Prospectus - Smart Health Critical Illness Policy

I. Introduction:

This health insurance Policy provides cover when the Insured / Insured Person contracts any of the specified Critical Illnesses through either

a.Payment / reimbursement of hospitalisation expenses incurred for treatment of a specified Critical Illness. The Policy among other things covers Hospital (Room & Boarding and Operation theatre) charges, fees of Surgeon, Anaesthetist, Nurses, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker and artificial limbs etc.

or

b. Payment of compensation in case the Insured / Insured Person is diagnosed to have contracted any of the specified critical illnesses.

The Policy offers varying options, details of which are given in the Exhibit of Benefits.

II. Eligibility

- This Policy covers persons in the Age group 91 days to 65 years.
- The minimum entry age is 91 days and maximum entry Age is restricted upto 65 years.
- Children below the age of 5 years can be covered only in the event of either or both the parents being covered
- There is no maximum cover ceasing age in this policy for renewal This Policy can be issued to an individual and/or family as a Family Floater.
- The family includes self, spouse, upto 2 Dependent children upto the age of 23 years.
- Policy can also be offered to group of individuals, association of persons, other groups, employers to cover their employees etc wherein the premium rating structure for group insurance needs to be followed.
- All the conditions, terms and restrictions of the individual/family policy shall also apply to group policies.
- Residents in India shall include all Citizens of India and permanent residents of India as well as expatriates or foreigners who are holding an employment pass, dependant pass or work permit and residing in India.
- Expatriates or foreigners must provide a copy of either a valid employment pass or work permit, and a bona-fide residential address in India.

III. Sum Insured

	Option 1	Option 2	Option 3	Bharti Plan A	Bharti Plan A	Bharti Plan A
Hospitalisation Expenses Reimbursement	200000	300000	500000	-	300000	500000
Payment of Compensation	200000	300000	500000	200000	300000	500000

IV. Scope of coverage

The Policy provides for -

This Policy provides for coverage of expenses that are reasonably and necessarily incurred for treatment of any of the specified Critical Illnesses. The coverage can be either in the form of payment /reimbursement of expenses incurred for treatment of such specified Critical Illness in a Hospital / Nursing Home or lump sum benefit amount as selected by the Insured.

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Section I

Hospitalisation expenses payment/reimbursement

This Section provides for payment/reimbursement of hospitalisation expenses incurred by or on behalf of the Insured / any of the Insured Person for treatment of Critical Illnesses at any Hospital/ Nursing Home in India as an inpatient, upto the specific Sum Insured stated against this benefit in the following manner.

a. Hospitalisation Expenses

Hospitalisation Expenses benefit provides cover for payment/ reimbursement of hospitalisation expenses that are reasonably and necessarily incurred for treatment of Critical Illness 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, 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. The benefit under this Section is limited to the Sum Insured specified for this Section in the Schedule to the Policy.

b. Pre and post hospitalisation

Payment or reimbursement of pre-hospitalisation expenses incurred for 30 days prior to hospitalisation and post-hospitalisation expenses incurred for 60 days following discharge from Hospital / Nursing Home.

c. Dread Disease recuperation

Payment of an allowance towards recuperation expenses incurred by the Insured/Insured Person post discharge from the Hospital, in case 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.

Transplantation of Organs

Payment or reimbursement of hospitalisation expenses incurred towards donor for a major organ transplant in case the Insured/Insured Person contracts any of the specified 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 the Policy is admissible. This benefit is subject to overall limit of the Sum Insured

Section II

Payment of Compensation

Under this Option, if the Insured / Insured Person is diagnosed as contracting any of the specified Critical Illnesses and surviving for more than 30 days post such diagnosis, the Sum Insured for this benefit shall be payable to the Insured / Insured Person as compensatory benefit.

This Section operates as a benefit cover.

Compensation shall be payable under both these section, if the Insured / Insured Person is surviving for more than 30 days post diagnosis of any Critical Illness and after a waiting period of 60 days from the date of inception of the Policy in the first year of cover.

The Insured / Insured Person can either opt for the benefit under Section I or Section II of the Policy.

