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redefining / general insurance

Group*Health* Insurance Policy - Policy Wordings

UIN: IRDA/NL-HLT/BAXAGI/P-H/V.I/94/13-14

Preamble

WHEREAS the Insured designated in the Schedule to this Policy having by a proposal and declaration together with any statement, report or other document which shall be the basis of this contract and shall be deemed to be incorporated herein, has applied to Bharti AXA General Insurance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth and paid appropriate premium for the period as specified in the Schedule.

Now this Policy witnesseth that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon the Company, undertakes, that if during the period as specified in the Schedule to this Policy, the Insured Person shall contract any disease, illness or sustain any injury and if such disease, illness or injury shall upon the advice of a duly qualified Medical Practitioner require such Insured Person, to incur hospitalisation and / or other related expenses towards treatment of such disease, illness or injury at any Hospital/ Nursing Home in India (hereinafter called "Hospital") as an inpatient or domiciliary hospitalisation expenses in any of the circumstances mentioned hereunder, then the Company will pay to the Insured Person, his /her nominee, or legal representatives, as the case may be, the amount of such hospitalisation or related expenses/charges as would fall under the different heads mentioned below and as are reasonably and necessarily incurred by or on behalf of such Insured Person for

i) Hospital (Room & Boarding and Operation theatre) charges,

ii) Fees of Surgeon, Anesthetist, Nurse, Specialists etc.

iii) Cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.

iv) Pre and post hospitalization expenses

v) Ambulance charges

in manner, for the period and to the extent of the Sum Insured as specified in this Policy.

Definitions

Any word or expression to which a specific meaning has been assigned in any part of this Policy or the Schedule shall bear the same meaning wherever it appears. For purposes of this Policy, the terms specified below shall have the meaning set forth:

"Accident" is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

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

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

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

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

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

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

"Contribution" is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis

"Critical Illnesses" mean diseases / illnesses limited to the following:

I) **Cancer** represented by a malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

ii) **First Heart Attack of specified severity** - The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

a. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain).
b. new characteristic electrocardiogram changes.
c. elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

iii) **Open Chest CABG (Coronary Artery Bypass Graft)** surgery involving the actual undergoing of open-chest surgery for the correction of one or more coronary arteries, which is / are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner or physician.

iv) **Coronary Artery bypass surgery** involving the actual undergoing of open-chest surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts.

v) **Open heart replacement or repair of heart valves** involving the actual undergoing of open-heart surgery to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner or physician. Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded

vi) **Surgery to Aorta** involving actual undergoing of major surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

vii) **Stroke resulting in permanent symptoms** referring to any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source.

Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

viii) **Kidney Failure requiring regular dialysis** - End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner

ix) **Aplastic Anaemia** involving Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment.

x) **End Stage Lung Disease** causing chronic respiratory failure.

xi) **End Stage Liver Failure** evidenced by Permanent jaundice ascites and Hepatic Encephalopathy.

xii) **Coma of specified severity** is a state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

a. no response to external stimuli continuously for at least 96 hours;
b. life support measures are necessary to sustain life; and
c. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

xiii) **Major Burns** representing third degree (full thickness of the skin) burns covering at least 30% of the surface of the Insured / Insured person's body.

xiv) **Major Organ/Bone Marrow Transplantation** is the actual undergoing of a transplant of:

a. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
b. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

xv) **Multiple Sclerosis with persisting symptoms is t**he definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

a. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis
b. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and
c. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.

Other causes of neurological damage such as SLE and HIV are excluded.

xvi) **Fulminant Hepatitis** involving sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure.

xvii) **Motor Neurone Disease with permanent Symptoms** diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

xviii) **Primary Pulmonary Hypertension** with substantial right ventricular enlargement confirmed by investigations including cardiac catheterization, resulting in permanent physical impairment due to cardiac impairment resulting in not being able to engage in any physical activity without discomfort. Symptoms may be present even at rest.

xix) **Terminal Illness** involving conclusive diagnosis of an illness that is expected to result in the death of the Insured person within 12 months.

xx) **Benign Brain Tumour** which is life threatening tumour in the brain where all of the following conditions are met:

a) It has caused damage to the brain;
b) It has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit; and
c) Its presence must be confirmed by a neurologist or neurosurgeon and supported by findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques.

xxi) **Bacterial Meningitis** involving bacterial infection causing in severe inflammation of the membranes of the brain or spinal chord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks.

"Day Care treatment" means medical treatment, and / or surgical procedure which is:

a. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
b. Which would have otherwise require a hospitalization of more than 24 hours

I) Dialysis
ii) Chemotherapy
iii) Radiotherapy
iv) Eye surgery
v) Dental surgery
vi) Lithotripsy (Kidney stone removal)
vii) Tonsillectomy
viii) Dilatation & Curettage
ix) Cardiac Catheterization
x) Hydrocele surgery
xi) Hernia repair surgery
xii) Surgeries/procedures that require less than 24 hours hospitalisation due to medical/technological advancement and infrastructural facilities.
xiii) TURP (Prostate Surgery).

"Dependent Child" refers to a child (natural or legally adopted) below the age of 23 years, who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

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

"Disease" means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner.

"Domiciliary hospitalisation" means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

a) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
b) the patient takes treatment at home on account of non availability of room in a hospital.

"Domiciliary hospitalisation" benefits shall be subject to the limits as specified in the Schedule to this Policy, and shall, in no case, cover expenses incurred for:

a) pre and post hospitalization
b) treatment of any of the following diseases:

I) Asthma
ii) Bronchitis
iii) Chronic nephritis and nephritic syndrome
iv) Diarrhoea and all types of dysenteries including gastroenteritis
v) Diabetes mellitus and insipidus
vi) Epilepsy
vii) Hypertension
viii) Influenza, cough and cold
ix) All psychiatric or psychosomatic disorders
x) Pyrexia of unknown origin for less than 10 days
xi) Tonsillitis and upper respiratory tract infection including laryngitis and pharangitis, arthritis, gout and rheumatism.

"Emergency care" means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

"Family" means the Insured Person, his/her lawful spouse, dependent parents/ parents-in-law and maximum of two dependant children upto the age of 23 years.

"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:

a) has qualified nursing staff under its employment round the clock;

b) 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;

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

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

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

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

"Hospitalisation expenses" mean expenses on hospitalisation for minimum period of 24 hours, which are admissible under this Policy. However, this time limit will not apply for specific treatments defined under Day Care treatment taken in a Hospital / Nursing Home.

"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.

