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.

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.

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

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;
IX. All tumors in the presence of HIV infection.

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.

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:

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 ($PaO_2 < 55mmHg$); 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

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 and HIV 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:

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.

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.

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

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:

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

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

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

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

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

Insured(s) have an option to migrate from their existing health insurance policy at the time of renewal, provided the previous policy has been maintained without any break.

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

i. From another company to Bharti AXA Policy

(i). If the proposed Insured Person was insured continuously and without a break under another Indian retail health insurance Policy with any other Indian General Insurance company or stand-alone Health Insurance Company, it is understood and agreed that:

(1) If Insured person wish to exercise the Portability Benefit, The Company should have received the application for portability and the completed Portability Form with complete documentation at least 45 days before the expiry of the existing insurance Policy.
(2) This benefit is available only at the time of renewal of the existing health insurance Policy.
(3) Portability benefit is available only upto the existing cover. If the proposed Sum Insured is higher than the Sum Insured under the expiring Policy, waiting periods would be applied on the amount of proposed increase in Sum Insured only, in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.
(4) Waiting period credits would be extended to Pre-existing Diseases and time bound exclusions/ waiting periods in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.
(5) The Portability Benefit shall be applied by the Company within 15 days of receiving the completed Application and Portability Form from the proposer subject to the following:
(a) Proposer shall provide the Company all additional documentation and/or information requested;

(b) The proposer shall pay the Company the applicable premium in full;
(c) The Company may, subject to medical underwriting, restrict the terms upon which the Company may offer cover, the decision as to which shall be in the Company sole and absolute discretion; This is subject to Company's Board approved Underwriting policy filed with Authority.
(d) There is no obligation on the Company to insure all Insured Persons or to insure all Insured Persons on the proposed terms, even if the proposer have given all documentation to the Company; This is subject to Company's Board approved Underwriting policy filed with Authority.
(e) The Company shall be received necessary details of medical history and claim history from the previous insurance company for the Insured Person's previous health insurance Policy through the IRDA's web portal.

ii. No additional loading or charges shall be applied by the Company exclusively for porting the policy.

ii. From the Company's existing health insurance policies to this Policy

(i) If the proposed Insured Person was insured continuously and without a break under another health insurance Policy with the Company, it is understood and agreed that:

(1) If the Insured wish to exercise the Portability Benefit, the Company should have received the Insured's application and completed Portability Form before the expiry of the existing insurance Policy;
(2) This benefit is available only at the time of renewal of existing health insurance Policy ;
(3) Portability benefit is available only upto the existing cover. If the proposed Sum Insured is higher than the Sum Insured under the expiring policy, waiting periods would be applied on the amount of proposed increase in Sum Insured only, in accordance with the existing guidelines of the Insurance Regulatory and Development Authority ;
(4) Waiting period credits would be extended to Pre-existing Diseases and time bound exclusions/waiting periods in accordance with the existing guidelines of the Insurance Regulatory and Development Authority ;
(5) The Portability Benefit shall be applied by the Company within 15 days of receiving insured's completed Application and Portability Form subject to the following :
(a) Insured / Insured Person shall give the Company all additional documentation and/or information requests;
(b) Insured / Insured Person pay the Company the applicable premium in full;
(c) The Company may, subject to medical underwriting, restrict the terms upon which the company may offer cover, the decision as to which shall be in Company's sole and absolute discretion; This is subject to Company's Board approved Underwriting policy filed with Authority.
(d) There is no obligation on Company to insure all Insured Persons or to insure all Insured Persons on the proposed terms, even if Insured/ Insured person have given all documentation ; This is subject to Company's Board approved Underwriting policy filed with Authority.

(ii) No additional loading or charges shall be applied by Company exclusively for porting the Policy.

The Company reserves the right to modify or amend the terms and the applicability of the Portability Benefit in accordance with the provisions of the regulations and guidance issued by the Insurance Regulatory and Development Authority as amended from time to time.