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V. Additional Benefits:

Benefits under these Sections are payable as Additional Benefits upto the limits of Sum Insured specified. A valid claim should have been admitted under the Hospitalisation Expenses Section of the Policy, for admission of liability under these Sections.
Additional benefits are not payable when Insured opts for the benefit of payment of compensation (under Section II).

Hospital Cash Allowance
Payment of daily allowance for the days the Insured/Insured Person is hospitalised beyond a specified number of days for treatment of any of the Critical Illnesses for which a valid claim is admissible under the Policy. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits specified in Exhibit of Benefits.

Home Nursing
Payment of an allowance towards expenses incurred for availing medical care services of a nurse at the residence of the Insured/Insured Person following discharge from Hospital after treatment for any of the Critical Illnesses, if the same is recommended as necessary by the attending Medical Practitioner and is related directly to the treatment for the specified Critical Illness, for which the Insured/Insured Person has been hospitalized. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits specified in Exhibit of Benefits.

Ambulance Charges
Reimbursement of expenses incurred for the transportation of the Insured/Insured Person by ambulance to and from the Hospital for treatment of Critical Illness in a Hospital as an in-patient for which a valid claim under the Policy is admissible. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits specified in Exhibit of Benefits.

In-patient Physiotherapy Charges
Reimbursement of charges incurred towards physiotherapy in the Hospital as an in-patient that is confirmed as being necessary by the attending Medical Practitioner and the same relates directly to the Critical Illness for which the Insured/Insured Person has undertaken treatment in the Hospital for which a valid claim is admissible under the Policy. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits specified in Exhibit of Benefits.

Recovery Grant
In case the Insured/Insured Person is hospitalized for a period of 8 consecutive days or more for treatment of any Critical Illness for which a valid claim is admissible under the Policy, this benefit provides for payment of a fixed allowance/grant as mentioned in Exhibit of Benefits. This benefit is applicable irrespective of the number of occurrences during the Policy period.

Accompanying Person's Expenses
Payment of an allowance towards expenses incurred on the accompanying person at the Hospital/Nursing Home during hospitalisation treatment of the Insured/Insured Person for any of the Critical Illnesses for which a valid claim is admissible under the Policy. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits specified in Exhibit of Benefits.

Children Education Fund

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Payment of a fixed amount per dependent child, upto a maximum of two dependent children who pursue studies and are below the age of 23 years, in the event of death of the Insured/ Insured Person whilst under treatment in a Hospital as an in-patient for any Critical Illness for which a valid claim is payable under the Policy. The benefit is limited to the amount specified in the Exhibit of Benefits.

Mortal Remains
Reimbursement of expenses incurred for transportation of the mortal remains of the deceased Insured/Insured Person from Hospital to his/her place of residence in the event of death at the Hospital as an in-patient whilst under treatment of a Critical Illness for which a valid claim is payable under the Policy, subject to the limits specified in the Exhibit of Benefits.

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

Cancer of Specified Severity:

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

II. **The following are excluded:**

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

Myocardial Infarction (First heart attack - of specified severity):

I. The first occurrence of heart attack or 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 Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

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II. The following are excluded:

i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

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

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

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded

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

Open Heart Replacement or Repair of Heart Valves:

I. 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 diseaseaffected 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.

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

Stroke Resulting In Permanent Symptoms:

I. 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.

II. The following are excluded:

i. Transient Ischaemic Attacks(TIA);
ii. Traumatic injury of the brain;
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

Kidney Failure Requiring Regular Dialysis:

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

Aplastic Anaemia:

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

i. Blood product transfusion;
ii. Marrow stimulating agents;
iii. Immunosuppressive agents; or
iv. Bone marrow transplantation

The diagnosis must be confirmed by a haematologist.

End Stage Lung Disease:

I. End Stage Lung Disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
iv. Dyspnea at rest.

End Stage Liver Failure:

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
a) Permanent jaundice;
b) Ascites; and
c) Hepatic Encephalopathy.

II. Liver disease secondary to alcohol or drug abuse is excluded.

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.

Third Degree Burns:

I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

Major Organ/Bone Marrow Transplant:

I. 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

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ii. 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:**

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

Multiple Sclerosis With Persisting Symptoms:

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

- investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
- there must be current clinical impairment of motor or sensory function,which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE are excluded.