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

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 or relief o f symptoms

iii) it requires your rehabilitation or for you to be specially trained to cope with it

iv) it continues indefinitely

v) it comes back or is likely to come back.

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

"Insured" means the group, organization, institution, firm, society or body corporate engaged in any trade or business in India on whose name the Policy is issued.

"Insured Person" means the person named in the Schedule to the Policy, who has a permanent place of residence in India and for whom the insurance is proposed and appropriate premium paid.

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

i. Medical Expenses for a delivery (including complicated deliveries and caesarean sections) incurred during Hospitalization;

ii. The lawful medical termination of pregnancy during the Policy Period limited to 2 deliveries or terminations or either during the lifetime of the Insured Person;

iii. Pre-natal and post-natal Medical Expenses for delivery or termination.

"Medical Advise" means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

"Medical Practitioner" is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence. The term Medical Practitioner includes a physician, specialist and surgeon, provided that this person is not a member of the Insured Person's family.

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

"Medically Necessary" treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

a) is required for the medical management o f the illness or injury suffered by the insured;

b) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

c) must have been prescribed by a medical practitioner,

d) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

"Network Provider" means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility

"New Born Baby" means those babies born to you and your spouse during the Policy Period Aged between 1 day and 90 days.

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

"Notification of claim" is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

"OPD treatment" is 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.

"Period of Insurance" means the Policy period defined hereunder.

"Policy period" means the period between the inception date and the expiry date as specified in the Schedule to this Policy or the cancellation of this insurance, whichever is earlier.

"Policy" means this document of Policy describing the terms and conditions of this contract of insurance including the Company's covering letter to the Insured if any, the Schedule attached to and forming part of this Policy, the Insured's Proposal form and any applicable endorsement attaching to and forming part thereof either at inception or during the period of insurance. The Policy contains details of the scope and extent of cover available to the Insured Person, the exclusions from the scope of cover and the terms and conditions of the issue of the Policy.

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

"Post-hospitalization Medical Expenses" means Medical Expenses incurred immediately after the Insured Person is discharged from the hospital provided that:

a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

However this condition will not be incorporated in case the critical illness cover opted on benefit basis.

"Pre-Existing Disease" Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months to prior to the first policy issued by the insurer.

"Pre-hospitalization Medical Expenses" means medical expenses incurred immediately before the Insured Person is Hospitalised, provided that:

a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

However this condition will not be incorporated in case the critical illness cover opted on benefit basis.

"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.

"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.

"Renewal" defines 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 all waiting periods.

"Third Party Administrator (TPA)" means any organisation or institution that is licensed by the IRDA as a TPA and is engaged by the Company for a fee or remuneration for providing Policy and claims facilitation services to the Insured Person as well as to the Company for an insurable event.

"Schedule" means Schedule attached to and forming part of this Policy mentioning the details of the Insured/Insured Persons, the Sum Insured, the period, coverage and the limits to which benefits under the Policy are subject to.

"Subrogation" mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

"Sum Insured" means the sum as specified in the Schedule to this Policy against the name of Insured/Insured Person, which sum represents the Company's maximum liability for any or all claims under this Policy during the Policy period against the respective benefit(s) for which the sum is mentioned in the Schedule to this Policy.

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

"Terrorism/Terrorist Incident" means any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption, or the commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not. Robberies or other criminal acts, primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorist activity. Terrorism shall also include any act, which is verified or recognized by the relevant Government as an act of terrorism.

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

Scope of Cover

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed, to pay and/or reimburse the following benefits in manner, for the period and to the extent of the Sum Insured as specified in the Schedule to this Policy.

Section I

a) Hospitalisation Expenses

Hospitalisation Expenses benefit provides cover for reimbursement / payment of hospitalisation expenses which are reasonably and necessarily incurred by the Insured Person for treatment of disease, illness contracted or injury sustained by the Insured Person during the Policy Period as specified in the Schedule to this Policy, in a Hospital in India as in-patient which among other things, includes, Hospital (Room & Boarding and Operation theatre) charges, admission and registration charges in the Hospital, fees of Surgeon, Anesthetist, Nurses, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.

The Insured Person should have been hospitalized as an in-patient for a minimum period of 24 hours. However in respect of Day Care treatment undertaken in a Hospital, 24 hours hospitalization is not necessary. The benefit under this Section is limited to the Sum Insured specified for this Section in the Schedule to this Policy.

b) Pre-hospitalisation

This benefit covers relevant medical expenses incurred during a period up to the number of days as specified in the Schedule to this Policy, prior to hospitalisation/Day care treatment for treatment of disease, illness contracted or injury sustained for which the Insured Person was hospitalised, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a. The number of days for the coverage of pre-hospitalisation expenses will be mutually agreed.

c) Post-hospitalisation

This benefit covers relevant medical expenses incurred during a period up to the number of days as specified in the Schedule to this Policy, after discharge from Hospital for continuous and follow up treatment of the disease, illness contracted or injury sustained for which the Insured Person was hospitalised, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a. The number of days for the coverage of post-hospitalisation expenses will be mutually agreed by the Insurer and Insured.

Section II. Day Care Treatment

This benefit covers relevant hospitalisation expenses incurred by the Insured Person in case of day care treatment (where 24 hours of hospitalisation is not required) which includes treatments such as dialysis, chemotherapy, radiotherapy, eye surgery, lithotripsy (kidney stone removal), D & C, tonsillectomy undertaken in a Hospital. The benefit under this Section is limited to the available Sum Insured under Section 1a of this Policy as mentioned in the Schedule.

Section III. Domiciliary Hospitalisation

This benefit covers payment of expenses incurred for medical treatment pertaining to domiciliary hospitalisation for a period exceeding three days for disease, illness or injury, which in the normal course, would require care and treatment at a Hospital/Nursing Home, but is actually taken whilst the Insured Person is confined at home in India, under any of the following circumstances namely: -

a) the condition of the patient is such that he/she cannot be removed to Hospital/Nursing Home, or

b) the patient cannot be admitted to Hospital/Nursing Home for lack of accommodation therein.

Domiciliary hospitalisation benefits shall be subject to the Sum Insured as specified in the Schedule to this Policy, and shall, in no case cover expenses incurred for:

a) pre and post hospitalization,

b) Treatment of any of the following diseases / illness / injury:

- I) Asthma
- ii) Bronchitis
- iii) Chronic nephritis and nephritic syndrome
- iv). Diarrhoea & all types of dysenteries including gastroenteritis
- v) Diabetes mellitus and insipidus
- vi) Epilepsy
- vii) Hypertension
- viii) Influenza, cough and cold
- ix) All psychiatric or psychosomatic disorders
- x) Pyrexia of unknown origin for less than 10 days
- xi) Tonsillitis and upper respiratory tract infection including laryngitis & pharangitis
- xii) Arthritis, gout and rheumatism.

