Global Health Secure - 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 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. Our maximum, total and cumulative liability in respect of an Insured Person for any and all claims arising under a Benefit during the Policy Period for that Insured Person shall not exceed the Sum Insured/sub-limit specified against the applicable Benefit in the Policy Schedule / Product Benefit Table.

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. This Policy covers only treatment which is planned and scheduled in advance and taken outside India and does not cover any Emergencies occurring or Emergency Care required while the Insured Person is overseas or in India.

All claims paid under this Section will impact the Sum Insured available under the Policy, and must be made in accordance with the procedure set out in Section C.B.

(a) Worldwide Major Illness In-patient Hospitalization (outside India)

What is covered

We will cover the Medical Expenses incurred towards the Insured Person for one or more of the following arising out of an Insured Person's Inpatient Care outside India during the Policy Period caused solely and directly due to a Major Illness that occurs or manifests itself during the Policy Period:

(1) Reasonable and Customary Charges incurred towards the Room Rent of a Hospital room and other boarding charges, up to the sub-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 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 Major Illness for which the Insured Person is Hospitalized.
(8) Anaesthesia, blood, oxygen and blood transfusion charges.
(9) Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.
(10) Medication applied as per the medical prescription issued by the treating Medical Practitioner while the Insured Person is Hospitalized for treatment of a Major Illness.
(11) Medication prescribed for post-operative treatment is covered for up to 30 days from the date the Insured Person has completed the stage of the treatment received out of India and only when this medication is purchased prior to the Insured Person returning to India.

Conditions

(i) The Hospitalization is towards Medically Necessary Treatment, and follows the written advice of a Medical Practitioner.
(ii) For the purpose of this Benefit, the treatment should be taken in a registered Hospital or clinic as per law, rules and/ or regulations applicable to the country where the treatment is taken, and which is a listed Network Provider. For the list of Network Providers, You may please visit Our/Our Empanelled Service Provider's website or contact Us at Our call centre on the toll free number specified in the Policy Schedule.
(iii) Any payment shall be made only on a Cashless Facility basis.
(iv) Requisite pre-authorisation shall be obtained from Us/ Our Empanelled Service Provider for the said Illness/Injury in accordance with the Claims Procedure set out in Section C.B.
(v) The symptoms of the Major Illness first occur or manifest itself during the Policy Period and after completion of the initial waiting period of 30 days, subject to applicability of any waiting periods specified in the Policy Schedule.
(vi) The rate of exchange as published by the Reserve Bank of India (RBI) as on the date of payment to the Hospital shall be used for conversion of amounts not settled in Indian rupee into Indian rupees for calculation of claim payments under this Benefit. If the RBI rates are not published on the date of the Insured Person's discharge from the Hospital, the exchange rate next published by the RBI shall be considered for conversion of any amounts not settled in Indian rupee.
(vii) The Medical Expenses are incurred outside India.
(viii) Permanent Exclusion No. 40 is not applicable in respect of this Benefit.
(ix) No Pre-hospitalisation Medical Expenses are covered under this Benefit.

For the purpose of this Policy, Major Illness shall mean the Illnesses, medical events or Surgical Procedures as specifically defined below:

S. No	Major Illnesses	Definition
1	Cancer Treatment	I. We will be covering Primary Treatment of a malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer including but not limited to leukemia, lymphoma and sarcoma (except cutaneous lymphoma). II. Any In-situ Cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues. III. Any pre-cancerous change in the cells that are cytologically or histologically classified as high grade dysplasia or severe dysplasia IV. The following are excluded – All tumours in the presence of HIV infection.
2	Coronary Artery By-Pass Surgery	I. We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. II. The following are excluded: Angioplasty and/or any other intra-arterial procedures
3	Heart Valve Replacement	I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner. II. The following are excluded: Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.
4	Major Organ Transplantation	I. We will be covering the actual undergoing of a transplant of one of the following human organs: lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner. II. The following are excluded: a) Any transplant when the need for a transplant arises as a consequence of alcoholic liver disease. b) Any transplant when the transplant is conducted as a self-transplant. c) Any transplant when the Insured is a donor for a third-party. d) Any transplants from a dead donor. e) Any organ transplant that involves Stem Cells treatment. f) Where only islets of langerhans are transplanted g) The transplant made possible by the purchase of donor organs. h) Any disease which has been caused by an organ transplant save where the disease in question is qualified as a Major Illnesses covered under the product.
5	Bone Marrow Transplant	We will be covering Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured originating from: a. The Insured (Autologous bone marrow transplant); or b. From a living compatible donor (allogeneic bone marrow transplant).
6	Neurosurgery	We will be covering any I. Surgical intervention of the brain or any other intracranial structures; II. Surgical Treatment of benign solid tumours located in the spinal cord.
7	Pulmonary Artery Graft Surgery	I. We will be covering the undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.
8	Aorta Graft Surgery	I. We will be covering the actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches. II. The following are excluded: a. Surgery performed using only minimally invasive or intra-arterial techniques. b. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.
9	Coronary Artery By-Pass Surgery Post Occurrence of Myocardial Infraction	I. We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures, post the occurrence of myocardial infraction. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. II. The following are excluded: Angioplasty and/or any other intra-arterial procedures