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:

i. Rapid decreasing of liver size;
ii. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
iii. Rapid deterioration of liver function tests;
iv. Deepening jaundice; and
v. Hepatic encephalopathy

Motor Neurone Disease With Permanent Symptoms:

I. 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.

Primary (IDIOPATHIC) Pulmonary Hypertension

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
ii. Class IV: Unable to engage in any physical activity without discomfort.Symptoms may be present even at rest.
iii. Pulmonary hypertension associated with lung disease, chronic hypoventilation,pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

Terminal Illness:

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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.

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:

i. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
ii. A consultant neurologist.

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

For detailed and updated list of non payable items, kindly visit our website www.bharti-axagi.co.in

VI. ADDITIONAL FEATURES

Renewal Discount:

Discount equivalent to 5% of renewal premium every year on a progressive scale will be given back to the Insured as No claim Bonus at the time of renewal, where the Policy which is renewed is claim free in the expiring year. This renewal discount on a progressive scale will be allowed upto 25%. In case of renewal of a Policy where there is a loss, the Insured will lose the entire Renewal Discount accumulated. This additional benefit is available on the policies taken and renewed with our Company continuously without any break and without any claim.

VII. Policy Period

Policy will be issued for annual period of 12 months.

VIII. Policy Servicing

The Policy will be serviced by Third Party Administrator who will provide among other things cash less facility for hospitalisation treatment.
The scope of cover and the Sum Insured levels under the various Plans available are mentioned in Exhibit of Benefits.

IX. Free-look period:

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.
The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii.Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

X. Pre Policy Check:

The Company shall reimburse 50% of the cost of medical examination underwent by the Insured person(s) at designated Hospital/ Diagnostic centre, if the proposal is accepted

For all the variants Insured members have to undergo Pre Policy check if their age is above
List of test to be undergone:-

- MER
- Blood Test, FP & PP (Blood Sugar)
- Urine Test (ROUTINE & SUGAR) and
- ECG
- Lipid Profile
- Blood urea nitrogen
- Serum SGPT
- X Ray Chest

The Company can call for additional medical test(s) on the basis of declaration in proposal form or based on findings of first set of medical reports the entire cost of which have to be borne by the Insured.

XI. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per lRDAl guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per lRDAl guidelines on portability.

For Detailed Guidelines on portability, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast30 days before the policy renewal date as per lRDAl guidelines on Migration. If such person is presently co\/ered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per lRDAl guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link
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XII. Exclusions under the Policy:

A. Exclusion Name: Pre-Existing Diseases - Code- Excl01

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a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted byInsurer.

B. Exclusion Name: Specified disease/procedure waiting period- Code- Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures

1. Any types of gastric or duodenal ulcers
2. Benign prostatic hypertrophy
3. All types of sinuses
4. Hemorrhoids
5. Dysfunctional uterine bleeding
6. Endometriosis
7. Stones in the urinary and biliary systems
8. Surgery on ears/tonsils/adenoids/ paranasal sinuses
9. Cataracts,
10. Hernia of all types and Hydrocele
11. Fistulae in anus
12. Fissure in anus
13. Fibromyoma
14. Hysterectomy
15. Surgery for any skin ailment
16. Surgery on all internal or external tumours/ cysts/ nodules/polyps of any kind including breast lumps with exception of Malignancy
17. Dialysis required for Chronic Renal Failure.
18. Joint Replacement Surgeries unless necessitated by Accident happening after the Policy risk inception date.
19. Dilatation and curettage
20. Varicose Veins and Varicose Ulcers
21. Non Infective Arthritis and other form arthritis

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22) Gout and Rheumatism

23) Prolapse inter Vertebral Disc and Spinal Diseases including spondylitis/spondylosis unless arising from Accident

C. 30-day waiting period- Code- Excl03

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

D. Investigation & Evaluation- Code- Excl04

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

E. Exclusion Name: Rest Cure, rehabilitation and respite care- Code- Excl05

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment.This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

F. Obesity/ Weight Control:Code- Excl06

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1) Surgery to be conducted is upon the advice of the Doctor

2) The surgery/Procedure conducted should be supported by clinical protocols

3) The member has to be 18 years of age or older and

4) Body Mass Index (BMI);

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

G. Change-of-Gendertreatments:Code- Excl07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

H. Cosmetic or plastic Surgery:Code- Excl08

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

I. Hazardous or Adventure sports:Code- Excl09

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

J. Breach of law:Code- Excl10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

K. Excluded Providers: Code- Excl11 Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the lnsurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim. (Explanation: Details of
excluded providers shall be provided with the policy document. lnsurers to use various means of communication to notify the policyholders, such as email, SMS about the updated list being uploaded in the website.)

L. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.**Code- Excl12**

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

N. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.**Code- Excl14**

O. Refractive Error:Code- Excl15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

P. Unproven Treatments: Code- Excl16

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

Q. Sterility and Infertility: Code- Excl17

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

R. Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

S. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

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T. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

U. Any expenses incurred on OPD treatment unless covered under the policy.

V. Treatment taken outside the geographical limits of India

X. Maternity expenses where maternity cover is opted:The benefits will not be available for any condition(s) as defined in the Policy, until 9 months since inception of the first Policy with the Company. In all other cases where maternity benefit cover is not opted, all claims directly or indirectly related to maternity stands excluded always.

XIII. <u>Conditions to be fulfilled by the Insured / Insured person.</u> (*This list is not exhaustive. For detailed conditions see the Policy)*

1. Premium payable under this Policy shall be payable in advance.
2. Completely and duly filled and signed proposal form Supporting Medical papers, previous policy copies, IRDAI portability form as applicable
3. Pre- Policy Check-up as per the grid
4. The Insured/Insured Person is required to ensure there is no misrepresentation, misdescription or nondisclosure of any material fact.
5. The Insured /Insured Person shall ensure due observance and fulfillment of the terms, conditions and endorsements on the Policy.
6. Every notice and communication to the Company shall be in writing addressed to the Policy issuing office of the Company.
7. Upon the happening of any event giving rise or likely to give rise to a claim under the Policy, the Insured /Insured Person shall -
   a. give immediate notice to the Third Party Administrator (TPA) named in the Schedule to the Policy, by calling the toll free number as specified therein or by sending written communication to the address of the TPA shown in the Schedule with all available information.
   b. deliver to the TPA at their own expenses within 30 days of the Insured's/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.
   c. submit, if so required, to examination by a Medical Practitioner authorized by the Company.

<u>XIV. Terms of Renewal:</u>

<u>1. Maximum Age:</u>

The Company offers life-long renewal unless the Insured Person or any one acting on behalf of an Insured Person has acted in an improper, dishonest or fraudulent manner or has made misrepresentation in relation to this policy or the Policy poses a moral hazard.

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2. Renewal Premium:

The premium for renewal will be applicable as per the premium chart based on age and company will not load the premium for any adverse claims experience of particular insured.

The Company may change the renewal premium and/or benefits payable subject to approval from regulator (IRDA) and inform the same to the Insured at least 3 months prior to the date of revision and/ or modification or renewal

3. Sum Insured Enhancement:

- The Insured member can apply for enhancement of Sum Insured at the time of renewal by submitting a duly filled fresh Proposal Form to the Company.
- The acceptance of enhancement of Sum Insured would be at the discretion of the Company, based on the health condition of the Insured members, claim history and subject to acceptance by the Company post underwriting.
- The enhancement can be made subject to no claim in the previous policies and Good Health Declaration.
- Please note that medical examination would be required for enhancement of Sum Insured in respect of persons beyond 45 years and in respect of people of lesser age but having medical problems.
- All waiting periods as defined in the Policy shall apply afresh for this enhanced Sum Insured from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy in respect of such increased Sum Insured.