Domiciliary hospitalisation benefits also cover expenses on nurses engaged on the recommendation of the attending Medical Practitioner. The benefit under this Section is limited to the Sum Insured for Section 1a of this Policy as mentioned in the Schedule.

The Insured has the option to opt out of Domiciliary Hospitalisation benefit if the same is specifically agreed to and mentioned in the Schedule to this Policy.

Pre-existing diseases

This Policy covers relevant hospitalisation expenses incurred for treatment of pre-existing disease, illness or injury, in a Hospital as an in-patient, after a specific waiting period as mentioned in the Schedule to this Policy. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a. The waiting period for the coverage of pre-existing disease will be decided by mutual agreement between the Proposer and Company.

Critical Illness

This benefit provides for coverage of treatment for critical illness and the coverage depends upon the type of critical illness cover (benefit basis or hospitalisation & reimbursement basis) selected and mentioned in the Schedule to this Policy.

In case the type of cover opted is benefit basis:

If, 30 days after the inception of this Policy, the Insured Person is at any time during the Policy period (after the above waiting period of 30 days), being diagnosed as contracting any Critical Illness and surviving for more than 30 days post such diagnosis, the Sum Insured specified in the Schedule to this Policy for this benefit shall be payable to the Insured Person as compensatory benefit.

This Section operates as a benefit cover and compensation shall be payable if the Insured Person is surviving for more than 30 days post diagnosis of any critical illness.

Where this cover is forming part of Hospitalisation Policy, the Sum Insured available for this cover is separate and additional to that of Hospitalisation Sum Insured available under Section Ia. In case the Insured Person is diagnosed to be suffering from any of the Critical Illnesses and survives for a period of 30 days, then Sum Insured specified under Section III will be paid as a lump sum. After availing the benefit under Section III, if the Insured Person takes treatment for the Critical Illness in a Hospital, the hospitalisation expenses incurred for the same would be payable/reimbursed, subject to the terms and conditions of the Policy, out of the Sum Insured available for Hospitalisation benefit cover under Section Ia of this Policy. However, in case of diagnosis of multiple illnesses qualified as Critical Illness as defined under this Policy, the payment of compensation shall be limited to the Insured as specified above and shall be payable once.

If the type of cover opted is Hospitalisation Reimbursement Basis:

If, 30 days after the inception of this Policy, the Insured Person is at any time during the Policy period (after the above waiting period of 30 days), being diagnosed as contracting any Critical Illness and is required to undertake treatment in a Hospital for the same, the Hospitalisation expenses incurred towards such treatment is covered under this benefit upto the specific Sum Insured stated against this benefit.

Where this cover is forming part of Hospitalisation Policy, the Sum Insured available for this cover is separate and additional to that of Hospitalisation Sum Insured available under Section Ia. In case the Insured Person is diagnosed to be suffering from any of the Critical Illnesses and takes treatment for the same in a Hospital, the hospitalisation expenses incurred for the same would be payable/ reimbursed, subject to the terms and conditions of the Policy, first out of the Sum Insured available for Critical Illness cover under Section III. Where the hospitalisation expenses incurred for the treatment of the Critical Illness are in excess of the Sum Insured available under Critical Illness Cover under Section III, the excess may be paid / reimbursed out of the available Sum Insured under the Hospitalisation benefit under Section 1a of this Policy.

The benefits available under Sections 1b and 1c of this Policy as mentioned above are also applicable and available under Critical Illness Section in case the type of cover opted is Hospitalisation Reimbursement basis. In respect of pre-hospitalisation and post hospitalisation the limits of benefits are the same as per the respective Sections of the Policy and mentioned in the Schedule to this Policy. Where the Sum Insured under Critical Illness is exhausted the excess amounts (which are within the limits of these respective benefits) can be paid / reimbursed out of the available Sum Insured under Section Ia of this Policy. In case of diagnosis of multiple critical illnesses requiring treatment covered under this Policy, the maximum liability under this Section shall not exceed the Sum Insured as mentioned against this particular Section in the Schedule to this Policy.

Critical Illnesses in respect of which benefits are payable under this Policy are as set in the Schedule attached to this policy.

I) **Cancer:** A malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue. This diagnosis must be supported by histological evidence of malignancy and confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded:

a. Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non invasive, including but not limited to:

Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.

b. Any skin cancer other than invasive malignant melanoma

c. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

d. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter

e. Chronic lymphocyctic leukaemia less than RAI stage 3

f. Microcarcinoma of the bladder

g. All tumours in the presence of HIV infection

ii) **First Heart Attack of specified severity:** The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

a. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)

b. new characteristic electrocardiogram changes

c. elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

i. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T

ii. Other acute Coronary Syndromes

Iii. Any type of angina pectoris.

iii) **Coronary Artery Disease:** The narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, as proven by coronary arteriography, regardless of whether or not any form of coronary artery surgery has been performed. Coronary arteries herein refer to left main stem, left anterior descending circumflex and right coronary artery.

iv) **Open Chest CABG**: The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

ii. any key-hole or laser surgery.

v) **Open Heart Replacement Or Repair Of Heart Valves:** The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

vi) **Surgery to Aorta:** The actual undergoing of major surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches. Surgery performed using only minimally invasive or intra arterial techniques are excluded.

Angioplasty and all other intra arterial, catheter based techniques, "keyhole" or laser procedures are excluded

vii) **Stroke Resulting In Permanent Symptoms:** Any cerebrovascular incident producing permanent neurological sequelae.This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

viii) **Kidney Failure Requiring Regular Dialysis:** End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

ix) **Aplastic Anaemia:** Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

a) Blood product transfusion;

b) Marrow stimulating agents;

c) Immunosuppressive agents; or

d) Bone marrow transplantation.

The diagnosis must be confirmed by a haematologist.

x) **End Stage Lung Disease:** End Stage Lung Disease, causing chronic respiratory failure. This diagnosis must be supported by evidence of all of the following:

a) FEVI test results which are consistently less than one litre;

b) Permanent supplementary oxygen therapy for hypoxemia;

c) Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less (PaO2 <- 55 mm Hg); and

d) Dyspnea at rest.