10	Surgical Treatment for Stroke	I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced. II. We will be covering surgical treatment of Stroke limited to; a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy b. Stenting of Intra cranial blood vessels, needed for the treatment of Stroke III. The following are excluded: a. Transient ischemic attacks (TIA) b. Traumatic injury of the brain c. Vascular disease affecting only the eye or optic nerve or vestibular functions.
11	Surgical Treatment for benign Brain Tumour	I. We will be covering surgical treatment of Benign solid brain tumour limited to; a. Surgical Removal of solid brain tumour through Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy b. Embolization of Intra cranial blood vessels, needed for the treatment of solid brain Tumour II. Benign solid brain tumour is defined as a life threatening, non-cancerous tumour in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI. III. This brain tumour must result in at least one of the following and must be confirmed by the relevant medical specialist. a. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or b. Undergone surgical resection or radiation therapy to treat the brain tumour.
12	Lung Transplant Surgery in case of End Stage Lung Disease	I. We will be covering Lung Transplant Surgery due to following cases a. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following: i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and iv. Dyspnea at rest.
13	Kidney Transplant Surgery in case of End Stage Renal Failure	We will be covering Kidney Transplant Surgery due to following cases I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner.
14	Skin Grafting Surgery for Major Burns	I. We will be covering the undergoing of skin transplantation due to accidental major burns where major burns is as defined below. a. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area. II. Skin grafting surgery for Major Burns should be medically required and not aesthetic/cosmetic in nature
15	Surgical Treatment of Coma	I. We will be covering surgical treatment of Coma limited to; a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy II. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following: a. no response to external stimuli continuously for at least 96 hours; b. life support measures are necessary to sustain life; and c. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma. d. The condition has to be confirmed by a specialist Medical Practitioner. III. The following are excluded: Coma resulting directly from alcohol or drug abuse is excluded.
16	Surgery for Pheochromocytoma	I. We will be covering the actual undergoing of surgery to remove the tumour II. Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines and the Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who is an endocrinologist.

(b) Post – hospitalization Medical Expenses:

What is covered

We shall cover the Insured Person's Post-hospitalization Medical Expenses incurred following a Major Illness as specified under Section B.I.(a) that occurs or manifests during the Policy Period on a reimbursement basis, up to the limit specified against this Benefit, for the number of days specified in the Policy Schedule / Product Benefit Table of this Policy.

Conditions

i. We have accepted a claim for In-patient Hospitalization under Section B.I.(a) for the same Major Illness.
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 Major Illness.
iii. Permanent Exclusion no. 45 is not applicable in respect of this Benefit.

(c) Organ Donor Expenses:

What is covered

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

Conditions

(i) The organ donation conforms to the Transplantation of Human Organs Act 1994 as amended from time to time.
(ii) The Insured Person is the recipient of the organ so donated by the organ donor.
(iii) The Insured Person has been advised to undergo an organ transplant based on the Medical Advice of the treating Medical Practitioner.
(iv) Permanent Exclusion no. 32 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) Any costs incurred towards donor screening expenses.
(3) Any other Medical Expenses or treatment incurred by the organ donor 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.

