Activ Care- Policy Terms and Conditions

Section A. PREAMBLE

This Policy has been issued on the basis of the Disclosure to information Norm, including the information provided by You in respect of the Insured Persons in the Proposal Form, any application for insurance cover in respect of any Insured Person and any other information or details submitted in relation to the Proposal Form. This Policy is a contract of insurance between You and Us which is subject to the receipt of premium in full and accepted by Us in respect of the Insured Persons and the terms, conditions and exclusions as specified in the Policy/ Policy Schedule / Product Benefit Table of this Policy.

Key Notes:
The terms listed in Section D (Definitions) and which have been used elsewhere in the Policy shall have the meaning set out against them in Section D (Definitions), wherever they appear in the Policy.

The Policy Schedule shall specify which of the following covers are in force and available for the Insured Persons under the Policy during the Policy Period.

Section B. BENEFITS UNDER THE POLICY

Section I: Basic Covers:
Benefits under this Section B.I are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and/or the Sub-limit and /or Co-Payment as may be applicable for each Benefit under Section B.I is specified against that Benefit in the Policy Schedule / Product Benefit Table of this Policy. Payment of the Benefit shall be subject to the availability of the Sum Insured and the applicable Sub-limit for that Benefit.

We will indemnify the Reasonable and Customary Charges incurred towards medical treatment taken by the Insured Person during the Policy Period for an Illness, Injury or conditions described in the Benefits below if it is contracted or sustained by an Insured Person during the Policy Period.

All claims must be made in accordance with the procedure set out in Section C.C. Claims paid under this Section will impact the Sum Insured and eligibility for No Claim Bonus.

(a) In-patient Hospitalization:

What is covered

We shall cover the Medical Expenses for one or more of the following arising out of an Insured Person's Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period:

(1) Reasonable and Customary Charges for Room Rent for accommodation in Hospital room and other boarding charges up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy;
(2) ICU Charges;
(3) Operation theatre expenses;
(4) Medical Practitioner's fees, including fees of surgeon, consultants, physicians, specialists and anaesthetists treating the Insured Person;
(5) Qualified Nurses charges;
(6) Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
(7) Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized;
(8) Anaesthesia, blood, oxygen and blood transfusion charges, Cost of Pacemaker, Diagnostic materials and X rays, Dialysis, Chemotherapy, radiotherapy;
(9) Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Conditions

1) The Hospitalization is medically necessary and follows the written advice of a Medical Practitioner.
2) If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule / Product Benefit Table of this Policy, then the Insured Person shall bear a rateable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category to the Room Rent actually incurred.
   (i) For the purpose of this Section "Associated Medical Expenses" shall include - Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioner including surgeon/ anaesthetist/ specialist within the same Hospital where the Insured Person has been admitted. "Associated Medical Expenses" does not include cost of pharmacy and consumables, cost of implants and medical devices and cost of diagnostics.
   (ii) Proportionate deductions are not applicable for ICU charges.
   (iii) Proportionate deductions are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

(b) Pre – hospitalization Medical Expenses:

What is covered

We shall cover on a reimbursement basis, in accordance with the limits specified in the Policy Schedule / Product Benefit Table of this Policy, the Insured Person's Pre-hospitalization Medical Expenses incurred in respect of an Illness or Injury that occurs during the Policy Period.

Conditions

(i) We have accepted a claim for In-patient Hospitalization under Section B (I)(a) or Day Care Treatment under Section B.I.(d) or Domiciliary Hospitalization under section B.I.(e) for the same Illness/Injury;
(ii) The date of admission to Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Illness/ Injury.

(c) Post – hospitalization Medical Expenses:

What is covered

We shall cover on a reimbursement basis, in accordance with the limits specified in the Policy Schedule / Product Benefit Table of this Policy, the Insured Person's Post-hospitalization Medical Expenses incurred following an Illness or Injury that occurs during the Policy Period.

Conditions

(i) We have accepted a claim for In-patient Hospitalization under Section B.I.(a) or Day Care Treatment under Section B.I.(d) or Domiciliary Hospitalization under section B.I.(e) for the same Illness/ Injury;
(ii) The date of discharge from Hospital for the purpose of this Benefit shall be the date of the Insured Person's discharge from Hospital in relation to the same Illness/ Injury.

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(d) Day Care Treatment:

What is covered

We shall cover the Medical Expenses incurred on the Insured Person's Day Care Treatment, up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy, during the Policy Period following an Illness or Injury that occurs during the Policy Period. The list of covered Day Care Treatments is mentioned in Annexure II.

Conditions

(i) The Day Care Treatment is Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
(ii) The Medical Expenses are incurred, including for any procedure which requires a period of specialized observation or care after completion of the procedure undertaken by the Insured Person as Day Care Treatment.

What is not covered

OPD treatment is not covered under this Benefit.

(e) Domiciliary Hospitalization:

What is covered

We shall cover the Medical Expenses incurred for the Insured Person's Domiciliary Hospitalization, up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy, during the Policy Period following an Illness or Injury that occurs during the Policy Period.

Conditions

(i) The Domiciliary Hospitalization continues for at least 3 consecutive days in which case We shall make payment under this Benefit in respect of Medical Expenses incurred from the first day of such Domiciliary Hospitalization;
(ii) The treating Medical Practitioner confirms in writing that Domiciliary Hospitalization was medically necessary and the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital OR the Insured Person satisfies Us that a Hospital bed was unavailable;
(iii) If a claim is accepted under this Benefit, then We shall pay Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses under Section B.I.(b) and Section B.I.(c) respectively for the same Illness/Injury.

What is not covered

We shall not be liable to pay for any claim made under this Benefit in connection with:

(1) Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
(2) Arthritis, gout and rheumatism;
(3) Chronic nephritis and nephritic syndrome;
(4) Diarrhea and all type of dysenteries, including gastroenteritis;
(5) Diabetes mellitus and insipidus;
(6) Epilepsy;
(7) Hypertension;
(8) Psychiatric or psychosomatic disorders of all kinds;
(9) Pyrexia of unknown origin.

(f) Road Ambulance Cover:

What is covered

We shall cover the costs incurred up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy, towards transportation of the Insured Person by road Ambulance to a nearest Hospital from the place of occurrence of an Emergency for treatment, where such Emergency occurs during the Policy Period.

Coverage shall also be provided under the below circumstances, if the Medical Practitioner certifies in writing that:

(i) it is medically necessary to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.
(ii) it is medically necessary to transfer the Insured Person to another Hospital during the course of Hospitalization due to lack of super speciality treatment in the existing Hospital.

Conditions

(i) The Ambulance/ healthcare service provider is duly registered;
(ii) We have accepted a claim for In-patient Hospitalization under Section B.I.(a) above for the same Illness/Injury;

What is not covered

Any expenses in relation to transportation of the Insured Person from Hospital to the Insured Person's residence are not payable under this Benefit.

(g) Organ Donor Expenses:

What is covered

We shall cover the Medical Expenses, up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy, incurred by or in respect of the organ donor, for organ transplant Surgery accepted by Us under Section B.I.(a) solely towards the harvesting of the organ donated.

Conditions

(i) The organ donation conforms to the Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;
(ii) The Insured Person is the recipient of the organ so donated by the organ donor.
(iii) The organ transplant is medically necessary for the Insured Person as certified by a Medical Practitioner;
(iv) Permanent Exclusion mentioned in Section C.B.v.33 does not apply to this Benefit.

What is not covered

(1) Pre-hospitalization Medical Expenses or Post-Hospitalization Medical Expenses of the organ donor.
(2) Screening expenses of the organ donor.
(3) Any other Medical Expenses as a result of the harvesting from the organ donor.
(4) Costs directly or indirectly associated with the acquisition of the donor's organ.
(5) Transplant of any organ/tissue where the transplant is experimental or investigational.
(6) Expenses related to organ transportation or preservation.
(7) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

(h) Reload of Sum Insured:

What is covered

Once in the Policy Year, We shall provide for a reload of the Sum Insured up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy, in case the available Sum Insured which shall be considered to be inclusive of accumulated No Claim Bonus (if any), is insufficient for covering a claim under the Policy as a result of previous claims in that Policy Year. Such reloading of Sum Insured shall be available only once during a Policy Year.

Conditions

(i) A claim shall be admissible under this Benefit only if the claim is admissible under In-patient Hospitalization under Section B.I.(a) or Day Care Treatment under Section B.I.(d).
(ii) The reload of Sum Insured shall not apply to the first claim in the Policy Year.
(iii) The reload of Sum Insured shall be available only for subsequent claims and not in relation to any Illness/ Injury (including its complications) for which a claim has been admitted for the Insured Person during that Policy Year.
(iv) The reload of Sum Insured shall be available only for claims admitted under Section B.I.(a) and Section B.I.(d).
(v) The reloaded Sum Insured shall not be considered while calculating the No Claim Bonus.
(vi) In case of an Individual Policy, reloading of the Sum Insured is available to each Insured Person and can be utilised by Insured Persons who are covered under the Policy.
(vii) In case of a Family Floater Policy, the reload of Sum Insured shall be available once in a Policy Year on a floater basis for all Insured Persons in the family that are covered under the Policy.
(viii) If the reload of Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.
(ix) During a Policy Year, any single claim amount payable, subject to admissibility of claim, shall not exceed the sum of:
  (1) The Sum Insured; and
  (2) No Claim Bonus (if earned)
(x) During a Policy Year, the aggregate of all claims amount payable, subject to admissibility of the claim, shall not exceed the sum of:
  (1) The Sum Insured; and
  (2) No Claim Bonus; and
  (3) The reloaded Sum Insured; and
  (4) HealthReturns™(If earned).

