, eligibility requirements and availability specified under this Policy and, where applicable, the terms of use of the relevant Service Provider/its network partner.

ii. Our role in relation to such Benefit shall, unless expressly stated otherwise in this Policy, be limited to arranging or facilitating access to the Benefit through the Service Provider. The actual provision, performance and delivery of the Benefit shall be undertaken by the Service Provider.

iii. We do not make any representation or warranty, whether express or implied, regarding the quality, suitability, condition, merchantability, fitness for a particular purpose, accuracy or outcome of any product or service independently rendered by a Service Provider and/its network partner, except to the extent expressly provided under this Policy or required under applicable law.

iv. **Exclusion and Limitation of Liability**

We shall not be liable for any loss, damage, injury, cost, expense or other consequence arising solely from any act, omission, negligence, deficiency, error, misconduct, representation, advice or failure in the performance/provision of benefits by a Service Provider or its network partner, including:

a) the quality, condition, suitability, merchantability or fitness for a particular purpose of any product or service provided by the Service Provider its network partner;
b) any delay, interruption, cancellation, non-availability or failure in the delivery or performance of the Benefit attributable to the Service Provider or its network partner or to circumstances beyond Our reasonable control;
c) any representation, advice, recommendation or information independently provided by the Service Provider or its network partner; or
d) Your use of or reliance upon any product, facility or service provided by the Service Provider or its network partner.

The above exclusion shall not apply to:

a) Our obligations to facilitate the benefits expressly covered under this Policy,
b) any act, omission, negligence or deficiency directly attributable to Us
c) Our obligations relating to grievance redressal or Insured servicing under applicable law; or
d) any liability which cannot lawfully be excluded, restricted or limited under applicable law.

Nothing contained in this clause shall operate to reduce, restrict or prejudice any coverage, benefit, right or remedy expressly available to You under this Policy or under applicable law.

14. Nationality
    i. Indian nationals residing in India would be considered for this Policy.
    ii. This Policy can be opted by Non-Resident Indians/ Overseas citizens of India (OCI) also and premium paid in Indian currency.

15. We shall make payment in Indian Rupees only.

16. Service Delivery Process
    Kindly download Our Company's App, where you will be able to locate the step-by-step guide for availing the benefits under the My Health Companion Policy.

17. Claims Procedure

A. Cashless Claims Procedure

The Insured Person may avail consultations/sessions/vouchers on a cashless basis through the Company's empanelled Service Provider network, subject to the terms and conditions of the policy.

Procedure:

1. The Insured Person shall locate a network healthcare provider or service partner through the Our Company's App.
2. The Insured Person shall schedule an appointment with an empanelled healthcare provider through the Our Company's App.
3. The cashless facility is subject to the availability of the network healthcare provider or service partner and compliance with the terms, conditions, exclusions, and limits specified under the Policy.

B. Reimbursement Claims Procedure

1. The reimbursement claim is to be submitted through the Company's app along with the required documents.
2. The following documents may be required:
    - Doctor's prescription and consultation records.
    - Original invoices, bills, and payment receipts.
    - Diagnostic reports, if applicable.
    - Any other document as may be required by the Company for claim assessment.
3. Claims should be submitted within the timelines specified under each coverages in the Policy.
4. Upon receipt of all required documents, the claim shall be assessed as per the Policy terms and conditions and shall be settled within 15 days from intimation of the claim subject to receipt of all required documents.

5. The Company reserves the right to seek additional information or documents, wherever deemed necessary, for claim processing.
6. Admissible claim amounts shall be reimbursed to the Insured Person following successful claim assessment and approval.
7. The detailed reimbursement claim submission process, applicable requirements, and document checklist is available on the Company's App.

Annexure I- List of Invasive Tests (excluded from Doctor Prescribed Investigations Cover – Pathology & Radiology expenses)

Sr. No.	Invasive Test Names
1	USG guided kidney biopsy
2	Tru-cut biopsy breast
3	Excision biopsy of any lump
4	Prostate needle biopsy
5	Fine Needle Aspiration Cytology- FNAC
6	Pleural fluid cytology
7	Pleural Biopsy
8	Pleuroscopic Biopsy
9	Endometrial Biopsy
10	Upper GI Endoscopy
11	Upper GI Endoscopic Biopsy
12	Colonoscopy
13	Colonoscopy Biopsy
14	Diagnostic Laparoscopy
15	Office Hysteroscopy
16	Cystoscopy
17	Cystoscopy with bladder biopsy
18	Urethroscopy
19	MRI guided breast biopsy
20	MRI Fusion Biopsy
21	USG guided biopsy of abdominal organs
22	USG guided biopsy of pelvic organs
23	Core biopsy of Brest
24	Incisional biopsy of breast
25	Bronchoscopy
26	Bronchoscopy guided biopsy
27	CT Angiography
28	Coronary Angiography
29	CT guided lung biopsy
30	CT guided bone biopsy
31	CT guided biopsy of growth- Abdomen/ Chest/ Pelvic/ Paraspinal region
32	Lumbar Puncture
33	CSF biopsy
34	CSF liquid biopsy
35	Oral biopsy
36	ENT Endoscopic biopsy
37	Lymph node biopsy
38	Hysteroscopy biopsy