(d) Travel Expenses

What is covered

If We have admitted a claim under Section B.I.(a) in respect of the Insured Person and Our pre-authorization has been obtained , then We/Our Empanelled Service Provider shall arrange the following travel expenses up to the limit specified against this Benefit in the Policy Schedule / Product Benefit Table, for the Insured Person, one accompanying attendant from the Country of Residence and the living donor (only in the case of any organ transplant Surgery accepted by Us) for the same Major Illness:

i. Transportation from the Insured Person's place of residence to the designated airport.
ii. One-time economy class air fare by direct route to the city of treatment and onwards transportation to the designated place of accommodation in the city of treatment or the Hospital.
iii. Transportation from the airport to the Hospital or place of accommodation in the city of treatment.
iv. Transportation from the place of accommodation in the city of treatment or the Hospital to the nearest airport in the city of treatment.
v. One-time economy class air fare by direct route to the city of the Insured Person's permanent address, and onwards transportation to his/her place of residence.

Conditions:

I. We shall be liable to pay an amount only up to the costs of direct route economy class fare (business class, air ambulance or medical stretcher may be provided subject to availability in the international carrier, but only for the Insured Person under written advice of the attending Medical Practitioner due to the severity of his/her medical conditions) as available on the date of the journey.
II. The costs for the accompanying attendant's and/ or living donor's airfare shall be indemnified by Us only if the treating Medical Practitioner has certified in writing that an accompanying attendant and /or living donor must accompany the Insured Person.
III. Permanent Exclusion no. 45 is not applicable in respect of this Benefit.
IV. We/Our Empanelled Service Provider will provide an onward travel date based on the agreement reached with the treating Medical Practitioner and Hospital.
V. We/Our Empanelled Service Provider will arrange the onward travel subject to a ready to fly certificate from the attending Medical Practitioner in the Insured Person's Country of Residence.
VI. We/Our Empanelled Service Provider will arrange the return travel based on the completion of the Medically Necessary Treatment and the agreement with the treating Medical practitioner that the Insured Person is fit to travel.
VII. In the event that the Insured Person changes the dates of travel from those booked and communicated by Us/Our Empanelled Service Provider, You will be liable to compensate Us for all the associated costs of organizing and providing new arrangements, unless the changes are proven to be necessary from a medical standpoint and Our prior approval is obtained in writing.
VIII. This benefit is available on Cashless Facility basis only, unless a prior approval in writing has been taken from Us before making such travel booking.

Documents to be submitted for any Claim under this Benefit

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

I. A certificate from the Medical Practitioner specifying the period of Hospitalization.
II. Discharge summary of the Hospital furnishing details including the date of admission and date of discharge.
III. Original bill and receipt from the carrier indicating the amount paid for the travel.
IV. Payment receipt of any change in the travel booking with the documentation, if Cashless Facility for the same is not provided.
V. Pre Authorization form and Claim form duly filed and signed by the Insured Person for Cashless Facility.

(e) Accommodation Expenses

What is covered

If We have admitted a Claim under Section B.I.(a) and Our pre-authorization has been obtained, then We/Our Empanelled Service Provider shall arrange a reasonable accommodation for the Insured Person and/or accompanying attendant and/or living donor (only in the case of any organ transplant Surgery accepted by Us) in the city of treatment which is not the Insured Person's permanent address as specified in the Policy Schedule, up to the limit specified in the Policy Schedule / Product Benefit Table of this Policy.

Conditions:

I. We/Our Empanelled Service Provider will arrange the accommodation booking dates based on the approved treatment schedule. These dates will be communicated to the Insured Person to allow for sufficient time for the Insured Person to make all the necessary personal arrangements.
II. We/Our Empanelled Service Provider will arrange a checking-out date for the place of accommodation based on the completion of the treatment and the agreement with the treating Medical practitioner that the Insured Person is fit to travel.
III. In the event that the Insured Person changes the dates of travel from those booked and communicated by Us/Our Empanelled Service Provider, You will be liable to compensate Us for all the associated costs of organizing and providing new accommodation arrangements, unless the changes are proven to be necessary from a medical standpoint and Our prior approval is obtained in writing.
IV. The accommodation arrangements will include bookings for a double room or twin bed room in a three or four-star hotel or accommodation category. (The choice of accommodation will always be subject to availability and the proximity to the Hospital or treating Medical Practitioner.)
V. The accommodation arrangements exclude any expenses towards breakfast, meals and incidental costs (not limited to minibar, laundry, personal expenses) at the place of accommodation, and any upgrades to the room.
VI. This benefit is available on Cashless Facility basis only, unless a prior approval in writing has been taken from Us before making such accommodation booking.