(i) Ayush (In-patient Hospitalization)

What is covered

We shall cover on a reimbursement basis, up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy, towards the Medical Expenses for In-patient Hospitalization incurred with respect to the Insured Person's Ayush Treatment undergone in any AYUSH Hospital.

Conditions

(I) Treatment taken is within India; and
(ii) Permanent Exclusion mentioned in Section C.B.v.13 does not apply to this Benefit.

What is not covered

The Pre-hospitalization Medical Expenses and Post- Hospitalization Medical Expenses related to Ayush Treatment are not covered under this Benefit.

(j) Sublimit for listed illnesses:

We will cover the Medical Expenses arising out of an Insured Person's in-patient Hospitalization for the listed Illness/ conditions and limit as specified in the Policy Schedule / Product Benefit Table.

Conditions

I. The conditions as specified under section B.I.(a) shall apply for this section B.I.(j) as well.
II. The diagnosis is confirmed by a Medical Practitioner and such treatment is taken in a Hospital

(k) Home Treatment:

What is covered:

We shall cover the treatment expenses upto the limits as specified in the Policy Schedule/ Product Benefit Table for the Insured Person's treatment at his/her home for Illnesses / Injuries such as chemotherapy, dengue, gastroenteritis, hepatitis on a cashless basis only availed through our Network Provider / Empanelled Service Providers providing such facility, listed on Our website.

Conditions

(i) Requisite pre-authorisation is obtained from Us for the said Illness/Injury.
(ii) OPD Treatment is not covered under this section
(iii) The same illness is payable as per the conditions specified in Section B.I.(a)
(iv) Insured Person may avail a treatment in a network Hospital under section B.I.(a) in case of Pre-Authorisation is not received by the Insured Person(s) by Us, as per the terms and conditions of section B.I.(a).
(v) The amount, frequency and time period of the home treatment services should be reasonable and supported in agreement by the treating Medical Practitioner and the Insured Person availing the service.
(vi) The maximum number of days , of covered services per Insured Person, for each Policy Year, covered under this section shall not exceed 15 days.
(vii) The condition of the Insured Person must be expected to improve in a reasonable and generally predictable period of time.
(viii) Treatment under this Benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the home treatment plan, in accordance with the condition of the Insured Person.
(ix) We do not assume any liability towards, and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner and/or Network Service Provider / Empanelled Service Provider or in any service under this Benefit or for any consequences of actions taken or not taken in reliance thereon.
(x) The exclusion no. 52 as specified in Annexure I – Non Medical Expenses are waived off to the extent of benefit(s) as specified in this section no. B.I.(k).
(xi) We do not assume any liability towards any additional or incidental charges/expenses, including but not limited to any charges towards breakage, damage, deposit for equipment, and equipment transportation . All such charges/expenses shall be borne by the Insured Person.
(xii) Home Treatment services are provided through Network Service Provider / Empanelled Service Provider in select cities for select treatment procedures only. Please contact Us or refer to Our website for updated list of treatment procedures and cities where Home Treatment service is provided.

Section II: Additional Benefits

The Benefits listed below are in-built Additional Benefits and shall be available under the Policy with applicable Sub-Limits, if any, to all Insured Persons in accordance with the applicable Plan as specified in the Policy Schedule / Product Benefit Table of this Policy.

Benefits under this Section B.II are subject to the terms, conditions and exclusions of this Policy.

Claims under this Section B.II will not impact the Sum Insured or the eligibility for No Claim Bonus.

(l) No Claim Bonus:

What is covered

We shall apply a Cumulative Bonus in the form of No Claim Bonus at such rates as specified in the Policy Schedule/ Product Benefit table of this Policy on the Sum Insured of the expiring Policy as specified for Section B.I in the Policy Schedule on a cumulative basis, provided that the Insured Person(s) has not made any claim under Section B.I in a Policy Year and has successfully Renewed the Policy with Us continuously and without any break. The accumulated No Claim Bonus shall not exceed 50% of the Sum Insured on the Renewed Policy. In the event of a claim impacting the eligibility of a No Claim Bonus, the accumulated No Claim Bonus shall be reduced by 10% of the Sum Insured at the commencement of subsequent Policy Year.

Conditions

(i) If the Policy is a Family Floater Policy, then the No Claim Bonus will accrue only if no claims have been made in respect of all Insured Person(s) in the expiring Policy Year. The No Claim Bonus which is accrued during the claim free Policy Year will only be available to those Insured Persons who were insured in such claim free Policy Year and continue to be Insured Persons in the subsequent Policy Year.

(ii) No Claim Bonus shall not be applied if the Policy is not Renewed with Us by the end of the Grace Period.

(iii) If the Policy Period is two years, No Claim Bonus that has accrued for the first Policy Year will be credited at the end of the first Policy Year and will be available for claims made in the subsequent Policy Year.

(iv) The accumulated No Claim Bonus can be utilised for Benefits covered under Section B.I.

(v) The accumulated No Claim Bonus can be utilised only when Sum Insured has been completely exhausted.

(vi) The No Claim Bonus shall not enhance or be deemed to enhance any condition of this Policy or limits as prescribed in the Policy Schedule and Product Benefit Table of this Policy.

(vii) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated No Claim Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater Policy basis then the No Claim Bonus to be carried forward for credit in such Renewed Policy shall be the lowest accrued amongst all the Insured Persons.

(viii) If the Insured Persons in the expiring Policy are covered on a Family Floater Policy basis and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two Individual Policies, then the No Claim Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.

(ix) If the Sum Insured under the Policy has been increased at the time of Renewal the No Claim Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

(x) The No Claim Bonus is provisional and is subject to revision if a claim is made in respect of the expiring Policy Year, which is notified after the acceptance of Renewal premium. Such awarded No Claim Bonus shall be withdrawn only in respect of the expiring Policy Year in which the claim was admitted.

(m) Domestic Emergency Assistance Services (including Air Ambulance)

What is covered

We will provide the Emergency medical assistance as described below when an Insured Person is travelling, within India for 150 (one hundred and fifty) kilometres or more away from his/her residential address as mentioned in the Policy Schedule.

(1) Emergency Medical Evacuation: When an adequate medical facility is not available in the proximity of the Insured Person, as determined by Our Empanelled Service Provider for providing such Emergency services, the consulting Medical Practitioner and the Medical Practitioner attending to the Insured Person, transportation under appropriate medical supervision will be arranged, through an appropriate mode of transport to the nearest medical facility which is able to provide the required Emergency Care.

(2) Medical Repatriation (Transportation): When medically necessary, as determined by Us and the consulting Medical Practitioner, transportation under medical supervision shall be provided in respect of the Insured Person to the residential address as specified in the Policy Schedule, provided that the Insured Person is medically cleared for travel via a commercial carrier, and provided further that the transportation can be accomplished without compromising the Insured Person's medical condition.

Conditions

i. No claims for reimbursement of expenses incurred for services arranged by Insured Person will be allowed unless agreed by Us or Our authorized representative.

ii. Please call Our call centre with details on the name of the Insured Person and/ or Policyholder and Policy number, on the toll free number specified in the Policy Schedule for availing this Benefit.

What is not covered

We will not provide the foregoing services in the following instances:

(1) Travel undertaken specifically for securing medical treatment.

(2) Injuries resulting from participation in acts of war or insurrection.

(3) Commission of an unlawful act(s).

(4) Attempt at suicide.

(5) Incidents involving the use of drugs unless prescribed by a Medical Practitioner.

(6) Transfer of the Insured Person from one medical facility to another medical facility of similar capabilities which provides a similar level of care.

We will not evacuate or repatriate an Insured Person in the following instances:

(1) Without medical authorization.

(2) With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness which can be treated by local Medical Practitioner and do not prevent the Insured Person from continuing his/her trip or returning home.

(3) With a pregnancy beyond the end of the 28th week and will not evacuate or repatriate a child born while the Insured Person was traveling beyond the 28th week.

(4) With mental or nervous disorders unless Hospitalized.

(n) International Emergency Assistance Services (including Air Ambulance)

What is covered

We will provide the Emergency medical assistance outside India as described below when an Insured Person is travelling 150 (one hundred and fifty) kilometres or more away from his/her residential address as mentioned in the Policy Schedule for a period of less than 90(ninety) days.

(1) Emergency Medical Evacuation: When an adequate medical facility is not available in the proximity of the Insured Person, as determined by Our Empanelled Service Provider for providing such Emergency services, the consulting Medical Practitioner and the Medical Practitioner attending to the Insured Person, transportation under appropriate medical supervision will be arranged, through an appropriate mode of transport to the nearest medical facility which is able to provide the required Emergency Care.

(2) Medical Repatriation (Transportation): When medically necessary, as determined by Us and the consulting Medical Practitioner, transportation under medical supervision shall be provided in respect of the Insured Person to the residential address as specified in the Policy Schedule, provided that the Insured Person is medically cleared for travel via a commercial carrier, and provided further that the transportation can be accomplished without compromising the Insured Person's medical condition.

Conditions

i. No claims for reimbursement of expenses incurred for services arranged by Insured Person will be allowed unless agreed by Us or Our authorized representative.
ii. Please call Our call centre with details on the name of the Insured Person and/ or Policyholder and Policy number, on the toll free number specified in the Policy Schedule for availing this Benefit.

What is not covered

We will not provide the foregoing services in the following instances:

(1) Travel undertaken specifically for securing medical treatment.
(2) Injuries resulting from participation in acts of war or insurrection.
(3) Commission of an unlawful act(s).
(4) Attempt at suicide.
(5) Incidents involving the use of drugs unless prescribed by a Medical Practitioner.
(6) Transfer of the Insured Person from one medical facility to another medical facility of similar capabilities which provides a similar level of care.
(7) Trips exceeding 90 days from residential address without prior notification to Us.