The diagnosis must be confirmed by a respiratory Medical Practitioner.

xi) **End Stage Liver Failure:** End Stage Liver Failure evidenced by all of the following:

a) Permanent jaundice;

b) Ascites; and

c) Hepatic Encephalopathy.

Liver disease secondary to alcohol or drug abuse is excluded.

xii) **Coma Of Specified Severity:** A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;

ii. life support measures are necessary to sustain life; and

iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

xiii) **Major Burns:** Third degree (full thickness of the skin) burns covering at least 80% of the surface of the Insured Person's body.

xiv) **Major Organ /bone Marrow Transplant:** The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

xv) **Multiple Sclerosis With Persisting Symptoms:** The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

i. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;

ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and

iii. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.

Other causes of neurological damage such as SLE and HIV are excluded.

xvi) **Fulminant Hepatitis:** A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

a) rapid decreasing of liver size;

b) necrosis involving entire lobules, leaving only a collapsed reticular framework;

c) rapid deterioration of liver function tests;

d) deepening jaundice; and

e) Hepatic encephalopathy.

xvii) **Motor Neurone Disease With Permanent Symptoms:** Motor neurone disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

xviii) **Primary Pulmonary Hypertension:** Primary Pulmonary Hypertension with substantial right ventricular enlargement confirmed by investigations including cardiac catheterization, resulting in permanent physical impairment of at least Class IV of the New York Heart Association (NYHA) Classification of Cardiac Impairment.The NYHA Classification of Cardiac Impairment (Source: "Current Medical Diagnosis & Treatment- 39th Edition"):

CLASS i: No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea, or anginal pain.

CLASS ii: Slight limitation of physical activity. Ordinary physical activity results in symptoms.

CLASS iii: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

CLASS iv: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

ix) **Terminal Illness:** The conclusive diagnosis of an illness that is expected to result in the death of the Insured Person within 12 months. This diagnosis must be supported by a specialist and confirmed by the Company's appointed Doctor.

Terminal illness in the presence of HIV infection is excluded.

xx) **Benign Brain Tumour:** A benign tumour in the brain where all of the following conditions are met:

a) It is life-threatening;

b) It has caused damage to the brain;

c) It has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit; and

d) Its presence must be confirmed by a neurologist or neurosurgeon and supported by findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques.

The following are excluded:

a) Cysts;

b) Granulomas;

c) Vascular Malformations;

d) Haematomas; and

e) Tumours of the pituitary gland or spinal chord.

xxi) **Bacterial Meningitis:** Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal chord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:

a) The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and

b) A consultant neurologist supported by medical examination reports.

Bacterial Meningitis in the presence of HIV infection is excluded.

Critical illness benefit will lapse and no claim for this benefit will be paid if the Insured have already made a claim for the same critical illness.

Dread Disease recuperation

If the Insured Person contracts any of the Critical Illnesses and undertakes treatment for the same in a Hospital as an in-patient for which a valid claim under the Policy is admissible, a daily allowance for certain number of days as specified in the Schedule to this Policy towards Recuperation Expenses incurred post discharge from the Hospital after the treatment for the specified critical illness, is payable under this benefit subject to medical requirement as certified by the treating Medical Practitioner. The number of days for dread disease recuperation will be as per the mutual agreement between the Insured and Insurer.

Transplantation of Organs

Where the Insured Person contracts any of the critical illnesses requiring major Organ Transplantation surgery and undergoes surgery and treatment in a Hospital as an in-patient for which a valid claim under this Policy is admissible, the hospitalisation expenses incurred by/on the Donor towards donation of the major organ for the Insured Person for this treatment is covered under this benefit, subject to overall limit of the Sum Insured as specified in the Schedule to this Policy.

Hospital Cash Allowance

In case the Insured Person is hospitalized for treatment of any disease / illness / injury / critical illness for which a valid claim is admissible under the Policy and if the hospitalisation exceeds a specified number of days mentioned in the Schedule to this Policy, this benefit provides for payment to the Insured Person of a daily hospital allowance up to the specified limits as mentioned in the Schedule to this Policy.

This benefit is applicable irrespective of the number of occurrences during the Policy period subject to overall Sum Insured. The number of days for Hospital Cash Allowance will be as per the mutual agreement between the Insurer and Insured.

ICU Allowance

In case the Insured Person who is hospitalized for treatment of any disease / illness / injury / critical illness for which a valid claim is admissible under the Policy has been treated under ICU in the Hospital and if the stay in ICU exceeds a specified number of days mentioned in the Schedule to this Policy, this benefit provides for payment to the Insured Person of a daily allowance up to the specified limits as mentioned in the Schedule to this Policy.

This benefit is applicable irrespective of the number of occurrences during the Policy period subject to overall Sum Insured.

Second Opinion Cover

In case the Insured Person would like to have a second opinion on his / her medical report before undergoing any surgical treatment or major ailment treatment, the Section would provide for payment or reimbursement of the charges / fees incurred for availing a second opinion in case of hospitalisation for surgical treatment or major ailment treatment upto a limit specified and agreed.

Home Nursing

This benefit provides for payment to the Insured Person of an allowance for medical care services of a nurse at the residence of the Insured Person following discharge from hospital after a treatment for a disease / illness / injury / critical illness for which a valid claim under this Policy is admissible provided such medical care services are confirmed as being necessary by the attending Medical Practitioner and the same relate directly to the disease/ illness/ injury / critical illness for which the Insured Person has undertaken treatment during the hospitalisation, subject to the limit prescribed in the Schedule to this Policy.

This benefit is applicable irrespective of the number of occurrences during the Policy period subject to the overall Sum Insured.

Ambulance Charges

This benefit provides for reimbursement to the Insured Person of expenses incurred for his /her transportation by ambulance to and from the Hospital for treatment of disease / illness / injury / critical illness in a Hospital as an in-patient for which a valid claim under this Policy is admissible, subject to the limits as specified in the Schedule to this Policy.

This benefit is applicable irrespective of the number of occurrences during the Policy period subject to the overall Sum Insured.

In-patient Physiotherapy Charges

This benefit provides for reimbursement of charges incurred towards physiotherapy in the Hospital that is confirmed as being necessary by the attending Medical Practitioner and the same relates directly to the disease / illness / injury / critical illness for which the Insured Person has undertaken treatment in the Hospital for which a valid claim is admissible under this Policy, subject to limits as specified in the Schedule to this Policy.

Recovery Grant

In case the Insured Person is hospitalized for a period of 8 days or more for treatment of any disease / illness / injury / critical illness for which a valid claim is admissible under the Policy, this benefit provides for payment to the Insured Person of a fixed allowance as mentioned in the Schedule to this Policy.