Documents to be submitted for any Claim under this Benefit

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

I. A certificate from the Medical Practitioner specifying the period of Hospitalization.
II. Discharge summary of the Hospital furnishing details including the date of admission and date of discharge.
III. Original bill and receipt or letter obtained from the hotel indicating the amount paid for the accommodation.
IV. Payment receipt of extension of hotel booking with the documentation, if Cashless Facility for the same is not provided.
V. Pre Authorization form and Claim form duly filed and signed by the Insured Person for Cashless Facility.

(f) Repatriation of Mortal Remains

What is covered

If the Insured Person dies whilst undergoing treatment which has been pre-authorised by Us/ Our Empanelled Service Provider under Section B.I.(a) in the Policy Period for any of the Major Illnesses, We shall reimburse the costs of repatriation of the mortal remains of the Insured Person up to the limit specified against this Benefit in the Policy Schedule / Product Benefit Table, to the city of his/her permanent address in the Country of Residence, up to an equivalent amount, for a local burial (excluding costs incurred towards buying / procuring a grave) or cremation at the country where death has occurred.

Conditions

(i) This Benefit may also be provided on a Cashless Facility basis, provided that the costs are authorized by Us or Our Empanelled Service Provider in advance.

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 or Our Empanelled Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

I. Copy of the death certificate providing details of the place, date, time, and the circumstances and cause of death.
II. Copy of the post-mortem report/certificate.
III. Documentary proof for expenses incurred towards disposal of the mortal remains.
IV. In case of transportation of the body of the deceased to the city of his/her permanent address in the Country of Residence, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the transportation of the mortal remains of the deceased.
V. Copy of Embalming certificate.

Section II: Additional Benefits

The Benefits listed below are in-built Additional Benefits and shall be available under the Policy 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 made under this Section will not impact the Sum Insured.

(g) International Second E-opinion for Major Illness

What is covered

If an Insured Person is diagnosed with any listed Major Illnesses as specified under Section B.I.(a) during the Policy Period, the Insured Person may at his/her sole discretion choose to avail an e-opinion from Our panel of internationally available Medical Practitioners, provided that.

(1) The Insured on diagnosis of Major Illness should share the following for the e-opinion:
    a) First consultation paper.
    b) Final Diagnosis paper.
    c) Treating doctor certification on final diagnosis.
    d) All investigation reports supporting documents.
    e) Consent Form to collect documents from various source.
    f) Any other relevant documents to ascertain eligibility of claim.
(2) On the basis of the Insured Person's reported medical condition, We/Our Empaneled Service Provider will identify Medical Practitioners from our network.
(3) The Insured Person may choose one of the Medical Practitioners out of the 3 choices given by Us/Our Empaneled Service Provider.
(4) Medical Reports and all other information pertaining to the Insured Person is shared with the chosen Medical Practitioner.
(5) After receipt of all Medical information, a detailed e- opinion from the selected Medical Practitioner would be delivered to the Insured Person as soon as it is available.

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 Our empanelled Medical Practitioners and is subject to the conditions specified below:

(i) 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.
(ii) Appointments to avail of this Additional 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.
(iii) Under this Additional Benefit, We are only providing the Insured Person with access to an e-opinion and such e-opinion shall not be deemed to substitute the Insured Person's physical visit or consultation to an independent Medical Practitioner.
(iv) The e-opinion provided under this Additional Benefit shall be limited to the covered listed Major Illnesses under Section B.I.(a) and not be valid for any medico legal purposes.
(v) 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/ Our Empanelled Service Provider.
(vi) This benefit is available on Cashless Facility basis only.