We will not evacuate or repatriate an Insured Person in the following instances:

(1) Without medical authorization.
(2) With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness which can be treated by local Medical Practitioner and do not prevent the Insured Person from continuing his/her trip or returning home.
(3) With a pregnancy beyond the end of the 28th week and will not evacuate or repatriate a child born while the Insured Person was traveling beyond the 28th week.
(4) With mental or nervous disorders unless Hospitalized.

(o) OPD Treatment

What is covered

We will cover the Reasonable and Customary Charges incurred for medically required consultations, visit(s) to a Medical Practitioner who is a qualified doctor and diagnostic tests which are incurred on an out-patient basis up to the limits as specified in the Policy Schedule / Product Benefit Table. Ayush Treatment for OPD shall also be covered under this Benefit.

Conditions

I. These services can be availed at Our Network Provider / Empanelled Service Providers (such as Outpatient clinics or Medical Practitioners who are qualified General Physicians / Diagnostic centers / Pharmacy Stores) on a Cashless basis only.
II. Section C.B.v.18 & 19 of the Permanent Exclusions shall not apply only to the extent of cover under this Benefit.
III. Section C.B.v.13 and C.B.v.14 of the Permanent Exclusions shall not apply only to the extent of cover under this Benefit.
IV. Waiting periods do not apply in respect of this Benefit.
V. Pharmacy expenses are not covered under this Benefit.

Section III: Care Benefits

The Benefits listed below are in-built value added Care Benefits and shall be available to all Insured Persons in accordance with the applicable Plan as specified in the Policy Schedule/ Product Benefit Table. Benefits under this Section are subject to the terms, conditions and exclusions of this Policy.

Claims under this Section III will not impact the Sum Insured or the eligibility for No Claim Bonus

(p) Health Assessment™

What is covered

All Insured Persons in the Policy may avail a Health Assessment™ once in a Policy Year post successful Renewal of their Policy, in accordance with the table below:

List of tests
MER including BP, BMI, HWR and smoking status
Blood sugar
Total Cholesterol

Reference

MER - Medical Examiner's Report stamped and signed
BP – Blood Pressure
BMI - Body Mass Index,
HWR – Hip Waist Ratio

Conditions

I. The Health Assessment™ shall be arranged by Us only on cashless basis at Our Network Providers/ Empanelled Service Providers (such as Diagnostic centres);
II. The Network Provider / Empanelled Service Provider shall be assigned by Us post receiving customer's request to avail this benefit;
III. The Insured Person shall be eligible to avail this Benefit in the manner specified in the Policy Schedule / Product Benefit Table.
IV. Section C.B.v.(Permanent Exclusion-9), is not applicable in respect of coverage under this Benefit.
V. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider / Empanelled Service Providers in relation to the health check-up.
VI. Any tests conducted during PPMC (Pre policy Medical Check-up) and / or Comprehensive Health Check-up (if applicable), would not be considered for any repeat testing under this Benefit in the same Policy Year. However, the report of the same shall be provided to the Insured Person(s), The same may be requested by the Insured Person by calling at our call centre number .
VII. For a Policy Period of 2 years, Health Assessment™ would be available from the 2nd Policy Year onwards for the first Policy Period. For all subsequent Policy Years, the Insured Person(s) is eligible to avail a Health Assessment™ once per Policy Year, subject to the Policy being renewed with Us continuously without any break.

(q) Comprehensive Health Check-up

What is covered

All Insured Person(s) may avail a comprehensive health check-up once in a Policy Year on successful Renewal of the Policy, as specified in Policy Schedule/ Product Benefit Table in accordance with the table below :

List of tests
CBC
C- reactive protein
Hba1c
Lipid Profile
Liver profile
Kidney profile
Urine Routine
PSA for Male
ECG
S Electrolytes

Reference
CBC - Complete Blood Count
ECG – Electrocardiogram,
Hba1c - glycated haemoglobin test
PSA- Prostate-Specific Antigen

Conditions

I. The Comprehensive Health Check-up shall be arranged by Us only on cashless basis at Our Network Providers/ Empanelled Service Providers (such as Diagnostic centres);
II. The Network Provider / Empanelled Service Provider shall be assigned by Us post receiving customer's request to avail this benefit;
III. The Insured Person shall be eligible to avail this benefit as specified in the Policy Schedule / Product Benefit Table every Policy Year.
IV. Section C.B.v (Permanent Exclusion-9), is not applicable in respect of coverage under this Benefit.
V. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider / Empanelled Service Providers in relation to the health check-up.
VI. Any tests conducted during PPMC (Pre policy Medical Check-up) and / or Health Assessment™, would not be considered for repeat testing under this benefit comprehensive Health check-up in the same Policy Year. However, the report of the same shall be provided to the Insured Person(s), The same may be requested by the Insured Person by calling at our call centre number.
VII. For a Policy Period of 2 years, the Comprehensive Health Check-up would be available from the 2nd Policy Year onwards for the first Policy Period. For all subsequent Policy Years the Insured Person(s) is eligible to avail a Comprehensive Health Check-up once in a Policy Year, subject to the Policy being renewed with Us continuously without any break.

(r) Health Coach

Insured person(s) suffering from any one or more of the listed chronic conditions namely Asthma, Hypertension, Hyperlipidemia or Diabetes Mellitus is/are eligible for a health coaching session with Our expert Health Coach. Our Health Coach shall be coaching the Insured Person on better lifestyle management to take care of such chronic condition.

Conditions

a) These coaches shall be available over a telephonic discussion as a call back service. The request for call back may be placed through our toll free number or via E-Mail.
b) Coaching sessions as specified in the Product Benefit Table/Policy Schedule may be availed by the Insured Person during a Policy Year.
c) It is agreed and understood that Our Health Coaches are not providing and shall not be deemed to be providing any Medical Advice. They shall only provide a suggestion for the Insured Person's consideration and it is the Insured Person's sole and absolute choice to follow the suggestion for any health related advice.
d) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this Benefit.

(s) Personal Health Coach

All Insured person(s) are eligible for health coaching session(s) with Our expert health coach over a telephonic conversation. Our Health Coach shall be coaching the Insured Person on the following aspects for a better lifestyle management

1. Listed chronic conditions namely Asthma, Hypertension, Hyperlipidemia or Diabetes Mellitus, in case the Insured Person is suffering from any of the said condition(s).
2. General nutritional and medical counselling.
3. Wellness counselling.

Conditions

a) These coaches shall be available over a telephonic discussion as a call back service. The request for call back may be placed through our toll free number or via E-Mail.
b) It is agreed and understood that Our Health Coaches are not providing and shall not be deemed to be providing any Medical Advice. They shall only provide a suggestion for the Insured Person's consideration and it is the Insured Person's sole and absolute choice to follow the suggestion for any health related advice.
c) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this Benefit

(t) HealthReturns™

An Insured Person can earn HealthReturns™ during the Policy Period by looking after his/her health and being physically active on a regular basis.

How to Earn HealthReturns™
Earned by way of a percentage of Premium through Healthy Heart Score™and Active Dayz™

Step 1 – Complete Health questionnaire & Health Assessment™ (applicable for each individual Insured Person)- This is not applicable for individuals that have undergone pre-Policy medical examination before issuance of the Policy, for the first Policy Year.

(i) Complete the online health questionnaire through Our website or mobile application. If requested, We would assist the Insured Person in completing the questionnaire over a call. The result of this questionnaire would help the Insured Person understand his/her current health status. This is not mandatory to earn HealthReturns™.

(ii) Undergo a Health Assessment™ as specified under Section III (p) that measures MER including BP, BMI, HWR and smoking status, Blood Sugar and Total Cholesterol. Charges for the same shall be borne by Us once in a Policy Year. All tests mentioned as a part of Health Assessment™ shall be conducted together.

Health Assessment™ can be undertaken at Our Network Providers /Empanelled Service Providers on cashless basis. An appointment for the medical examination can be scheduled at a time convenient to the Insured Person by calling Our call centre.

Based on the completed Health Assessment™, the Insured Person's test results will be used to calculate the Healthy Heart Score™. The Healthy Heart Score™ will then be used to identify which category the Insured Person's heart health falls in:

- o Green: low risk of heart disease compared to peers in the same Age and gender group.
- o Amber: moderate risk of heart disease compared to peers in the same Age and gender group – intervention will be beneficial.
- o Red: high risk of heart disease compared to peers in the same Age and gender group – immediate intervention is required.

The Healthy Heart Score™ is valid for 12 months, and will automatically be updated based on latest available test result if another Health Assessment™ is completed.

Charges for Health Assessment™ shall be borne by Us once a Policy Year. In case the Insured Person wants to undergo another Health Assessment™ at Our Network Providers/Empanelled Service Providers, he/she can do so by payment of requisite charges to the Network Providers /Empanelled Service Providers.

Conditions

For Healthy Heart Score™ to be calculated Health Assessment™ needs to be carried out minimum once in Policy Year.

Step 2 – Earn Active Dayz™ by being physically active on an ongoing basis

(i) Active Dayz™ encourages and recognizes all types of exercise/fitness activities by making use of activity tracking apps, devices and visits to the Fitness centre or yoga centres to track and record the activities members engage in.

(ii) One Active Dayz™ can be earned by:
  (1) completing a Fitness centre or yoga centre activity for a minimum of 30 minutes at Our panel of Fitness or yoga centers, OR;
  (2) Recording of steps as per grid in a day (tracked through Our mobile application or a wearable device linked to the Policy number) OR;
  (3) burning 300 calories in one exercise session per day OR;
  (4) participation in a recognized marathon/ walkathon/ cyclothon or a similar activity which offers a completion certificate with timing

(iii) In order to make it easier for the Insured Person to earn HealthReturns™, We provide two fitness assessments per Policy Year. These fitness assessments will measure the Insured Person's cardiovascular endurance, flexibility, strength, height to weight ratio and body fat percentage. The Insured Person will receive fitness assessment results based on his/her measurements.

