Bharti AXA General Insurance Company Limited

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redefining / general insurance

SmartHealth Insurance Policy - Policy Wordings

UIN: IRDA/NL-HLT/BAXAGI/P-H/V.I/93/13-14

1) 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.

1.1) 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 / 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/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 / 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 / Insured Person for

1) Hospital (Room & Boarding and Operation theatre) charges;
2) Fees of Surgeon, Anaesthetist, Nurse, Specialists etc.;
3) Cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.
4) Pre and post hospitalization expenses
5) Ambulance charges

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

2) Definitions

Any word or expression to which a specific meaning has been assigned in a n y 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:

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

2.2) **"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.

2.3) **"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 ratable proportion of Sum Insured.This clause shall not apply to any Benefit offered on fixed benefit basis.

2.4) **"Critical Illnesses"** means 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** - 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 arrow 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** 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** is the 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 necrosisof the liver by the Hepatitis virus, leading precipitously to liver failure

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

2.5) **"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.

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

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

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

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

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

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

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

a) Dialysis
b) Radiotherapy
d) Eye surgery
e) Dental surgery
f) Lithotripsy (kidney stone removal)
g) Tonsillectomy
h) Dilatation & Curettage
i) Cardiac Catheterization
j) Hydrocele surgery
k) Hernia repair surgery
l) Surgeries/procedures that require less than 24 hours hospitalisation due to medical/ technological advancement and infrastructural facilities.
m) TURP (Prostate Surgery)

2.9) **"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

2.10) **"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.

2.11) **"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.

2.12) **"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 o f 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 Hospital treatment,

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 astroenteritis
   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 aryngitis and pharangitis
   xii) Arthritis, gout and rheumatism

2.13) **"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.

2.14) **"Family"** means the Insured, his/her lawful spouse and maximum of two dependant children upto the age of 23 years.

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

2.16) **"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:

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

2.16.2) 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;

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

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

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

2.17) **"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.

2.18) **"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

2.19) **"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.

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

2.21) **"Insured"** means the individual who has a permanent place of residence in India and on whose name the Policy is issued.

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

2.23) **"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/ Insured Person's family.

2.24) **"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.

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

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

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

2.25.3) must have been prescribed by a medical practitioner,

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

2.26) **"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.

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

2.28) **"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

2.29) **"Period of insurance"** means the Policy period defined hereunder.

2.30) **"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.

2.31) **"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 Proposer form and any applicable endorsement thereon. The Policy contains details of the scope and extent of cover available to the Insured/Insured Person, the exclusions from the scope of cover and the terms and conditions of the issue of the Policy.

2.32) **"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.

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

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

and

2.33.2) 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.

2.34) **"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.

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

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

2.35.2) 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.

2.36) **"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.

2.37) **"Renewal"** defines the terms on which the contract of insurance can be renewed on mutual consent with a provision o f grace period for treating the renewal continuous for the purpose of all waiting periods.

2.38) **"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.

2.39) **"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/ Insured Person as well as to the Company for an insurable event.

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

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

2.42) **"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.

2.43) **"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 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.

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

3) 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 Expense benefit provides cover for reimbursement / payment of hospitalisation expenses which are reasonably and necessarily incurred by the Insured / Insured Person for treatment of disease, illness contracted or injury sustained by the Insured / 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 charges (Room and Boarding and Operation Theatre charges), admission and registration charges in the Hospital, fees of Surgeon, Anaesthetist, Nurses, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.
The Insured/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 / 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.

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/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.

d) 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 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.

Section II

Day Care Treatment

This benefit covers relevant hospitalisation expenses incurred by the Insured / 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 to this Policy.

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 / 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 Hospital treatment,
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 astroenteritis
   v) Diabetes mellitus and insipidu
   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.
c) 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 available Sum Insured for Section 1a of this Policy as mentioned in the Schedule to this Policy.