This benefit is applicable irrespective of the number of occurrences during the Policy period subject to overall limit of the Sum Insured.

Accompanying Person's Expenses

This benefit provides for payment an allowance to the Insured Person towards expenses incurred on the accompanying person at the Hospital/Nursing Home during hospitalisation treatment of the Insured Person for the disease / illness / injury / critical illness necessitating hospitalization, subject to the limit of Sum Insured as mentioned in the Schedule to this Policy.

Parent Accommodation as Companion for Child

This benefit provides for payment of a fixed daily allowance towards meeting the expenses for the stay of one of the parents at the Hospital/Nursing Home when an Insured Person who is a child below the age of 12 years is hospitalized, subject to the limit of Sum Insured as mentioned in the Schedule to this Policy.

Parents Cover

This benefit provides for reimbursement or payment of hospitalisation expenses incurred for the parents of the employee / member covered under the Policy subject to the manner and limit of cover shall be as mentioned in the Schedule to this Policy.

Corporate Buffer

This benefit provides for a buffer amount as mentioned in the Schedule to this Policy. Insured Persons can avail benefit from this buffer whenever they exhaust their respective Sum Insured limit. The manner and method of availing this benefit shall be as mentioned in the Schedule to this Policy.

Out-patient Dental Emergency Treatment (arising out of Accident only)

This benefit provides for reimbursement of medical expenses incurred towards emergency treatment by a Dentist following an accident where the Insured Person suffers injuries or damage to his natural teeth and/or gums. This benefit further provides cover for medical expenses incurred for follow up treatment for the same accidental dental injury up to a maximum of 15 days by the same Dentist. This benefit is subject to overall limit of indemnity as specified in the Schedule to this Policy.

Out-patient Emergency treatment for accidents

This benefit provides for reimbursement of medical expenses incurred towards emergency treatment by a Medical Practitioner following an accidental injury to the Insured Person and such Emergency Treatment administered within 24 hours following the accident.

It also provides cover for medical expenses incurred for follow-up treatment by the same Medical Practitioner up to 30 days from the date of accident, including expenses incurred for medication prescribed on a written basis by the attending Medical Practitioner for that same treatment or consultation.

Children Education Fund

This benefit provides for payment of a fixed amount, to a maximum of two dependant children upto the age of 23 years pursuing studies, in the event of death of the Insured Person at Hospital whilst under treatment for disease / illness / injury / critical illness, as specified in the Schedule to this Policy.

Mortal Remains

This benefit provides for reimbursement of expenses incurred for transportation of the mortal remains of the Insured Person from Hospital to his/her place of residence in the event of death of the Insured Person at the Hospital while under treatment for disease / illness / injury / critical illness, as specified in the Schedule to this Policy.

Maternity Benefit

This benefit provides cover for Maternity hospitalisation expenses. The benefit under this Section is limited to the Sum Insured as specified in the Schedule to this Policy.

These benefits are applicable only if the expenses are incurred in

Hospital/Nursing Home as an in-patient. A waiting period of 9 months is applicable for payment of any claim relating to normal delivery or caesarean section or abdominal operation for extra uterine pregnancy. The waiting period may be relaxed only in case of delivery, mis-carriage or abortion induced by accident or other medical emergency.

Where specifically agreed for and mentioned in the Schedule to this Policy, the waiting period condition may be relaxed.

Claim in respect of delivery for only first two children and/or operations associated therewith will be considered in respect of any one Insured Person covered under the Policy or any renewal thereof.

Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered. Pre-natal and post-natal expenses are not covered unless admitted in Hospital/Nursing Home and treatment is taken there.

Floater Cover

Where agreed the cover can be offered on family floater basis covering the family members of member / employee of the Group on a floater Sum Insured basis. Where the Policy is obtained on floater basis covering the family members, the Sum Insured will be available to the Insured and all and any one of the Insured Persons for one or more claims during the Policy period.

Removal of 30 days waiting period

This benefit provides for waiver of exclusion No 2 of the Policy and the coverage under the Policy will commence from the day one of the Policy period.

Removal of first year exclusion

This benefit provides for waiver of exclusion No 3 of the Policy and treatment in respect of diseases, illness, injury as mentioned in exclusion No 3 of this Policy shall stand covered from day one of the Policy period without any waiting period.

Baby cover for first three months

This benefit provides for coverage of hospitalisation expenses incurred on the new born baby upto three months of birth. The amount of coverage under this benefit is limited to the Sum Insured as specified in the Schedule to this Policy.

Doctor on call for emergency for suggestion and guidance

This benefit provides for suggestion and guidance from a Medical Practitioner on a call in case of any medical emergency. This service is of advisory nature and the Company holds no responsibility.

Portability

Insured(s) covered under Group Medi claim Policy shall have the right to migrate to an individual health policy or a family floater plan of Bharti Axa General Insurance Company at the time of renewal, provided the previous policy has been maintained without any break.

If the Insured is presently covered or has been continuously covered without any break then the waiting periods specified in the Exclusion wordings of the Policy shall be reduced by the number of continuous preceding years of coverage of the Insured Persons(s) under the previous health insurance policy.

Individual members covered under group health insurance policies, shall be given credit on the basis of the number of years of continuous insurance coverage, irrespective of, whether the previous policy had any pre-existing disease exclusion and /or time bound exclusions.

Exclusions

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

I) Pre-existing diseases / illness / injury / conditions: The benefits will not b e available for any condition(s) as defined in the Policy, until 48 months of continuous coverage have lapsed, since inception of first Policy with the Company.

ii) Hospitalisation expenses incurred for treatment undertaken for disease or illness and/or for critical illness within 30 days of the inception date of this Policy. This exclusion, however, doesn't apply for subsequent renewals with the Company without a break. Further this exclusion shall not apply in case the Insured Person having been covered under any similar health insurance policy of any other General Insurance or Health Insurance Company in India or Group Insurance schemes with us for a continuous period of preceding 12 months without any break.

iii) Hospitalisation Expenses incurred on treatment of following diseases, illness, injury within the first year from the inception of this Policy, will not be payable:

- Cataract
- Benign Prostatic Hypertrophy
- Myomectomy, Hysterectomy or menorrhagia or fibromyoma unless because of malignancy
- Dilatation and curettage
- Hernia, hydrocele, fistula in anus, sinusitis
- Skin and all internal tumors/ cysts/ nodules/ polyps of any kind including breast lumps unless malignant/ adenoids and hemorrhoids
- Dialysis required for chronic renal failure
- Gastric and Duodenal ulcers