(iv) The fitness assessment results will be valid for six months and the best of the fitness assessment result and number of Active Dayz™ will be used in a given month to calculate HealthReturns™.

'Active Dayz' can be earned by undertaking any one of the four activities under point (ii) or 'Fitness Assessment' under point (iii).
The Insured Person shall earn HealthReturns™ based on the Healthy Heart Score™, the fitness assessment result and the number of Active Dayz™ recorded. HealthReturns™ is accrued on a monthly basis according to the following grid.

7500 steps daily			Healthy Heart Score™		
No of Active Dayz™ in a calendar month	OR	Fitness Assessment Result*	Red	Amber	Green
13 or more		Level 5	5.00%	10.00%	20.00%
10 – 12		Level 4	3.00%	6.00%	12.00%
07—09		Level 3	2.00%	4.00%	8.00%
4 – 6		Level 2	1.00%	2.00%	4.00%
0 – 3		Level 1	0.00%	0.00%	0.00%

In order to achieve a particular level of HealthReturns™ the Insured Person must achieve either the required number of Active Dayz™ or achieve a level (as shown in table above) under Fitness Assessment.

The grid above is calculated on the Monthly Premium. The Insured Person can earn up to 20% of their Monthly Premium as HealthReturns™ based on the grid above.

All Insured Person(s) in the Policy will be credited with an additional 1% HealthReturns™ annually on successful completion of following conditions

1. Successful completion Health Assessment™ (in case of Standard Plan)/ Comprehensive Health Check-up(in case of Classic and Premier plan) as specified in the Policy Schedule / Product benefit Table and successful generation of Healthy Heart Score™.
2. First Successful interaction in a Policy Year with Health Coach / Personal Health Coach as specified in the Policy Schedule / Product benefit Table.

How it works for an Individual Policy

In case of an Individual Policy, each Insured Person would be tracked separately and shall earn HealthReturns™ based on individual performance as per grid of Healthy Heart ScoreTM and Active Dayz™.

How it works for a Family Floater Policy

In case of a Family Floater Policy, each Insured Person would be tracked separately and shall earn HealthReturns™ based on individual performance as per grid of Healthy Heart Score™ and Active Dayz™. For the purpose of calculating HealthReturns™, We will allocate the overall premium to the adults in the Policy. Weightages for allowed family combinations are as described in the table below.

Family size	Weightage
Self and Spouse	1:1

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Earned HealthReturns™ can be utilized by any covered Insured Person under a Policy.

How can one spend HealthReturns™:

Funds under HealthReturns™ may be utilized towards the following expenses:

(i) In-patient Medical Expenses and Day Care Treatment, provided that the Sum Insured, No Claim Bonus (if any) and Reloaded Sum Insured (if any) are exhausted during the Policy Year as specified in section C.BB.
(ii) Payment of Co-payment (wherever applicable).
(iii) For non-payable claims, in case of an In-patient Hospitalization or Day Care Treatment.
(iv) Non-Medical Expenses listed in Annexure I 'Non-Medical Expenses' that would not otherwise be payable under the Policy.
(v) Out-patient expenses up to the value of accrued funds.
(vi) Ayush Treatments in excess of the limits as specified in Policy Schedule / Product Benefit Table of this Policy.

Alternatively, funds can also be utilized to pay Renewal Premium. Funds earned as HealthReturns™, once earned can be carried forward each month/ each Policy Year (as applicable) and as long as the Policy is Renewed with Us in accordance with the Renewal Terms under the Policy.

Permanent Exclusions and Waiting Periods do not apply under this Benefit.

The claim for accumulated HealthReturns™ can be made a maximum 4 times in a Policy Year. If You /Insured Person wish to know the present value of the funds earned as HealthReturns™, then You may contact Us at our toll free number or through Our website.

(u) Second E-Opinion on major Illnesses

What is covered

If an Insured Person is diagnosed during the Policy Period with any major Illnesses such as Cancer of Specified Severity, Myocardial Infarction (First Heart Attack of specific severity), Open Chest CABG, Open Heart Replacement or Repair of Heart Valves, Kidney Failure Requiring Regular Dialysis, Stroke Resulting in Permanent Symptoms, Major Organ / Bone Marrow Transplant, Permanent Paralysis of Limbs, Multiple Sclerosis with Persisting Symptoms, Coma of Specified Severity, Motor Neuron Disease with Permanent Symptoms, Third Degree Burns, Deafness, Loss of Speech, Aplastic Anaemia, End Stage Liver Failure End Stage Lung Failure, Bacterial Meningitis, Fulminant Hepatitis, Muscular Dystrophy, or any other major Illness accepted by Us at our sole discretion, the Insured Person may at his/her sole discretion choose to avail an E-opinion from Our panel of Medical Practitioners.

Conditions:

It is agreed and understood that the Second E- Opinion will be based only on the information and documentation provided to Us, which will be shared with the Medical Practitioner and is subject to the conditions specified below:

(i) This Benefit can be availed by the Insured Person only once during the Policy Period for the same major Illness.
(ii) It is agreed and understood that the Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained, it is the Insured Person's sole and absolute discretion to follow the suggestion for any advice related to his/her health. .
(iii) Appointments to avail of this Benefit may be availed through Our Website or Our mobile application or through calling Our call centre on the toll free number specified in the Policy Schedule.
(iv) Under this Benefit, We are only providing the Insured Person with access to an E-opinion and We shall not be deemed to substitute the Insured Person's physical visit or consultation to an independent Medical Practitioner.
(v) The E-opinion provided under this Benefit shall be limited to the covered major Illnesses and not be valid for any medico legal purposes.
(vi) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

(v) Health and Wellness discount

The Insured Person(s) may avail discounts primarily on the OPD consultations, Diagnostics and Pharmacy offered through our Network Service Providers and / or Empanelled Service Providers listed on Our website.

Section IV: Optional Care Benefits

The following Optional Care Benefits shall apply only if the premium in respect of the Optional Care Benefits has been received and the Policy Schedule states that the optional cover is in force. The Policy Schedule shall specify which of the following optional care benefits are in force and available for the Insured Persons under the Policy. Benefits under this Section are subject to the terms, conditions and exclusions of this Policy.

The Sum Insured and/or the Sub-limit and /or Co-Payment as may be applicable for each Benefit under Section B.IV is specified against that Benefit in the Policy Schedule / Product Benefit Table of this Policy. Payment of the Benefit shall be subject to the availability of the applicable Sub-Limit for that Benefit.

All claims under this Section must be made in accordance with the procedure set out in SectionC.C. Wherever a claim qualifies under more than one Benefit in Section IV, We shall pay for all such eligible Optional Care Benefits opted and in force. Claims under this Section IV will not impact the Sum Insured or the eligibility for No Claim Bonus.

In case of Individual Policy, each individual Insured Person can opt for any of the below Optional Care Benefits as per their requirements. In case of Family Floater Policy, once selected, the Optional Care Benefits shall apply to all Insured Persons without any individual selection on a floater basis.

(w) Nursing at Home:

If the Illness or Injury suffered (if this Optional Benefit is applicable to the Insured Person along with Section B.I.(a) or B.I.(d)) by the Insured Person requires the Insured Person to be necessarily attended by a Qualified Nurse immediately from the subsequent day to the Insured Person's discharge from Hospital, We shall pay upto the daily payable benefit amount specified in the Policy Schedule/Product Benefit Table for each continuous and completed day of attendance by the Qualified Nurse at the Insured Person's home. This Benefit can be availed through Our Network Providers / Empanelled Service Providers on a Cashless basis, where available.

Conditions:

I. Our maximum liability under this cover shall not exceed the number of days and amount per day as specified in Policy Schedule / Product Benefit Table, commencing the subsequent day of discharge from the Hospital for the same Illness / Injury for which We have accepted claim under Sections B.I.(a) or B.I.(d) of the Insured Person;
II. The treating Medical Practitioner's Prescription must specify that medical services of a Qualified Nurse are required to be provided to the Insured Person at his/her home;
III. We have accepted a claim for In-patient Hospitalization under Section B.I.(a) or Day Care Treatment under Section B.I.(d) for the same Illness/Injury;
IV. Section C.B. v. 18 & 19 of the Permanent Exclusions and exclusion no. 52 as specified in Annexure I – Non Medical Expenses are waived off to the extent of benefit(s) as specified in this section no B(IV)(w)
V. Waiting periods as per Section C.B.i, C.B.ii and C.B.iv applicable from the inception of the start of this optional benefit being opted initially.

(x) Lifestyle support equipment

We shall pay the amount upto the limits as specified in Product Benefit table / Policy Schedule in case the Insured Person necessarily incur cost on the Lifestyle support equipment as specified in Product Benefit table / policy Schedule, if the Insured Person requires the same on the written advice of a Medical Practitioner, immediately from the subsequent day to the Insured Person's discharge from Hospital for the same Injury / Illness suffered by the Insured Person in respect of which We have accepted a Claim under Section B.I.(a) or B.I.(d). This benefit may also be availed through Our Network Provider / Empanelled Service Providers on a Cashless basis, where available.