Section IV

Critical Illness

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

a) In case the type of cover opted is benefit basis:
   If, 30 days after the inception of this Policy, the Insured / 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/Insured Person as compensatory benefit.
   This Section operates as a benefit cover and compensation shall be payable if the Insured / Insured Person is surviving for more than 30 days post diagnosis of any critical illness.
   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 / Insured Person is diagnosed to be suffering from any of the Critical Illnesses and survives for a period of 30 days, then the Sum Insured specified under Section IV will be paid as a lump sum. After availing the benefit under Section IV, if the Insured / 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 under the Policy, the payment of compensation shall be limited to the Sum Insured as specified above and shall be payable only once.

b) In case the type of cover opted is Hospitalisation Reimbursement basis
   If, 60 days after the inception of this Policy, the Insured / Insured Person is at any time during the Policy period (after the above waiting period of 30 days), being diagnosed as contracting any of the Critical Illnesses 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.
   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 / 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 IV. 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 IV, the excess may be paid / reimbursed out of the available Sum Insured under the Hospitalisation Benefit under Section Ia. The benefits available under Sections 1b, 1c and 1d 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 the Policy. In case of diagnosis of multiple critical illnesses requiring treatment covered under this Policy, the maximum liability of the company 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 out below:

1) **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 an oncologist or pathologist. The term cancer includes leukemia, lymphoma and sarcoma.
   The following are excluded:
   a) Tumours showing the malignant changes of carcinoma-in-situ and tumours which are histologically described as pre-malignant or non-invasive, included, but not limited to: Carcinoma-in-situ of the Breasts, Cervical Dysplasia CIN-1, CIN-2 and 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.

2) **First heart attack of specified severity:** The First occurrence of myocardial infarction which means death of a portion of the heart muscle arising from inadequate blood supply to the relevant area. This diagnosis must be supported by all of the following criteria:
   a) History of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain);
   b) New characteristic electrocardiogram (ECG) 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.

3) **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.

4) **Open Chest CABG (Coronary Artery By-pass Graft) surgery:** 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:

a) Angioplasty and / or any other intra-arterial procedures

b) Any key-hole or laser surgery

5) **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.

6) **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.

7) **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.

8) **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.

9) **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.

10) **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 55mm Hg or less (PaO2 <- 55 mm Hg); and

d) Dyspnea at rest.

The diagnosis must be confirmed by a respiratory physician.

11) **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.

12) **Coma Of Specified Severity:**

I. 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.

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

13) **Major Burns:** Third degree (full thickness of the skin) burns covering at least 30% of the surface of the insured person's body.

14) **Major Organ/Bone Marrow Transplant:**

I. 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.

II. The following are excluded:

a. Other stem-cell transplants

b. Where only islets of langerhans are transplanted

15) **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.

16) **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) reticular framework;

c) Rapid deterioration of liver function tests;

d) Deepening jaundice; and

e) Hepatic encephalopathy.

17) **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.

18) **Primary Pulmonary Hypertension:** Primary Pulmonary Hypertension with substantial right ventricular enlargement confirmed by investigations including cardiac catheterization resulting in permanent physical impairment of 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 IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

19) **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.

20) **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.
   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/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 for 60 days subject to medical requirement as certified by the treating Physician.

Transplantation of Organs: Where the Insured/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 / 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.

4) Additional benefits :

Benefits under this Section are payable as Additional Benefits upto the limits specified in the Schedule to this Policy. A valid claim should have been admitted under the Hospitalisation Section of the Policy, for admission of liability under this Section. These benefits are payable also when there is a Hospitalisation claim for Critical Illness treatment under the Critical Illness Section.

Hospital Cash Allowance: In case the Insured / 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/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.

Home Nursing: This benefit provides for payment to the Insured/Insured Person of an allowance for medical care services of a nurse at the residence of the Insured/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/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/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/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 / 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 / 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/Insured Person towards expenses incurred on the accompanying person at the Hospital/Nursing Home during hospitalisation treatment of the Insured/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 the 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.

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 / 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 for the Insured / Insured Person following an accidental injury 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 / 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 / Insured Person from Hospital to his/her place of residence in the event of death of the Insured / Insured Person at the Hospital while under treatment for disease / illness / injury / critical illness as specified in the Schedule to this Policy.

Renewal Discount: The Policy shall provide for a discount, equivalent to 5% of renewal premium every year on a progressive scale, as Renewal Discount at the time of renewal, provided that the Policy being renewed is claim free in the expiring year. This renewal discount on a progressive scale will be allowed upto a maximum of 25%. In case of renewal of a Policy where there is a loss, the Insured will lose the entire Renewal Discount accumulated. The Company offers life long renewal, subject to the renewal being effected before the expiry of the policy or within grace period allowed.