XII. Exclusions under the Policy:

The Policy will not cover expenses relating to –

- Pre-existing diseases / illness / injury / conditions - All diseases, illnesses, injuries which are pre-existing when the Policy cover incepts for the first time are excluded from the purview of the Policy.
- Hospitalisation expenses incurred for treatment undertaken for disease or illness and/or for Critical Illness 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. Further in case of a group policy, this exclusion shall not apply in case of the Insured / Insured Person having been covered under any similar Critical Illness insurance policy of any other general insurance company in India for a continuous period of preceding 12 months without any break.
- Circumcision unless necessary for treatment of any critical illness not excluded hereunder.
- Dental treatment unless necessary for treatment of any critical illness not excluded hereunder.
- Birth control procedures, hormone replacement therapy, treatment arising from or traceable to pregnancy, childbirth including caesarean section and voluntary medical termination of pregnancy.
- Any fertility, sub-fertility or assisted conception operation.
- 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.
- Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex syndrome (ARCS) and all diseases / illness / injury caused by and/or related to HIV.
- Vitamins and tonics unless forming part of treatment for disease, illness or injury as certified by the Medical Practitioner,
- Treatment of obesity, general debility, convalescence, run down condition or rest cure, congenital external / internal disease/ illness or defects or anomalies, sterility, venereal disease or intentional self-injury and use of intoxicating drugs/alcohol.
- Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics or similar establishments.
- 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.
- Sex change or treatment, which results from, or is in any way related to, sex change.
- Vaccination and inoculation of any kind.
- Treatment by a family member and self-medication or any treatment that is not scientifically recognized.
- Medical treatment required following any criminal act of the Insured / Insured Person.
- 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, act of terrorism or any terrorist incident.
- Contracting of critical illness whilst performing duties as a serving member of a military or a

police force.

- Prostheses, corrective devices and medical appliances, which are not required intra-operatively or for the treatment of critical illness for which the Insured / Insured Person was hospitalised.
- Any stay in Hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner.
- Treatment of mental disease / illness, stress, psychiatric or psychological disorders.
- Aesthetic treatment, cosmetic surgery and plastic surgery unless necessitated due to or as a part of treatment of critical illness not excluded hereunder.
- Critical illness, 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).
- Critical illness, directly or indirectly, due to Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
- Disease, illness, injury, directly or indirectly, caused by or contributed to by nuclear weapons/materials or radioactive contamination.
- Experimental and unproven treatment.
- 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 critical illness, for which confinement is required at a Hospital/Nursing Home as defined.
- 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.
- 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.
- Costs of donor screening or treatment, unless specifically covered and specified in the Schedule to this Policy.
- Naturopathy or unani treatment.
- Any treatment received outside India.
- Treatment taken from persons not registered as Medical Practitioners under respective medical councils.
- 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.
- 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.

Please refer the policy wordings for complete exclusion list.

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.

<u>2. Renewal Premium:</u>

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

<u>3. Sum Insured Enhancement:</u>

- 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. In the likelihood of this policy being withdrawn in future, the Company will inform the same to the Insured at least 3 months prior to expiry of the policy. Insured will have the option to migrate to other plan under similar health insurance policy at the time of renewal, provided the policy is maintained without a break.

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

SmartHealth Critical Illness Insurance Polic

XVI. Termination/ Cancellation:

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, mis representation, fraud, non disclosure of material facts in which case the the policy shall stand cancelled ab-initio and there will be no refund of premium.
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%

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 - Bharti AXA General Insurance Company Limited, 1st Floor, Ferns Icon, Survey No.28, Doddanekundi, Bangalore – 560037
- Directly Contacting our Company office but in writing. - Bharti AXA General Insurance Company Limited, 1st Floor, Ferns Icon, Survey No.28, Doddanekundi, Bangalore – 560037, Dial :+ 91 80 49123900

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 Service Guarantee

Notwithstanding the above, upon the receipt of all required documents and processing of the claim, tthe claim will be settled 30 days from the date of submission of the said documents. 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 of 2% higher than bank rate (prevailing as on the date of beginning of financial year in which the claim is reviewed) will be paid.

XX Tax Benefit:

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

XXI Withdrawal:

In the likelihood of this policy being withdrawn in future, we will intimate you about the same 90 days prior to expiry of the policy. You will have the option to migrate to similar health insurance policy available with us at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period etc. provided the policy has been maintained without a break as per portability guidelines issued by IRDA.

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

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, both the Company and TPA have established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen's channel of the Company or TPA for faster attention or speedy disposal of grievance, if any.

- Website : www.bharti-axagi.co.in
- Email : customerservice@bharti-axagi.co.in
- Phone : 080-49123900
- 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

Smart Health Critical Illness Policy Benefit (

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