Conditions:

1. Section C.B.v.24 & 25 of the Permanent Exclusions and exclusion no(4 of List I), (4 of List II), (18 of List I), , (42 & 43 of List I), (48 & 49 of List I) of Annexure I - Non-Medical Expenses are waived off to the extent of benefit(s) as specified in this section no B(IV)(x).
2. These services can be availed at Our Network Provider / Empanelled Service Providers on a Cashless basis, where available.
3. We do not assume any liability towards any loss or damage arising out of or in relation to any equipment or service, provided by Our Network Provider / Empanelled Service Providers.
4. We do not assume any liability towards any additional or incidental charges/expenses, including but not limited to breakage, damage, deposit for equipment, and equipment transportation . All such charges/expenses shall be borne by the Insured Person.
5. Waiting periods as per Section C.B.i, C.B.ii and C.B.iv applicable from the inception of the start of this optional benefit being opted initially.

Documents to be submitted for any Claim under this Benefit:

It is a Condition Precedent to Our liability under this Benefit that the following necessary information and documentation shall be submitted to Us immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

1. Discharge summary of the Hospital furnishing details including the date of admission and date of discharge.
2. Medical advice of medical practitioner furnishing the requirement of the lifestyle support equipment as mentioned in this section.
3. Pre Authorization & Claim form dully Filled & signed by the insured for Cashless & Re-imbursement Claims respectively
4. Original invoice with payment receipt for all lifestyle support equipment's used under this benefit

(y) Portable medical equipment

We shall pay the amount upto the limits as specified in Product Benefit table / Policy Schedule in case the Insured Person necessarily incur cost on the Portable medical equipment as specified in Product Benefit table / policy Schedule, if the Insured Person requires the same on the written advice of a Medical Practitioner, immediately from the subsequent day to the Insured Person's discharge from Hospital for the same Injury / illness suffered by the Insured Person in respect of which We have accepted a Claim under Section B.I(a) or B.I(d). This benefit can be availed through Our Network Provider / Empanelled Service Providers on a Cashless basis, where available.

Conditions:

1. Section C.B.v(24 & 25) of the Permanent Exclusions and exclusion no 5 & 6 of List IV and 35 of List I of Annexure I Non-Medical Expenses are waived off to the extent of benefit(s) as specified in this section no B(IV)(y).
2. These services can be availed at Our Network Provider / Empanelled Service Providers on a Cashless basis, where available.
3. We do not assume any liability towards any loss or damage arising out of or in relation to any equipment or service, provided by Our Network Provider / Empanelled Service Providers.
4. We do not assume any liability towards any additional or incidental charges/expenses, including but not limited to breakage, damage, deposit for equipment, and equipment transportation . All such charges/expenses shall be borne by the Insured Person.
5. Waiting periods as per Section C.B.i, C.B.ii and C.B.iv applicable from the inception of the start of this Optional Benefit being opted initially.

Documents to be submitted for any Claim under this Benefit:

It is a Condition Precedent to Our liability under this Benefit that the following necessary information and documentation shall be submitted to Us immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

1. Discharge summary of the Hospital furnishing details including the date of admission and date of discharge.
2. Medical advice of medical practitioner furnishing the requirement of the listed portable medical equipment.
3. Pre Authorization & Claim form dully Filled & signed by the insured for Cashless & Re-imbursement Claims respectively
4. Original invoice with payment receipt for all portable medical equipment's used under this Benefit.

(z) Advance Health Check-up

What is covered

All Insured Persons in the Policy may avail an advance health check-up once in a Policy Year in accordance with the table below:

List of tests	List of tests
Mammography	ENT check up
PAP smear	OPG (Dental x ray)
Thyroid function test	Vitamin D
TMT (2 D Echo if customer is not able to walk in tread mill)	Vitamin B12
Chest X ray	Calcium
Sonography Abdomen	

Reference
PAP- Papanicolaou
2D ECHO - Two-Dimensional Echocardiography
TMT – Tread Mill Test
ENT – Ear Nose Throat
OPG - Orthopantomogram

Conditions

(i) The health check-ups shall be arranged by Us only on cashless basis at Our Network Providers/ Empanelled Service Providers (such as Diagnostic centres);
(ii) The Network Provider /Empanelled Service Provider shall be assigned by Us post receiving customer's request to avail a health check-up under this Benefit;
(iii) The Insured Person shall be eligible to avail a health check-up upto the limit as specified in the Policy Schedule / Product Benefit Table every Policy Year.
(iv) Section C.B.v (Permanent Exclusion-9), is not applicable in respect of coverage under this Benefit.

(v) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider / Empanelled Service Providers in relation to the health check-up.
(vi) Claims under this Benefit will not impact the Sum Insured or the eligibility for No Claim Bonus
(vii) Any tests conducted during PPMC (Pre policy Medical Check-up) and / or Health Assessment™ and / or Comprehensive Health Check-up, would not be considered for repeat testing under this Benefit for the same Policy Year.

Section V: Optional Covers

The following Optional Covers shall apply only if the premium in respect of the optional cover has been received and the Policy Schedule states that the optional cover is in force. The Policy Schedule shall specify which of the following optional covers are in force and available for the Insured Persons under the Policy.

Benefits under this Section V are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and/or the Sub-Limit and /or Co-Payment as may be applicable for each Benefit under Section B.V is specified against that Benefit in the Policy Schedule / Product Benefit Table of this Policy Payment of the Benefit shall be subject to the availability of the applicable Sub-Limit for that Benefit.

All claims under this Section must be made in accordance with the procedure set out in Section C.C. Wherever a claim qualifies under more than one Benefit in Section V, We shall pay for all such eligible covers opted and in force.

In case of Individual Policy, each individual Insured Person can opt for any of the below Optional Covers as per their requirements. In case of Family Floater Policy, once selected, the Optional Covers shall apply to all Insured Persons without any individual selection on a floater basis.

(aa) Room Upgrade

What is covered

The Insured Person shall be eligible to upgrade the room category eligibility as specified in the Policy Schedule/ Product Benefit Table of the Policy.

(bb) PPN Discount

What is covered

If this option is chosen by the Policyholder on the basis of the conditions provided below, then the Policyholder is entitled for a discount of 10% on the premium.

Conditions

i. If the Insured Person takes Inpatient hospitalization treatment as applicable under section B.I.(a) in a Hospital other than those listed as "Preferred Provider Network", then the Policyholder / Insured Person shall bear a Co-Payment of 15% on each and every claim arising in such regard, which will be in addition to any other Co-Payment applicable under the Policy.
ii. The updated list of Hospitals listed as "Preferred Provider Network" can be referred to on Our website.

Section C. Terms and Conditions

A. Co-payment

Insured Person(s) shall bear a Co-payment per payable claim as specified in Product Benefit Table/Policy Schedule.
In case a Sub-Limit is applicable along with Co-Payment as specified in the Policy Schedule/ Product Benefit Table, the claim payout would be adjudicated in following sequence:
a. Step 1: Co-payment would be first applied on the total admissible claim amount.
b. Step 2: Sub-Limit shall be applied on the amount arrived from the Step 1.

B. Waiting periods and Permanent Exclusions

All waiting periods and permanent exclusions shall apply individually for each Insured Person and claims shall be assessed accordingly. We shall not be liable to make any payment under this Policy directly or indirectly for, caused by or arising out of or howsoever attributable to any of the following:

i. 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.

ii. 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:

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Body System	Illness	Treatment/ Surgery
Eye	Cataract	Cataract Surgery
	Glaucoma	Glaucoma Surgery
	Refractive Error Correction	Correction Surgery
Ear Nose Throat	Sinusitis	Medical & Surgical Treatment
	Rhinitis	Medical & Surgical Treatment
	Tonsillitis & Adenitis	Medical & Surgical Treatment
	Tympanitis & Non Traumatic Perforation	Medical & Surgical Treatment
	Deviated Nasal Septum	Medical & Surgical Treatment
	Otitis Media	Medical & Surgical Treatment
	Adenoiditis	Medical & Surgical Treatment
	Mastoiditis	Medical & Surgical Treatment
	Cholesteatoma	Medical & Surgical Treatment
Gynecology	All Cysts, Mass, Swelling, Lump, Granulomas, Polyps, Fibroids & Benign Tumour of the female genito urinary system	Medical & Surgical treatment
	Polycystic Ovarian Disease	Medical & Surgical treatment
	Uterine Prolapse	Medical & Surgical treatment
	Fibroids (Fibromyoma)	Medical & Surgical treatment
	Breast lumps (excluding Malignant)	Medical & Surgical treatment
	Dysfunctional Uterine Bleeding (DUB)	Medical & Surgical treatment
	Endometriosis	Medical & Surgical treatment
	Menorrhagia	Medical & Surgical treatment
	Pelvic Inflammatory Disease	Medical & Surgical treatment
Orthopedic / Rheumatological	Gout	Medical & Surgical treatment
	Rheumatism, Rheumatoid Arthritis	Medical & Surgical treatment
	Non infective arthritis	Medical & Surgical treatment
	Osteoarthritis	Medical & Surgical treatment
	Osteoporosis	Medical & Surgical treatment
	Prolapse of the intervertebral disc	Medical & Surgical treatment
	Spondilosis, Spondioarthritis, Spondylopathies	Medical & Surgical treatment
	Ankylosing Spondilitis / Spondylopathies	Medical & Surgical treatment
	Psoriatic Arthritis / Arthropathy	Medical & Surgical treatment
	Internal Derangement of Knee / Ligament or Tendon or Meniscus Tear	Medical & Surgical treatment
	Joint Replacement Surgery (48 months waiting period for Standard Plan)	Medical & Surgical treatment
	Non Specific Arthritis	Medical & Surgical treatment
Gastroenterology (Alimentary Canal and related Organs)	Stone in Gall Bladder, Bile duct & other parts of Biliary System	Medical & Surgical treatment
	Cholecystitis	Surgical treatment
	Pancreatitis	Surgical treatment
	Fissure, Fistula in ano, hemorrhoids (piles), Pilonidal Sinus, Ano-rectal & Perianal Abscess	Medical & Surgical treatment
	Rectal Prolapse	Medical & Surgical treatment
	Gastric or Duodenal Erosions or Ulcers, Gastritis,	Medical & Surgical treatment
	Duodenitis & Colitis	Medical & Surgical treatment
	Gastro Esophageal Reflux Disease (GERD)	Medical & Surgical treatment
	Cirrhosis	Medical & Surgical treatment
	Chronic Appendicitis	Surgical treatment
	Appendicular lump, Appendicular abscess	Medical & Surgical treatment
Urogenital (Urinary and Reproductive system	Stones in Urinary system (Stone in the Kidney, Ureter, Urinary Bladder)	Medical & Surgical treatment
	Benign Hypertrophy / Enlargement of Prostate (BHP / BEP)	Medical & Surgical treatment
	Hernia, Hydrocele	Medical & Surgical treatment
	Varicocoele / Spermatocoele	Medical & Surgical treatment
Skin	skin tumour (unless malignant)	Medical & Surgical treatment
	All skin diseases	Medical & Surgical treatment