This exclusion, however, doesn't apply for subsequent renewals with the Company without a break. Further this exclusion shall not apply in case the Insured Person is covered under any similar health insurance policy of any other General Insurance or Health Insurance Company in India or Group Insurance schemes with us for a continuous period of preceding 12 months without any break.

iv) Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or, as may be necessitated due to an accident.

v) Dental treatment or surgery of any kind unless otherwise specified in the Schedule to the Policy.

vi) Birth control procedures, hormone replacement therapy, treatment arising from or traceable to pregnancy, childbirth including caesarean section and voluntary medical termination of pregnancy during the first 12 weeks from the date of conception. However, this exclusion will not apply to Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.

vii) Any fertility, sub-fertility or assisted conception operation.

viii) Routine medical, eye and ear examinations, cost of spectacles, laser surgery, contact lenses or hearing aids, issue of medical certificates and examinations as to suitability for employment or travel.

ix) Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex syndrome (ARCS) and all diseases / illness / injury caused by and/or related to HIV.

x) Vitamins and tonics unless forming part of treatment for disease, illness or injury as certified by the Medical Practitioner,

xi) Treatment of obesity, general debility, convalescence, run down condition or rest cure, congenital internal disease / Illness, congenital external disease / illness or defects or anomalies, sterility, venereal disease or intentional self-injury and use of intoxicating drugs/alcohol.

xii) Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics or similar establishments.

xiii) Medical treatment following use of intoxicating drugs and alcohol or drug abuse, solvent abuse or any addiction or medical condition resulting from or relating to such abuse or addiction

xiv) Sex change or treatment, which results from, or is in any way related to, sex change.

xv) Vaccination and inoculation of any kind, unless necessitated due to an accident.

xvi) Treatment by a family member and self-medication or any treatment that is not scientifically recognized.

xvii) Medical treatment required following any criminal act of the Insured Person.

xviii) Disease / illness / injury, directly or indirectly, caused by or arising from or attributable to war foreign invasion, act of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, riot, strike, lockout, military or popular uprising or civil commotion, act of terrorism or any terrorist incident.

xix) Disease / illness / injury whilst performing duties as a serving member of a military or a police force.

xx) Prostheses, corrective devices and medical appliances, which are not required intra-operatively or for the disease/ illness/ injury for which the Insured Person was hospitalised.

xxi) Any stay in Hospital without undertaking any treatment or where

there is no active regular treatment by the Medical Practitioner

xxii) Treatment of mental disease / illness, stress, psychiatric or psychological disorders.

xxiii) Aesthetic treatment, cosmetic surgery and plastic surgery unless necessitated due to accident or as a part of any disease/ illness/ injury not excluded hereunder.

xxiv) Any loss, directly or indirectly, due to contamination due to an act of terrorism, regardless of any contributory causes (if the Company alleges that by reason of this exclusion any loss is not covered by this insurance, the burden of proving the contrary shall be upon the Insured Person).

xxv) Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.

xxvi) Disease, illness, injury, directly or indirectly, caused by or contributed to by nuclear weapons/materials or radioactive contamination.

xxvii) Experimental and unproven treatment.

xxviii) Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any disease, illness or injury, for which confinement is required at a Hospital/Nursing Home or at home under domiciliary hospitalisation as defined.

xxix) Cost incurred for medicines which are not under the advice of the Medical Practitioner and which are not consistent with or incidental to the diagnosis and treatment.

xxx) Any treatment which is undertaken as an out-patient without any admission as an in-patient at the Hospital, unless specifically mentioned in the Policy Schedule.

xxxi) Costs of donor screening or treatment, unless specifically covered and specified in the Schedule to this Policy.

xxxii) Naturopathy treatment.

xxxiii) Any treatment received outside India.

xxxiv) Treatment taken from persons not registered as Medical Practitioners under respective medical councils.

xxxv) Medical treatment in respect of the Insured Person whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, para gliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports.

xxxvi) Medical treatment in respect of the Insured Person whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular Scheduled airline or air charter company.

General Conditions

i) **Duty of Disclosure**

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent` means or device being used by the Insured/Insured Person or any one acting on their/his/her behalf to obtain a benefit under this Policy.

ii) **Floater Policy**

Where the Policy is obtained on floater basis covering family members, the Sum Insured as specified in the Schedule to this Policy, shall be available to the Insured and all and any one of the Insured Persons for one or more claims during the Policy period.

iii) **Reasonable Care**

The Insured Person shall take all reasonable steps to safeguard his/her interests against accidental loss or damage that may give rise to a claim.

iv) **Observance of terms and conditions**

The due observance and fulfilment of the terms, conditions and endorsements of this Policy in so far as they relate to anything to be done or complied with by the Insured/Insured Person, shall be a condition precedent to any liability of the Company to make any payment under this Policy.

v) **Material Change**

The Insured shall immediately notify the Company by fax or in writing of any material change in the risk and cause at his own expense such additional precaution to be taken as circumstances may require to ensure safety thereby containing the circumstances that may give rise to a claim and the Company may adjust the scope of the cover and/or the premium, if necessary, accordingly.

vi) **Fraudulent Claims**

If any claim 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 Person or anyone acting on his/her behalf to obtain any benefits under the Policy, all benefits under this Policy shall be forfeited. The Company will have the right to reclaim all benefits paid in respect of a claim which is fraudulent as mentioned above under this condition as well as under Condition No.1 of this Policy.

vii) **No Constructive Notice**

Any knowledge or information of any circumstances or condition in connection with the Insured Person, in possession of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the company notwithstanding subsequent acceptance of the premium.

viii) **Notice of Charge**

The Company shall not be bound to take notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy; but the payment by the Company to the Insured/Insured Person, his/her nominee or legal representative of any compensation or benefit under the policy shall in all cases be an effectual discharge to the Company.

ix) **Overriding effect**

The terms and conditions contained herein and in the Schedule shall be deemed to form part of the Policy and shall be read as if they are specifically incorporated herein.

x) **Electronic Transaction**

The Insured/Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof)or by means of electronic, computer, automated machines network or through other means of telecommunication established by or on behalf of the Company for and in respect of the Policy or its terms or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDA regulations for protection of policy holder's interests.

xi) **Duty of the Insured Person on occurrence of loss** On the occurrence of loss within the scope of cover under the Policy, the Insured Person shall:

a) forthwith file/submit a claim form in accordance with "Claim Procedure" clause

b) Allow the Medical Practitioner or Surveyor or any agent of the Company to inspect the medical and hospitalisation records and to examine the Insured Person.