Income Tax Benefit: Premium paid under this Policy shall be eligible for income tax deduction benefit under Sec 80 D as per the Income Tax Act.

Cost of Health Check-up: This Policy provides for reimbursement of cost of medical check-up once at the end of a block of every four continuous underwriting years, provided there were no claims reported/made under the Policy during the block. This benefit shall be limited to 1% of the average Sum Insured per person/family as the case may be during the block of four underwriting years.
This additional benefit is available on the policies taken and renewed with the Company for four continuous years, without any claim.

5) Portability:

Insured(s) have an option to migrate from their existing health insurance policy of any other Indian non life insurer to any other similar policy with Us, at the time of renewal, provided the previous policy/policies has been maintained without any break.

Portability benefit will be offered to the extent of previous year's sum insured, and shall not apply to additional increased sum insured in our policy.

However it may be noted that:
(a) 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/ Insured Person under the previous health insurance policy / policies; AND
(b) If the proposed Sum Insured for an Insured Person is more than the Sum Insured applicable under the previous health insurance policy, then the reduced waiting period shall only be applicable to the extent of the Sum Insured in previous policy/ policies).

6) 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:

1) Pre-existing diseases / illness / injury / conditions - The benefits will not be available for any condition(s) as defined in the policy, until 48 months of continuous coverage have elapsed, since inception of the first policy with the Company.
However, if the renewal premium is paid with in 15 days from the date of policy expiry, coverage shall be deemed to be continuous with out break for the purpose of this exclusion.

2) Any benefit under Critical Illness Section within 60 days of the inception date of this Policy. This exclusion, however, doesn't apply for subsequent renewals with the Company without a break. Such a waiting period will reckon from the time the Policy has been taken with the Company and renewed with the Company without any break. In case of policies taken from other companies and renewed with the Company with or without break, the waiting period as mentioned above would be counted only from the time the Policy is renewed with the Company and no credit will be given for the earlier years.
However, if the renewal premium is paid with in 15 days from the date of policy expiry, coverage shall be deemed to be continuous with out break for the purpose of this exclusion.

3) 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 of the Insured / Insured Person having been covered under any similar health insurance policy of any other general insurance company including group insurance schemes in India for a continuous period of preceding 12 months without any break.
However, if the renewal premium is paid with in 15 days from the date of policy expiry, coverage shall be deemed to be continuous with out break for the purpose of this exclusion.

4) Hospitalisation Expenses incurred on treatment of following diseases, illness, injury within the first two years from the inception of this Policy, will not be payable:
   - Cataract
   - Benign Prostatic Hypertrophy
   - Myomectomy, Hysterectomy or menorrhagia or fibromyoma unless because of malignancy
   - Dilation 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
   - Joint Replacement Surgeries unless necessitated by accident

   This exclusion, however, doesn't apply for subsequent renewals with the Company without a break. Further this exclusion shall not apply in case of the Insured / Insured Person having been covered under any similar health insurance policy of any other general insurance company including group insurance schemes in India for a continuous period of preceding 24 months without any break. However, if the renewal premium is paid within 15 days from the date of policy expiry, coverage shall be deemed to be continuous without break for the purpose of this exclusion.

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

6) Dental treatment which are not excluded hereunder or surgery of any kind unless requiring hospitalisation.

7) 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.

8) Any fertility, sub-fertility or assisted conception operation

9) 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.

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

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

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

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

14) 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.

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

16) Vaccination and inoculation of any kind.

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

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

19) Disease / illness / injury / critical illness directly or indirectly, caused by or arising from or attributable to 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.

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

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

22) Any stay in Hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner.

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

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

25) Any loss, directly or indirectly, due to contamination due to an act of terrorism or terrorist incident, 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 / Insured Person).

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

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

28) Experimental and unproven treatment.

29) 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.

30) 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.

31) Any treatment which is undertaken as an out-patient without any admission as an in-patient at the Hospital except those that are specifically mentioned as covered in the Schedule to this Policy.

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

33) Naturopathy treatment.

34) Any treatment received outside India.

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

36) Medical Treatment in respect of the Insured/Insured Person whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, 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.

37) Medical Treatment in respect of the Insured/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.

6) General conditions

6.1) **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 his/their behalf to obtain a benefit under this Policy.