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General Surgery	Any Swelling, Tumour, Cyst, Nodule, Ulcer, Polyp, Mass, Swelling, Lump, Granulomas, Benign Tumour anywhere in the body (unless malignant)	Medical & Surgical treatment
	Varicose veins, Varicose ulcers	Medical & Surgical treatment
	Internal Congenital Anomaly or internal congenital diseases	Medical & Surgical treatment

If any of the Illness/conditions listed above are Pre-Existing Diseases, then they shall be covered only after the completion of the Pre-Existing Disease Waiting Period described in Section C.B.iv below.

iii. 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 48 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. Genetic Disorders

iv. Pre-Existing Diseases (Code- Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with Us.
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 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

v. Permanent Exclusions:

1. Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, uprising, revolution, insurrection, military or usurped acts, nuclear weapons / materials, chemical and biological weapons, ionizing radiation, contamination by radioactive material or radiation of any kind, nuclear fuel, nuclear waste.
2. 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.
3. Willful or deliberate exposure to danger, intentional self-Injury, participation or involvement in naval, military or air force operation.
4. Hazardous or Adventure sports: (Code- Excl09) - Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or\ scuba diving, hand gliding, sky diving, deep-sea diving.
5. Any Illness/injury/accident due to abuse of intoxicants, smoking cessation programs and the treatment of nicotine addiction, unless prescribed by a Medical Practitioner.
6. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code- Excl12)
7. 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
8. Refractive Error:(Code- Excl15) - Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
9. All routine examinations and preventive health check-ups, except where expressly stated to be covered under the Policy.
10. 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.
11. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment);
12. Change-of-Gender treatments: (Code- Excl07)
    Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
13. Non allopathic treatment, except where expressly stated to be covered under the Policy.
14. Conditions for which treatment could have been done on an outpatient basis without any Hospitalization
15. Investigational treatments, Experimental treatment, or drugs yet under trial, devices and pharmacological regimens.
16. 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.
17. 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.
    Diagnostic expenses means and includes Diagnostic tests/procedures/treatment/consumables
18. 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.

19. Convalescence, cure, sanatorium treatment, private duty nursing, treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification centre, home for the aged, mentally disturbed remodeling clinic or any treatment taken in an establishment which is not a Hospital.
20. Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment); any examinations or testing.
21. Admission for other nutritional and electrolyte supplements unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
22. Hearing aids, spectacles or contact lenses including optometric therapy, multifocal lens
23. Treatment for alopecia, baldness, wigs, or toupees, and all treatment related to the same.
24. Medical supplies including elastic stockings, diabetic test strips, and similar products.
25. Any expenses incurred on prosthesis, corrective devices external durable medical equipment of any kind, like wheelchairs crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.), devices used for ambulatory monitoring of blood pressure, blood sugar, glucometers, nebulizers and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Cost of artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment. Sleep-apnea and other sleep disorders
26. Parkinson disease.
27. External Congenital Anomalies or diseases or defects.
28. Stem cell therapy except Hematopoietic stem cells for bone marrow transplant for haematological conditions) or Surgery, or growth hormone therapy or Hormone Replacement Therapy.
29. Venereal disease, all sexually transmitted disease or Illness including but not limited to HPV, Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
30. "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus) including Opportunistic infections but not limited to any conditions related to or arising out of HIV/AIDS such as ARC (AIDS Related Complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis, Pneumocystis Carinii Pneumoniae etc.
31. Maternity Expenses (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.
32. 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
33. Expenses for organ donor screening, and to the extent provided for the treatment of the donor (including Surgery to remove organs from a donor in the case of transplant Surgery).
34. Admission for Organ Transplant but not compliant under the Transplantation of Human Organs Act, 1994 as amended from time to time.
35. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.
36. Dentures, implants and artificial teeth, Dental Treatment and Surgery of any kind, unless requiring Hospitalization due to an Accident.
37. Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose.
38. Treatment for all kind of magnetic therapy, Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy, KTP Laser Surgeries, cyber knife treatment, Femto laser surgeries, SMILE surgery for vision correction, bioabsorbable stents, bioabsorbable valves, bioabsorbable implants, chondrocyte implantation,immunotherapy, intra vitreal injections & implants, chelation therapy, use of Infliximab, rituximab, avastin, lucentis, Ozurdex, immunomodulators & similar drugs.
39. Expenses which are medically not necessary such as items of personal comfort and convenience including but not limited to television (if specifically charged), charges for access to telephone and telephone calls (if specifically charged), food stuffs (save for patient's diet), cosmetics, hygiene articles, body care products and bath additives, barber expenses, beauty service, guest service as well as similar incidental services and supplies, vitamins and tonics unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim. Non-Medical Expenses including but not limited to RMO, CMO, DMO charges, surcharges, night charges, service charges levied by the Hospital under any head as specified in the Annexure I for Non- Medical Expenses and on Our website www.adityabirlahealth.com/healthinsurance.
40. Treatment taken from a person not falling within the scope of definition of registered Medical Practitioner with any state medical council/ medical council of India.
41. Treatment charges or fees charged by any Medical Practitioner acting outside the scope of license or registration granted to him by any medical council.
42. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's immediate family or stays with him in the same residence, except if pre-approved by Us.
43. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.
44. 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)
45. Administrative charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, bio-medical, linen, documentation and filing, including MRD charges (medical records department charges).
46. Treatment taken outside India
47. Use of Radio Frequency (RF) probe for ablation or other procedure unless specifically approved by Us in writing in advance.
48. Excluded Providers: (Code- Excl11)
    Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer as per Annexure IV of this policy and as disclosed in website (www.adityabirlahealth.com/healthinsurance) / 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
49. 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)
50. General debility or exhaustion ("rundown condition").
51. In respect of the existing diseases, disclosed by the insured and mentioned in the Policy Schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

C. Claims Administration & Process

The fulfillment of the terms and conditions of this Policy (including payment of premium in full and on time) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the following in relation to claims, shall be conditions precedent to admission of Our liability under this Policy:

(1) On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed.

(2) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
(3) We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

I. Claims Procedure

On the occurrence or the discovery of any Illness or Injury that may give rise to a claim under this Policy, then as a Condition Precedent to Our liability under the Policy the following procedure shall be complied with:

a. For Availing Cashless Facility

i. Cashless Facilities can be availed only at Our Network Providers/ Empaneled Service Providers. The complete list of Network Providers and Empaneled Service Providers is available on Our website and at Our branches and can also be obtained by contacting Us over the telephone.
ii. We reserve the right to modify, add or restrict any Network Provider/ Empaneled Service Provider for Cashless Facilities at Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers.

b. Process for Obtaining Pre-Authorization for Planned Treatment:

(i) We must be contacted to pre-authorize Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Each request for pre-authorization must be accompanied with all the following details:
(1) The health card issued by Us to the Insured Person, along with the Insured Person's KYC documents.
(2) The Policy Number;
(3) Name of the Policyholder;
(4) Name and address of Insured Person in respect of whom the request is being made;
(5) Nature of the Illness/Injury and the treatment/Surgery required;
(6) Name and address of the attending Medical Practitioner;
(7) Hospital where treatment/Surgery is proposed to be taken;
(8) Proposed date of admission.
(ii) If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.
(iii) When We have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.
(iv) The Authorization letter shall be issued to the Network Provider within 24 hours of receiving the complete information.

c. Process to be followed for Availing Cashless Facilities in Emergencies:

(I) We must be contacted to pre-authorize Cashless Facility within 24 hours of the Insured Person's Hospitalization if the Insured Person has been Hospitalized in an Emergency. Each request for pre-authorization must be accompanied with all the following details:
(1) The health card issued by Us to the Insured Person, along with the Insured Person's KYC documents.
(2) The Policy Number;
(3) Name of the Policyholder;
(4) Name and address of Insured Person in respect of whom the request is being made;
(5) Nature of the Illness/Injury and the treatment/Surgery required;
(6) Name and address of the attending Medical Practitioner;
(7) Hospital where treatment/Surgery is to be taken;
(8) Date of admission.
(ii) If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.
(iii) When We have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.
(iv) Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, Hospital and locations, match with the details of the actual treatment received. For Hospitalization where Cashless Facility is pre-authorized by Us, We will make the payment of the amounts assessed to be due directly to the Network Provider.
(v) The Authorization letter shall be issued to the Network Provider within 24 hours of receiving the complete information.

d. For Reimbursement Claims:

(i) For all claims for which Cashless Facilities have not been pre-authorized or for which treatment has not been taken at a Network Provider, We shall be given written notice of the claim along with the following details within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier:
(1) The Policy Number;
(2) Name of the Policyholder;
(3) Name and address of the Insured Person in respect of whom the request is being made;
(4) Health Card, Photo ID, KYC documents
(5) Nature of Illness or Injury and the treatment/Surgery taken;
(6) Name and address of the attending Medical Practitioner;
(7) Hospital where treatment/Surgery was taken;
(8) Date of admission and date of discharge;
(9) Any other information that may be relevant to the Illness/ Injury/ Hospitalization
(ii) If the claim is not notified to Us within the earlier of 48 hours of the Insured Person's admission to the Hospital or before the Insured Person's discharge from the Hospital, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

II. Claims Documentation:

We shall be provided the following necessary information and documentation in respect of all Claims at Your/Insured Person's expense within 30 days of the Insured Person's discharge from Hospital:

(i) Claims for Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses to be submitted to Us within 30 days of the completion of the post Hospitalization treatment.