The cost towards doing any such examination shall be borne by the Company

c) Assist and not hinder or prevent the Company or any of its agents in pursuance of their duties.

In case the Insured Person does not comply with the provisions of this clause or other obligations cast upon the Insured Person under this Policy or in any of the Policy documents, all benefit under the Policy shall be forfeited, at the option of the Company.

xii) **Right to Inspect**

If required by the Company, an agent/representative of the Company

including a Medical Practitioner appointed in that behalf shall in case of any loss or any circumstances that have given rise to a claim to the Insured Person be permitted at all reasonable times to examine into the circumstances of such loss. The Insured Person shall on being required s o to do by the Company produce all relevant documents relating to or containing reference relating to the loss or such circumstance in his/her possession including presenting himself for examination and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or will in any way assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy.

xiii) **Position after a claim**

As from the day of receipt of the claim amount by the Insured/Insured Person, the Sum Insured for the remainder of the period of insurance shall stand reduced by a corresponding amount.

xiv) **Subrogation**

In the event of any claim payment under this Policy, the Company shall be subrogated to all the Insured's/Insured Person's rights or recovery thereof against any person or organization and the Insured/Insured Person shall execute and deliver instruments and papers necessary to secure such rights. The Insured/Insured Person and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done all such acts and things as may be necessary and required by the Com before or after indemnification, in enforcing or endorsing any rights or remedies or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated.

xv) **Contribution**

If there shall be existing any other insurance of any nature whatsoever covering the same Insured Person/s whether effected by the Insured /Insured Person or not, then the Company shall not be liable to pay or contribute more than its rateable proportion of any loss or damage. However, the provision of this condition will not be applicable for any benefit cover including Critical Illness, Hospital Cash, Dread Disease Recuperation, Hospital Cash Allowance, Recovery Grant, Accompanying Person Expenses, Parent Accommodation as Companion for Child, Mortal Remains, and Children Education Funds.

xvi) **Free-look period**

You have a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy.

If You have any objections to any of the terms and conditions, You have the option of canceling the Policy stating the reasons for cancellation and You shall be refunded the premium paid by You after adjusting the amounts spent on any medical check-up, stamp duty charges and proportionate risk premium.

You can cancel your Policy only if You have not made any claims under the Policy. All Your rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy.

Free look provision is not applicable and available at the time of renewal of the Policy.

Free look period is also not available where the policy period is of the tenure less than one year.

xvii) **Forfeiture of claims**

If any claim is made and rejected and no court action or suit commenced within 12 months after such rejection or, in case of arbitration taking place as provided therein, within 12 calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

xviii) **Cancellation/Termination**

The Company may cancel this Policy, by giving 15 days notice in writing by Registered Post Acknowledgment Due to the Insured at his / their last known address in case of non-cooperation of the Insured / Insured Person in implementing the terms and conditions of this Policy or fraud committed by any insured person associated with the policy or claim, in which case the Company shall be liable to repay on demand a rateable proportion of the premium for the unexpired term from the date of the cancellation. The Insured may also give 15 days notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of notice cancel the Policy and retain the premium for the period this Policy has been in force at the Company's short period scales. Provided however that refund on cancellation of Policy by the Insured shall be made only if no claim has occurred up to the date of cancellation of this Policy.

Period On Risk	Rate Of Premium to be retained
Up to 1 month	25% of annual rate
Up to 3 months	50% of annual rate
Up to 6 months	75% of annual rate
Exceeding six months	100% of annual rate

xix) **Cause of action/Currency of payment**

No claim shall be payable under this Policy unless the cause of action arises in India. All claims shall be payable in India in Indian Rupees only.

xx) **Policy Disputes**

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian law. All matters arising hereunder shall be determined in accordance with the law and practice of such Court with in Indian Territory.

xxi) **Arbitration**

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole Arbitrator to be appointed in writing by the parties to the dispute/difference, or if they can not agree upon a single Arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 Arbitrators, comprising of two Arbitrators, one to be appointed by each of the parties to the dispute/difference and the third Arbitrator to be appointed by such two Arbitrators and the arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliations Act 1996.

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

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

xxii) **Renewal Notice**

The Company shall not be bound to accept any renewal premium or to give notice that such is due, in case of non-cooperation of the Insured / Insured Person in implementing the terms and conditions of this Policy or non-payment of required premium. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration hereinbefore mentioned and that nothing is known to the Insured/Insured Person that may result to enhance the risk of the Company. No renewal receipt shall be valid unless it is on the printed form of the Company and signed by an authorized official of the Company.

Disclosure on continuity: (applicable to group policy)- In case the group policy is not renewed or discontinued, the individual members have the option of applying for any of the similar individual health insurance policies with in 30 days from such termination of group cover. It is understood that company shall offer such insurance cover subject to underwriting guidelines and with time waivers including 30 days waiting period and waiver of exclusions for the first 1 or 2 years as applicable.

xxiii) **Notices**

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post or facsimile to -

a) in case of the Insured/Insured Person, at the address given in the Schedule to the Policy.

b) in case of the Company, to the Policy issuing office/nearest office of the Company.

Notice and instruction will be deemed served 7 days after posting or immediately on receipt in the case of hand delivery, facsimile or e-mail.

xxiii) **Customer Service**

If at any time the Insured/Insured Person requires any clarification or assistance, he/she may contact the Policy issuing office or any other office of the Company or the TPA.

xxiv) **Grievances**

In case the Insured/Insured Person is aggrieved in any way, the Insured/Insured Person may contact the Company at the specified address, during normal business hours. In case the Insured/Insured Person has not got his/her grievances redressed by the Company within 14 days, then he/she may approach the Insurance Ombudsman for the redressal of the same. A list containing the addresses of Offices of Ombudsman are attached to this Policy.