6.2) **Floater Policy:** Where the Policy is obtained on floater basis covering the 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

6.3) **Reasonable Care:** The Insured/Insured Person shall take all reasonable steps to safeguard the interests of the Insured / Insured Person against accidental loss or damage that may give rise to a claim.

6.4) **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.

6.5) **Material Change:** The Insured / Insured Person 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.

6.6) **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 / Insured Person or anyone acting on his 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 condition No. 6.1 of this Policy.

6.7) **No Constructive Notice:** Any knowledge or information of any circumstances or condition in connection with the Insured / 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.

6.8) **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 his legal representative, as the case may be, of any compensation or benefit under the Policy shall in all cases be an effectual discharge to the Company.

6.9) **Special Provisions:** Any special provisions subject to which this Policy has been entered into and endorsed on the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

6.10) **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 incorporate herein.

6.11) **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, teleservice 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.

6.12) **Duty of the Insured on occurrence of loss:** On the occurrence of loss within the scope of cover under the Policy, the Insured / 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 / Insured Person
c) Assist and not hinder or prevent the Company or any of its agents in pursuance of their duties

In case the Insured / Insured Person does not comply with the provisions of this clause or other obligations cast upon the Insured / 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.

6.13) Right to Inspect: If required by the Company, an agent/representative of the Company including a Physician appointed in that behalf shall in case of any loss or any circumstances that have given rise to a claim to the Insured / Insured Person be permitted at all reasonable times to examine into the circumstances of such loss. The Insured / Insured Person shall on being required so 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.

6.14) 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. On payment of any claim under Section IV of this Policy (in case of benefit basis), the Insured / Insured Person shall not be eligible for any further claim/benefit against the same disease any further including subsequent renewals.

6.15) Subrogation: In the event of any claim payment under this Policy, the Company shall be subrogated to all the Insured / 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 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 Company, 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. Remedies or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated.

6.16) Contribution: If there shall be existing any other insurance of any nature whatsoever covering the same Insured / Insured Person 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 provison 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, Children Education Funds.

6.17) 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.

6.18) **Free Look Period:** Insured / Insured person 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 the insured have any objections to any of the terms and conditions, he / she have the option of cancelling the Policy stating the reasons for cancellation and the premium will be refunded after adjusting the amounts spent on any medical check-up, stamp duty charges and proportionate risk premium.

The policy can be cancelled only if insured have not made any claims under the Policy.

Free look provision is not applicable and/or 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.

6.19) **Grace Period:** All applications for renewal of the policy must be received by us before the end of the policy. A Grace Period of 30 days for renewing the Policy is provided under this Policy.

However, there is no coverage for injury sustained or disease contacted during this period.

6.20) 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. The company shall exercise its right to cancel only in case of non-cooperation of the Insured / Insured Person in implementing the terms and conditions of this Policy 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%

6.21) 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.

6.22) 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.

6.23) 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 2 Arbitrators and 1 to be appointed by each of the parties to the dispute/difference and the third Arbitrator to be appointed by such 2 Arbitrators.

panel of 3 Arbitrators, comprising of 2 Arbitrators and 1 to be appointed by each of the parties to the dispute/difference and the third Arbitrator to be appointed by such 2 Arbitrators.

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 herein before 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.

6.24) Renewal Notice: The Company shall give notice for renewal of the Policy and accept renewal premium in all cases except in case of non-cooperation of the Insured/Insured Person in implementing the terms and conditions of this Policy. 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 herein before mentioned and that nothing is known to the insured that may result to enhance the risk of the Company under the guarantee hereby given. 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. However, in case the premium for renewal is paid with in 15 days from the policy expiring date, such renewal policy shall be effective only from the time and date of receipt of premium. It is further clarified that the company shall not be liable to pay claims arising out of any disease or injury contacted during the period between policy expiring date and receipt of renewal premium by the company.

6.25) 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, 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.

6.26) Customer Service: If at any time the Insured / Insured Person requires any clarification or assistance, the insured/ Insured Person may contact the policy issuing office or any other office of the Company or the TPA.

6.27) 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 addressees of Offices of Ombudsman are attached to this Policy. Policy holder may also obtain copy of IRDA circular number 1385_GI-2002_ENG dated 26-04-2002, notification on Insurance Regulatory and Development Authority (Protection of policy holders' interests) Regulations, 2002 from any of our offices.