(ii) For those claims for which the use of Cashless Facility has been authorised, We will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:
(1) Duly signed, stamped and completed Claim Form
(2) Photo ID & Age Proof
(3) Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents)
(4) Copy of the Network Provider's Registration Certificate / Copy of Form C in case of Hospitalization
(5) Original Discharge Card / Day Care Summary / Transfer Summary
(6) Original final Hospital Bill with all original deposit and final payment receipt
(7) Original invoice with payment receipt and implant stickers for all implants used during surgeries i.e. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery.
(8) All previous consultation papers indicating history and treatment details for current ailment
(9) All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription and invoice / bill with receipt from diagnostic center
(10) All original medicine / pharmacy bills along with Medical Practitioner's prescription
(11) MLC / FIR Copy – in Accidental cases only
(12) Copy of Death Summary and copy of Death Certificate (in death claims only)
(13) Pre and Post-Operative Imaging reports – in Accidental cases only
(14) Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress
(15) Original invoice for Vaccination and payment receipt
(16) KYC documents in accordance with the provisions of the regulations, circulars and guidelines issued by the IRDAI with respect to KYC from time to time.
(17) As per terms of IRDAI Circular ref: IRDA/SDD/GDL/CIR/020/02/2013 dated 08.02.2013, KYC shall be performed for the claims cases where the payment to the claimant is above Rs. 1 lakh or such revised limit as may be prescribed by the Authority from time to time in this regard.

Additional documents in case of below covers

In case of Multiple Policy claims:
- Photocopy of entire claim document duly attested by previous Insurer or TPA
- Original payment receipts for expenses not claimed/settled by previous insurer
- Discharge voucher/settlement letter by previous insurer

Road Ambulance Cover:
- Photocopy of discharge card
- Original Ambulance invoice & paid receipt

(iii) For acceptance of claims in electronic mode, the documents shall be submitted in such form and manner as may be specified by Us.

III. Claim Settlement (provision for Penal Interest)

i. 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.
ii. 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.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. 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.

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

IV. Claims Assessment & Repudiation:

For details on the claims process or assistance during the process, You may contact Us at Our call centre on the toll free number specified in the Policy Schedule or through the website. In addition, We will keep You informed of the claim status and explain requirement of documents. Such means of communication shall include but not be limited to mediums such as letters, email, SMS messages, and information on Our Website.

D. 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 IRDAI 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 IRDAI guidelines on portability.
For Detailed Guidelines on portability, kindly refer the link https://www.adityabirlacapital.com/healthinsurance/#!/homepage

E. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.
For Detailed Guidelines on migration, kindly refer the link https://www.adityabirlacapital.com/healthinsurance/#!/homepage

E. 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 (30 days in case of contracts with a term of 3 years, offered over distance marketing mode) 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;

G. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

H. Material Change

Material information to be disclosed includes every matter that You are aware of, or could reasonably be expected to know, that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk of insurance. You must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, or endorsement of the contract. The Policy terms and conditions shall not be altered.

I. Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective or valid unless approved in writing by Us, which approval shall be evidenced by a written endorsement, signed and stamped by Us.

J. No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder/ Insured Person which is in Our possession and not specifically informed by the Policyholder / Insured Person shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

K. Multiple Policies

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

L. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly. However, such special provisions will not be in form of permanent exclusion.

M. Records to be maintained

You or the Insured Person, as the case may be shall keep an accurate record containing all relevant medical records and shall allow Us or Our representative(s) to inspect such records. You or the Insured Person as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Period and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy.

N. Cancellation (other than Free Look Cancellation)

1. Cancellation by You

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

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.

In force Period-Up to	1 Year	2 Year
1 Month	75.00%	85.00%
3 months	50.00%	75.00%
6 months	25.00%	60.00%
12 months	NIL	50.00%
15 months		30.00%
18 months		20.00%
24 months		NIL

2. Automatic Cancellation:

a. Individual Policy:

The Policy shall automatically terminate on the death of all Insured Persons.

b. Family Policy

The Policy shall automatically terminate in the event of the death of all the Insured Persons.

c. Refund:

A refund in accordance with the grid above shall be payable if there is an automatic cancellation of the Policy provided that no claim has been filed under the Policy by or on behalf of any Insured Person.

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3. Cancellation by Us:

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.

4. Treatment of HealthReturns™ on Cancellation

All coverage, benefits, earning on HealthReturns™, shall automatically lapse upon cancellation of the Policy. However, any unclaimed and accrued HealthReturns™ (from previous Policy Year/ month) shall be available for a claim over the next 12 month period from the date of cancellation/termination, except if the policy has been cancelled as per section M (3) - Cancellation by Us.

O. Endorsements

The Policy shall allow the following endorsements during the Policy Period. Any request for endorsement must be made by You in writing along with the mandatory documents. Any endorsement would be effective from the date of the request as received from You, or the date of receipt of premium, whichever is later except in the case of date of birth and gender correction in which the endorsement effective date will be the Policy Start Date or the date of Renewal.

(i) Non-Financial Endorsements – which do not affect the premium.
- (1) Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)
- (2) Rectification in gender of the Proposer/ Insured Person (if this does not impact the premium) *
- (3) Rectification in relationship of the Insured Person with the Proposer
- (4) Rectification of date of birth of the Insured Person (if this does not impact the premium) *
- (5) Change in the correspondence address of the Proposer
- (6) Change/Updation in the contact details viz., Phone No., E-mail Id, alternate contact address of the Proposer etc.
- (7) Change in Nominee Details
- (8) Updation of PAN/passport/EIA/CKYC No.
- (9) Change in Height, weight, marital status (if this does not impact the premium) *
- (10) Change in bank details
- (11) Change in educational qualification
- (12) Change in occupation
- (13) Change in Nationality
- (14) Others

* These endorsements, if impact the premium, and if accepted, shall be effective from the Start Date of the Policy.

(ii) Financial Endorsements – which result in alteration in premium.
- (1) Addition of Insured Person^ (newly wedded spouse)
- (2) Deletion of Insured Person on death or separation or Policyholder/Insured Person leaving India
- (3) Change in Age/date of birth*
- (4) Change in Height, weight*
- (5) Others

* These endorsements, if impact the premium, and if accepted, shall be effective from the Start Date of the Policy.

^ The Policyholder should provide a fresh application in a proposal form along with marriage certificate as the case may be for addition of Insured person.

All endorsement requests may be assessed by Us and if required additional information/documents may be requested.

P. Grace Period

The Policy may be Renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the expiry date of the Policy and in no case later than the Grace Period of 30 days from the expiry date. We shall not be liable to pay for any claim arising out of an Illness/Injury/ Accident that occurred during the Grace Period. The provisions of Section 64VB of the Insurance Act 1938 shall be applicable. All policies Renewed within the Grace Period shall be eligible for continuity of cover. If the Policy is not Renewed within the Grace Period then We may agree to issue a fresh Policy subject to Our underwriting guidelines and no continuity of benefits shall be available from the expired Policy.

Q. 1. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavour 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.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience

2. Other Renewal Terms

(i) We shall not be liable for any claim arising out of an ailment suffered or Hospitalization commencing or Illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy and such disease/Illness/condition shall be treated as a Pre-Existing Disease.
(ii) Any unutilised funds under HealthReturns™ (from the previous Policy Year/ month) will be available for claims during the Grace Period.
(iii) You shall not be able to earn HealthReturns™ during the Grace Period.
(iv) In case the Policy is not renewed before the end of the Grace Period, any unutilized funds under HealthReturns™ shall be available for a claim as up to a period of 12 months from the date of expiry of the Policy.
(v) If the Insured Persons in the expiring Policy are covered in an Individual Policy, and such expiring Policy has been Renewed with Us on a Family Floater Policy basis then the accumulated amount under HealthReturns™ that will be carried forward in such Renewed Policy shall be the total of all the Insured Persons moving out and shall be maintained on an Individual Policy basis.
(vi) If the Insured Persons in the expiring Policy are in a Family Floater Policy and such Insured Persons renew their expiring Policy with Us by splitting the Sum Insured in to two Individual Policies then the accumulated amount under HealthReturns™ shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
(vii) Alterations like increase/ decrease in Sum Insured or Change in Plan/Product, addition/deletion of Insured Persons (Marriage or Death) will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the Proposal Form before the expiry of the Policy. We reserve Our right to carry out underwriting in relation to acceptance of request for changes on Renewal. The terms and conditions of the existing Policy will not be altered.
(viii) Any Sum insured enhancement at the time of renewal would be applicable only up to maximum entry age under the product.
(ix) Any enhanced Sum Insured during any Policy Renewals will not be available for an Illness, disease, Injury already contracted under the preceding Policy Periods. All waiting periods as specified in the Policy shall apply afresh for this enhanced limit from the effective date of such enhancement.
(x) Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned in the Policy Schedule shall be waived only up to the lowest Sum Insured as applicable to the relevant waiting periods of the Plan in force.