LIST OF INSURANCE OMBUDSMEN

Office of the Ombudsman	Name of the Ombudsmen	Contact Details	Areas of Jurisdiction
AHMEDABAD	Shri P.Ramamoorthy	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, **Ahmedabad – 380 014** Tel.: 079-27546150/139 Fax: 079-27546142 Email: ins.omb@rediffmail.com	State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu
BHOPAL	Shri Raj Kumar Srivastava	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, **Bhopal – 462 011.** Tel.: 0755-2769200/201/202 Fax: 0755-2769203 Email: bimalokpalbhopal@gmail.com	States of Madhya Pradesh and Chattisgarh
BHUBANESHWAR		Office of the Insurance Ombudsman, 62, Forest park, **Bhubneshwar – 751 009.** Tel.: 0674-2596461/2596455 Fax: 0674-2596429 Email: ioobbsr@dataone.in	State of Orissa
CHANDIGARH	Shri Manik B Sonawane	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, **Chandigarh – 160 017.** Tel.: 0172-2706196/5861/6468 Fax: 0172-2708274 Email: ombchd@yahoo.co.in	States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh
CHENNAI	Shri Virander Kumar	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, **Chennai – 600 018.** Tel.: 044-24333678/664/668 Fax: 044-24333664 Email: chennaiinsuranceombudsman@gmail.com	State of Tamil Nadu and Union Territories - Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry)
NEW DELHI		Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, **New Delhi – 110 002.** Tel.: 011-23239611/7539/7532 Fax: 011-23230858 Email: iobdelraj@rediffmail.com	States of Delhi and Rajasthan
GUWAHATI	Shri D. C. Choudhury	Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, **Guwahati – 781001 (ASSAM).** Tel.: 0361-2132204/2131307/ 2132205 Fax: 0361-2732937 Email: ombudsmanghy@rediffmail.com	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Shri G. Rajeswara Rao	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, **Hyderabad - 500 004.** Tel.: 040-23325325/23312122 Fax: 040-23376599 Email: insombudhyd@gmail.com	States of Andhra Pradesh, Karnataka and Union Territory of Yanam - a part of the Union Territory of Pondicherry
KOCHI		Office of the Insurance Ombudsman, 2nd Floor, CC 27 / 2603, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, **Ernakulam - 682 015.** Tel.: 0484-2358734/759/9338 Fax: 0484-2359336 Email: iokochi@asianetindia.com	State of Kerala and Union Territory of (a) Lakshadweep (b) Mahe - a part of Union Territory of Pondicherry
KOLKATA		Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4, C.R. Avenue, 4th Floor, **Kolkata - 700 072.** TEL: 033-22124346/22124339 Fax: 033-22124341 Email: insombudsmankolkata@gmail.com	States of West Bengal, Bihar, Sikkim, Jharkhand and Union Territories of Andaman and Nicobar Islands
LUCKNOW		Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, **Lucknow-226 001.** Tel.: 0522-2201188/31330/1 Fax: 0522-2231310 Email: insombudsman@rediffmail.com	States of Uttar Pradesh and Uttaranchal
MUMBAI	Shri A. K. Dasgupta	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), **Mumbai - 400 054.** Tel.: 022-26106928/360/6552/6960 Fax: 022-26106052 Email: ombudsmanmumbai@gmail.com	States of Maharashtra and Goa

i) Claims Procedure

It is a condition precedent to the Company's liability that upon the discovery or happening of a disease, illness or injury that may give rise to a claim under this Policy, the Insured Person shall undertake the following:

ii) Claim Notification:

The Insured Person shall give immediate notice to the Third Party Administrator (TPA) named in the Schedule to this Policy, by calling the toll free number as specified in the Schedule to this Policy or by sending written communication to the address of the TPA shown in the Schedule with particulars as below:

a) Policy Number

b) Name of Insured Person availing treatment

c) Nature of disease, illness or injury

d) Name and address of the attending Medical Practitioner/Hospital

e) Probable cost of treatment

f) Any other relevant information.

iii) Cashless Hospitalisation:

The Third Party Administrator of the Company upon receipt of satisfactory information from the Insured Person about the hospitalisation / proposed hospitalisation will arrange for cashless hospitalisation to the Insured Person, where the treatment is in a net work Hospital. The Company shall notify from time to time, the list of hospitals within the TPA network. The Insured Person can avail cashless hospitalisation up to the limit of the Sum Insured specified in the Schedule to this Policy subject to obtaining pre-authorisation from the TPA.

The Insured Person is required to submit to the TPA complete information of the disease, illness or the injury requiring treatment to be undertaken in a Hospital, along with certification from the Medical Practitioner and/or Hospital. Taking into account the information provided as above, the TPA will issue pre-authorisation to the Hospital concerned for cashless hospitalisation for the treatment of the Insured Person up to the limit of the Sum Insured specified in the Schedule to this Policy. Where cashless hospitalisation is pre-authorised by the TPA, the Insured Person need not pay the hospitalisation expenses for the treatment undertaken for the disease, illness or the injury which are covered under the Policy and the same shall be paid by the TPA directly to the Hospital. Cashless hospitalisation benefit shall be limited exclusively to the hospitalisation expenses incurred for the treatment undertaken for the disease, illness or injury in a network Hospital and shall not extend to other benefits.

However, cashless hospitalisation will not be available if the treatment is undertaken in a non-network hospital, in which case, the Insured Person shall, after due intimation about the hospitalisation details to the TPA as mentioned hereinabove, shall pay the hospitalisation expenses directly to the Hospital concerned and claim reimbursement from the Company for the same.

iv) Claim Processing:

The TPA appointed by the Company and named in the Schedule to the Policy, will process the claim on behalf of the Company and make all payments.

The Company requires the Insured Person to deliver to the TPA at his/her own expense within 30 days of the Insured Person's discharge from the Hospital (for post-hospitalisation expenses, completion of post-hospitalisation period or completion of treatment, whichever is earlier), any and all information and documents concerning the claim or the Company's liability for it, including but not limited to:

a) Duly filled in claim form(s)

b) Original bills, receipts, discharge/cards from the hospital/Medical Practitioner

c) Original bills from chemists supported by proper prescription

d) Original investigation test reports and payment receipts

e) Medical Practitioner's referral letter advising hospitalisation

f) Original bills and receipts for claiming the Ambulance charges

g) Original bills, receipts and the Medical Practitioner's prescription for claiming benefits under external mobility aids and appliances

If so requested by the Company, the Insured Person will have to submit himself for a Medical Examination by the Company's or the TPA's Medical Practitioner as often as the Company considers necessary.

Upon receipt of all required documents, the offer of settlement will be made within 30 days. Settlement (payment) of claim will be made within 7 days of receipt of acceptance in response to offer of settlement, failing which penal interest (in compliance with applicable regulations) at a rate 2% higher than bank rate prevailing as on the date of beginning of financial year in which the claim is reviewed

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Commercial Lines Growth Leadership Award 2012


Best Product Innovation Award 2012


Personal Lines Growth Leadership Award 2011


Risk Manager of the Year Award 2011


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