LIST OF INSURANCE OMBUDSMEN

Office of the Ombudsman	Name of the Ombudsmen	Contact Details	Areas of Jurisdiction
AHMEDABAD	Shri P.Ramamoorthy	Insurance Ombudsman Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U.Shah College, 5, Navyug Colony, Ashram Road, **AHMEDABAD – 380 014.** Tel. 079 - 27546840. Fax: 079-27546142 E-mail: ins.omb@rediffmail.com	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu
BHOPAL		Insurance Ombudsman Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, **BHOPAL(M.P) - 462 023.** Tel. 0755-2569201. Fax: 0755-2769203. E-mail: bimalokpalbhopal@airtelmail.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Shri B. P. Parija	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, **BHUBANESHWAR - 751 009.** Tel.:- 0674-2596455 Fax : 0674-2596429 Email: ioobbsr@dataone.in	Orissa
CHANDIGARH	Shri Manik Sonawane	Insurance Ombudsman Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103 2nd floor, Batra Building Sector 17-D, **CHANDIGARH – 160 017.** Tel.: 0172-2706468. Fax: 0172-2708274. E-mail: ombchd@yahoo.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh
CHENNAI		Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court , 4 th floor, 453 (old 312) Anna Salai, Teynampet, **CHENNAI – 600 018.** Tel.: 044-24333668 /5284. Fax: 044-24333664. E-mail: chennaiinsuranceombudsman@gmail.com	Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
NEW DELHI	Shri Surendra Pal Singh	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, **NEW DELHI - 110 002.** Tel.:- 011-23239633 Fax : 011-23230858 Email: iobdelraj@rediffmail.com	Delhi & Rajashthan
GUWAHATI	Shri D. C. Choudhury	Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5 th floor, Near Panbazar Overbridge , S.S. Road, **GUWAHATI – 781 001 (Assam).** Tel. : 0361-2131307 Fax:0361-2732937. E-mail: omb_ghy@sify.com	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD		Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46 , 1 st floor, Main Court, A.C.Guards, Lakdi-Ka-Pool, **HYDERABAD – 500 004.** Tel.: 040-65504123. Fax: 040-23376599. E-mail: insombudhyd@gmail.com	Andhra Pradesh, Karnataka and UT of Yanam – a part of the UT of Pondicherry
KOCHI	Shri R. Jyothindranathan	Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Building, Opp. Cochin Shipyard, M.G. Road, **ERNAKULAM – 682 015**. Tel : 0484-2358759 Fax : 0484-2359336 Email: iokochi@asianetindia.com	Kerala, UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry
KOLKATA	Ms. Manika Datta	Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindusthan Bldg. Annexe, 4, C.R.Avenue, **Kolkatta – 700 072.** Tel:033 22124346 /(40) Fax: 033 22124341 Email: iombsbpa@bsnl.in	West Bengal, Bihar, Jharkhand and UT of Andeman & Nicobar Islands, Sikkim
LUCKNOW	Shri G. B. Pande	Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Bhawan, Phase 2, 6th floor, Nawal Kishore Rd., Hazratganj, **LUCKNOW – 226 001.** Tel.:0522-2231331. Fax: 0522-2231310. E-mail: insombudsman@rediffmail.com	Uttar Pradesh and Uttaranchal
MUMBAI		Insurance Ombudsman Office of the Insurance Ombudsman, S.V. Road, Santacruz(W), **MUMBAI - 400 054.** Tel: 022-26106928 Fax: 022-26106052 Email: ombudsmanmumbai@gmail.com	Maharashtra, Goa

6.28) Claim Notification Multi Model Intimation : It is the endeavour of BhartiAxa to give multiple options to the insured/covered person/patient's care taker to intimate the claim to the Third party administrator (TPA)/Company. The intimation can be given in following ways

- Toll Free call centre of the TPA (24x7)
- Toll Free call centre of the Insurance Company(24x7)
- Login to the website of the Insurance Company and intimate the claim
- Send an email to the TPA/Company
- Send a fax to TPA/Company
- Post/courier to TPA/Company
- Direct Contact

In all the above the intimations are directed to a central team for prompt, standardized action.

Information Details

When the insured/covered person/patient's care taker intimate the claim as mentioned above the following information should be kept handy for prompt services.