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(xi) Where an Insured Person is added to this Policy, either by way of endorsement, all waiting periods under Section C.B will be applicable c onsidering such Policy Year as the first year of Policy with Us with respect to the Insured Person.
(xii) Applicable No Claim Bonus shall be accrued on each Renewal as per eligibility under the plan in force.

3. 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.

4. Possibility of Revision of Terms of the Policy Including the Premium Rates
   The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

R. Communications & Notices

Any communication or notice or instruction under this Policy shall be in writing and will be sent to:
(i) The Policyholder's, at the address/ E-mail ID as specified in the Policy Schedule/Proposal form or provided to Us by the Policyholder / Insured Person
(ii) To Us, at the address specified in the Schedule.
(iii) No insurance agents, brokers, other person or entity is authorised to receive any notice on the behalf of Us unless explicitly stated in writing by Us.

S. Electronic Transactions

The Policyholder and the Insured agree to adhere and comply with all such terms and conditions of electronic transactions as We may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of Us, for and in respect of the Policy or its terms, or Our other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with Our terms and conditions for such facilities, as may be prescribed from time to time.
Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Policyholder. A voice recording in case of tele-sales or other evidence for sales through the Internet shall be maintained and such consent shall be subsequently validated / confirmed by the Policyholder.

T. Policy Dispute

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

U. Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

V. Moratorium Period

After completion of eight continuous years under this Policy, no look back would be applied. This period of eight years is called as 'Moratorium Period'. The moratorium would be applicable for the Sums Insured of the first Policy with Us and subsequently completion of eight continuous years would be applicable from date of enhancement of Sum Insured only on the enhanced limits. After the expiry of Moratorium Period, no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the Policy contract. The Policy would however be subject to all limits, sub limits, co-payments as per the terms and conditions of the Policy contract.

W. Redressal of Grievances

In case of a grievance, the Insured Person/ Policyholder can contact Us with the details through:
Our website: adityabirlahealth.com/healthinsurance
Toll Free : 1800 270 7000
Email: customercare.abh@adityabirla.com
Address: Aditya Birla Health Insurance Co. Limited
9th Floor, Tower 1, One Indiabulls Centre, Jupiter Mills Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai 400013.

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at For updated details of grievance officer, refer the link https://www.adityabirlacapital.com/healthinsurance/#!/homepage

For senior citizens, please contact Our respective branch office or call at 1800 270 7000 or write an e- mail at seniorcitizen.abh@adityabirla.com.

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of the Ombudsman offices are provided on Our website and in this Policy at Annexure III.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irdai.gov.in/

X. Assignment

The Policy and the benefits under this Policy may be assigned in whole or in part.

Y. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

Material facts for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

Z. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

AA. Territorial Jurisdiction

All benefits are available in India only (except Section B.II.n), and all claims shall be payable in India in Indian Rupees only.

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BB. Sequence of Sum Insured Utilisation

The utilisation of Sum Insured and limits thereof as applicable across various Benefits shall be as follows

1. Sum Insured
2. Accumulated No Claim Bonus
3. Reload of Sum Insured

In the aforesaid sequence of utilization of Sum Insured, in case insured person has utilized a specific limit or is not eligible for a specific limit, then may choose to utilize from the next available limit in the given sequence as may be applicable.

CC. Premium Payment in instalments

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period of 15 days would be given to pay the instalment premium due for the policy.
ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

DD. Nomination:

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

Section D. DEFINITIONS

The terms and conditions, benefits, exclusions, various procedures and conditions which have been built in to the Policy are to be construed in accordance with the applicable provisions contained in the Policy. The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same and vice versa.

1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Age** or **Aged** means the completed age as on last birthday, and which means completed years as at the Policy Start date.
3. **Any Room** means any category room in a Hospital.
4. **Ambulance** means a road vehicle or aircraft operated by a licenced/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
5. **Annexure** means a document attached and marked as Annexure to this Policy
6. **Ayush Treatment** refers to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
7. An **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a. Central or State Government AYUSH Hospital; or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy;
      or
   c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i. Having at least 5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
8. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization is approved.
9. **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
10. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
11. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
    a. **Internal Congenital Anomaly**
       Congenital anomaly which is not in the visible and accessible parts of the body.
    b. **External Congenital Anomaly**
       Congenital anomaly which is in the visible and accessible parts of the body.
12. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without any associated increase in premium.
13. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
    i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    ii. which would have otherwise required hospitalization of more than 24 hours.

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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14. **Day Care Centre** - means any institution established for day care treatment of illness and / or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under: -
    i) has qualified nursing staff under its employment;
    ii) has qualified medical practitioner/s in charge;
    iii) has fully equipped operation theatre of its own where surgical procedures are carried out;
    iv) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

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

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

    "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

17. **Domiciliary Hospitalization** means medical treatment for an illness/disease/ injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    i) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    ii) the patient takes treatment at home on account of non-availability of room in a hospital.

18. **Emergency** shall mean a serious medical condition or symptom resulting from Injury or Illness which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an Emergency anymore.

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

20. **Empanelled Service Providers** means service provider (Doctor's clinic, Diagnostic centre, Medicine, Drug vendor, medical service provider and Home care treatment provider) enlisted by Us, TPA or jointly by Us and TPA to provide OPD medical services to an insured by a cashless facility.

21. **Family Floater Policy** means a policy named as a Family Floater Policy in the Policy Schedule under which the family members named as Insured Persons in the Policy Schedule are covered. The relationships covered in a Family Floater Policy are as follows:
    I) Self
    ii) legally married spouse as long as they continue to be married

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

23. **Hospital means** any institution established for in- patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act Or complies with all minimum criteria as under:
    i) has qualified nursing staff under its employment round the clock;
    ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    iii) has qualified medical practitioner (s) in charge round the clock;
    iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

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

25. **IRDAI** means the Insurance Regulatory and Development Authority of India.

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

    (a) Acute condition- Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery

    (b) Chronic condition- A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
    1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
    2. it needs ongoing or long- term control or relief of symptoms
    3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
    4. it continues indefinitely
    5. it recurs or is likely to recur

27. **Individual Policy** means a policy named as an Individual Policy in the Policy Schedule under which one or more persons are covered as Insured Persons. The following relationships shall be covered in an Individual policy: Self, legally married spouse as long as they continue to be married,

28. **Intensive Care Unit (ICU)** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

29. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

30. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

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

32. **Insured Person** means the person(s) named in the Policy Schedule who are covered under this Policy and in respect of whom the appropriate premium has been received.

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

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

35. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i) is required for the medical management of the illness or injury suffered by the insured;
    ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
    iii) must have been prescribed by a medical practitioner;
    iv)must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

38. **Monthly Premium** shall mean the applicable annual premium with respect to the Insured Person(s) split in 12 months in equal proportion only for the purpose of calculation of Benefit under this Policy.

39. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

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

41. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

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

43. **Policy** means this Terms & Conditions document, the Proposal Form, Policy Schedule, Add-On Benefit Details (if applicable) and Annexures which form part of the Policy contract including endorsements, as amended from time to time which form part of the Policy contract and shall be read together.

44. **Policy Period** means the period between the start date and the expiry date of the Policy as specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.

45. **Policy Year** means a period of 12 consecutive months commencing from the start date or any anniversary.

46. **Policy Schedule** means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

47. **Pre-Existing Disease (PED)** means any condition, ailment, injury or disease:
    a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement. or
    b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

48. **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

49. **Post-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:
    i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

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

51. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

52. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

53. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time- bound exclusions and for all waiting periods.

54. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

55. **Single Private A/C Room** means a basic (most economical of all accommodation) category of single room in a Hospital with air-conditioning facility where a single patient is accommodated and which has/does not have an attached toilet (lavatory and/or bath).

56. **Shared Room** means a basic (most economical of all accommodation) category of shared room in a Hospital with/without air-conditioning with two or three patient beds.

57. **Start Date of the Policy** means the inception date of the current Policy Period as specified in the Policy Schedule.

58. **Sum Insured** means:
    i) For an Individual Policy, the amount specified in the Policy Schedule against an Insured Person which represents Our maximum, total and cumulative liability for any and all claims arising under any and all Benefits during a Policy Year in respect of that Insured Person.
    ii) For a Family Floater Policy, the amount specified in the Policy Schedule which represents Our maximum, total and cumulative liability for any and all claims arising under any and all Benefits during a Policy Year in respect of any and all Insured Persons.

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

60. **Third Party Administrator (TPA)** means a Company registered with the IRDAI, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.. The updated list of TPAs (along with complete address and contact numbers) shall be available on Our website.

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

62. **We/Our/Us** means Aditya Birla Health Insurance Co. Limited.

63. **You/Your/Policyholder** means the person named in the Policy Schedule as the policyholder and who has concluded this Policy with Us.

Aditya Birla Health Insurance Co. Limited. IRDAI Reg.153. CIN No. U66000MH2015PLC263677.
Product Name: Activ Care, Product UIN: ADIHLIP21062V022021.
Address: 9th Floor, Tower 1, One Indiabulls Centre, Jupiter Mills Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai 400013. Email: care.healthinsurance@adityabirlacapital.com, Website: adityabirlahealthinsurance.com, Telephone: 1800 270 7000, Fax: +91 22 6225 7700. Trademark/Logo Aditya Birla Capital is owned by Aditya Birla Management Corporation Private Limited and Trademark/logo HealthReturns, Healthy Heart Score and Active Dayz are owned by Momentum Metropolitan Life Limited (Formerly known as MMI Group Limited). These trademark/Logos are being used by Aditya Birla Health Insurance Co. Limited under licensed user agreement(s).