4. 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

5. **Withdrawal of Policy**

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

6. **Renewal of Policy :** The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

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iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days (Note to insurers: Insurer to specify grace period as per product design) to maintain continuity of benefits withoutbreak in policy. Coverage is not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

XV: Premium Rates

- As per the Premium Chart enclosed
- The premium under individual coverage will be charged on the completed age of the individual insured member
- The premium under family floater coverage will be charged on the completed age of the eldest insured member
- Premium rates can be revised subject to approval from the IRDA

XVI. Termination/ Cancellation:

i. The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

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%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

XVII: 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) - - **1800-103-2292**
- Login to the website of the Insurance Company and intimate the claim - http://www.bharti-axagi.co.in/contact-us
- Send an email to the TPA/Company - customer.service@bharti-axagi.co.in
  Post/courier to TPA/Company - Claims, Bharti AXA General Insurance Company Limited spectrum Tower, 3rd flr, Chincholi Bunder Rd, Rajan Pada, Mindspace, Malad West, Mumbai, Maharashtra 400064

- Directly Contacting our Company office but in writing. - Bharti AXA General Insurance Company Limited, Unit No. 1902, 19th Floor, Parinee Crescenzo, 'G' Block, Bandra Kurla Complex, BKC Road, Near MCA Club, Bandra East, Mumbai – 400051, Ph: 1800-103-2292

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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 & given for prompt services.

- Policy number
- Name of the Insured/Covered person
- Contact details
- Nature of the disease, illness or injury
- Name and address, phone number of the attending medical practitioner/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 and on its website

XVIII 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 is provided to the Insured/Covered person along with the Policy .Insured/Covered person can view the updated Hospitals 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 preauthorization 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 after necessary discussion(approval) with insurance company. 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 guide issued along with the Policy, and also will be available in the Hospitals or can be downloaded from the website of the TPA/Company or 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. Such claims will be examined on merits and will be paid on reimbursement basis later if admissible.
- 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/she has received the authorization letter except;
  - If the bill amount is in excess of the Sum insured
  - Non-medical expenses
  - Unrelated treatments
  - Excess/deductible, if any which has to be borne by insured

- The Hospital will receive the payment from Company within 21 days from the date of receipt of complete claim documents.

Reimbursement claims

- All reimbursement claims should be intimated to TPA/Insurance company within 7 days from date of discharge.

- Insured/covered person admitted in a non-network Hospital can send the claim documents to the TPA/ Company for the reimbursement within 30 days from the date of discharge. However Pre and post hospitalization bills can be sent within 15 days from the end of post hospitalization period as specified in the Policy.

XIX Claim Settlement (provision for Penal Interest)

1. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
2. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
3. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
4. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

XX Tax Benefit:

The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act.

XXI Withdrawal of Policy

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

XXII Loading and / or exclusion

We may apply a risk loading on the premium payable and /or exclude an illness / disease (based upon the declarations made in the proposal form, investigation reports and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis / medical condition and an overall risk loading of over 150% per person. These loadings are applied from Commencement Date of the policy including subsequent renewal(s) with us or on the receipt of the request of increase in sum insured (for the increased Sum Insured).
We will inform you about the applicable risk loading and / or exclusion. You need to revert to us in writing with consent and additional premium (if any) and exclusion, within 15 days of such

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information. In case, you neither accept such loading and / or exclusion nor revert to us within 15 days, we shall cancel your application and refund the premium paid within next 7 days. Please note that we will issue policy only after getting your consent.

XXIII CUSTOMER SERVICE – SENIOR CITIZENS

In respect of Senior Citizens, the Company has established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen's channel of the Company for faster attention or speedy disposal of grievance, if any.

- Website: www.bharti-axagi.co.in
- Email: customer.service@bhartiaxa.com
- Phone: 18001032292
- Courier: Any of the Company's Branch office or corporate office

Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday.

XXV Exhibits of Benefits

GENERAL NOTE

- The Proposer can contact the agent / intermediary / any of our offices for a full version of the Policy document.
- This Policy is subject to IRDA - Protection of Policyholder's Interests Regulations, 2002.

14. PROHIBITION OF REBATES (UNDER SECTION 41 OF INSURANCE ACT, 1938)

No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an Insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurers which shall be in conformity with regulations.

Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to ten lakh rupees. .

Disclaimer

This document is only a summary of the product features. The actual benefits available are as described in the Policy, and will be subject to the Policy terms, conditions and exclusions. Please approach your insurance advisor if you require any further information or clarification.

Insurance is the subject matter of the solicitation. For more details you may refer to the Policy wordings which may be collected on request