- Policy number
- Name of the Insured/Covered person
- Contact details
- Nature of the disease, illness or injury
- Name and address of the attending medical ractitioner/hospital

Claim Form

Upon the notification of the claim the TPA/Company will dispatch the claim form to the Insured/Covered person. Claim forms will also be available with the network hospitals and Company offices.

6.29) Claim Procedure

Cashless hospitalisation:

- Company will work with one or more TPAs for providing cashless facility to the Insured/Covered person.
- List of network hospitals will be provided to the Insured/Covered person along with the policy and it will be regularly updated and informed to them. Insured/Covered person can view the updated hospital list from the website of the TPA/Company too.
- Insured/covered person on admission (emergency) or willing to admit (planned admission) in the network hospitals a pre-authorization request form has to be filled in by the treating doctor/hospital and the same has to be faxed to the TPA by the insured/hospital. The TPA after verifying the same will decide on the issuance of authorization. The action of pre-authorization will be done within 6 hours for emergency admission and 48 hours for planned admission.
- The preauthorization request form will be available in the benefit guide issued along with the policy, available in the hospitals, can be downloaded from the website of the TPA/Company, can request for the same to the TPA/Company via email or fax or can be collected in person from the branches of the TPA/Company.
- Denial of the cashless does not mean the claim has been rejected. The insured/covered person can send the requisite claim documents to the TPA/Company seeking reimbursement.
- The insured/covered person need not pay any amount to the hospital if he has received the authorization letter except
- If the bill amount is in excess of the sum insured
- Non medical expenses
- Unrelated treatments
- Excess, if any
- The hospital will receive the payment from TPA/Company within 21 days from the date of receipt of complete claim documents

6.30) **Documents**

It is the policy of the Company to seek documents in a single shot. If any further documentation is required then it will be sought promptly.

In cases where investigation is deemed necessary, the same will be conducted in all promptitude. Every attempt will be made to keep the process transparent.

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

6.31) **Repudiations**

The power to repudiate claims is vested in the corporate office to ensure transparency and standardization across the country. This is also with a view to keep the guidelines of regulator in mind. In the unfortunate event of repudiation, the retail customers will be informed of the existence of forums for grievance redressal.

Reimbursement claims

- Insured/covered person unwilling to utilize the cashless facility in the network hospital can send the claim documents along with the pre/post hospitalization documents for the period specified in the policy to the TPA/Company for the reimbursement with in 15 days of end of the post hospitalization period or the medical fitness certificate issued by the attending physician, which ever is earlier.
- Insured/covered person admitted in a non network hospital can send the claim documents along with the pre/post hospitalization documents for the period specified in the policy to the TPA/Company for the reimbursement with in 15 days of end of the post hospitalization period or the medical fitness certificate issued by the attending physician, which ever is earlier.
- Insured/covered person should intimate the claim to the TPA/Company within reasonable period of hospitalization.
- After receiving the complete documents the TPA/Company will reimburse the claim amount within 14 days to the insured.

6.30) Documents

It is the policy of the Company to seek documents in a single shot. If any further documentation is required then it will be sought promptly.

In cases where investigation is deemed necessary, the same will be conducted in all promptitude. Every attempt will be made to keep the process transparent.

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.

6.31) Repudiations

The power to repudiate claims is vested in the corporate office to ensure transparency and standardization across the country. This is also with a view to keep the guidelines of regulator in mind. In the unfortunate event of repudiation, the retail customers will be informed of the existence of forums for grievance redressal.

Checklist of documents for settling Claims:

Sl. No.	CHECKLIST	Tick the boxes
1.	Claim form duly signed along with attending physician statement	✓ ☐
2.	Pre auth form-if cashless claim	✓ ☐
3.	Discharge summary	✓ ☐
4.	Hospital final bill	✓ ☐
5.	Attending Surgeon's/Physician's Prescription advising hospitalization	✓ ☐
6.	Surgery/consultation bills and receipts	✓ ☐
7.	Operation theatre and pharmacy bills	✓ ☐
8.	Medicines bill with doctors prescription	✓ ☐
9.	Pre hospitalization bills with receipts	✓ ☐
10.	Post hospitalization bills with receipts	✓ ☐
11.	Hospital payment receipt in case of reimbursements	✓ ☐
12.	Diagnostic reports with doctors prescription	✓ ☐
13.	Others if any	✓ ☐

Insurance is the subject matter of solicitation.