(h) Visa Documentation Guidance

What is covered

We / Our Empanelled Service Provider shall provide information concerning visa documentation and guidance for overseas travel for the purpose of any Medically Necessary Treatment pre-authorized by Us/ Our Empanelled Service Provider under Section B.I.(a). This assistance shall be provided to the Insured Person at any time, whether or not the Insured Person is travelling or an emergency has occurred. We / Our Empanelled Service Provider shall inform the Insured Person requesting such information that We / Our Empanelled Service Provider is simply communicating the information set forth as per applicable procedure and We / Our Empanelled Service Provider shall specify the source of such information.

We / Our Empanelled Service Provider shall also provide the address, telephone number and hours of opening of the appropriate consulate and embassy worldwide, nearest to the Insured Person.

Conditions

(i) We do not assume any liability towards any loss or damage arising out of or in relation to any rejection of visa by the foreign country
(ii) We do not assume any liability towards any actual or alleged errors in the information provided by us, including any consequence of the Insured Person's actions taken or not taken in reliance thereon.
(iii) Under this Additional Benefit, We are only providing the Insured Person with information concerning visa documentation and this shall not be construed to be a provision of visa or facilitation of the visa process itself, on Our part.

Section C. Terms and Conditions

A. 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 waiting periods:

i. 30-day waiting period: (Code- Excl03)

i. 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.
ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
iii. 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:

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	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
		Medical & Surgical Treatment
	Rectal Prolapse	Medical & Surgical Treatment
	Gastric or Duodenal Erosions or Ulcers, Gastritis, Duodenitis & Colitis	Medical & Surgical Treatment
		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
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.A.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 number of months of continuous coverage after the date of inception of the First Policy with Us, as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.
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 the number of months as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table 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. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code- Excl12)
6. Any Illness / Injury / Accident due to the abuse of intoxicants smoking cessation programs and the treatment of nicotine addiction, unless prescribed by a Medical Practitioner.
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.
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.
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 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 or required intra-operatively. Cost of artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively). Sleep-apnea and other sleep disorders.

26. Any External Congenital Anomalies or diseases or defects.
27. Stem cell therapy or Surgery (except Hematopoietic stem cells for bone marrow transplant for haematological conditions) or Growth hormone therapy or Hormone Replacement Therapy.
28. 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.
29. "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.
30. 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.
31. 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.
32. Expenses for organ donor screening, and to the extent provided for in the treatment of the donor (including Surgery to remove organs from a donor in the case of transplant Surgery).
33. Admission for Organ Transplant but not compliant under the Transplantation of Human Organs Act, 1994 (amended).
34. 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.
35. Dentures, implants and artificial teeth, Dental Treatment and Surgery of any kind, unless requiring Hospitalization due to an Accident.
36. 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.
37. Treatment for 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, bioabsorbable stents, bioabsorbable valves, bioabsorbable implants, use of Infliximab, rituximab, avastin, lucentis.
38. 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 and as specified in the Annexure (B) for Non-Medical Expenses to this Policy, and on Our website www.adityabirlahealth.com/healthinsurance.
39. 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.
40. Treatment charges or fees charged by any Medical Practitioner acting outside the scope of license or registration granted to him by any Medical Council.
41. 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.
42. 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.
43. 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).
44. Administrative charges related to a Hospital stay not expressly specified 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).
45. Treatment taken inside India.
46. Use of Radio Frequency (RF) probe for ablation or other procedure unless specifically approved by Us in writing in advance.
47. General debility or exhaustion ("rundown condition").
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 (C) 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. 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.

B. 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 may be considered 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 Facility can be availed only at Our Network Providers/ Empaneled Service Providers.

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 and Empaneled Service Providers on Our website.

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

(i) We/ Empaneled Service Provider must be contacted to pre-authorise Cashless Facility for planned treatment at the earliest possible prior to the proposed treatment. Each request for pre-authorisation 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) The Insured Person on diagnosis of Major Illness should share the following for e-opinion:
   (I) First consultation paper from treating Medical Practitioner in India.
   (ii) Final Diagnosis paper.
   (iii) Treating doctor certification on final diagnosis.
   (iv) All investigation reports supporting documents.
   (v) Consent Form to collect documents from various source.
   (vi) Any other relevant documents to ascertain eligibility of claim.
8) On the basis of the Insured Person's medical condition, We/ Our Empaneled Service Provider will identify 3 Hospitals from our network.
9) The Insured Person may choose one of the Hospitals/treatment centres out of the 3 choices given by Us/ Our Empaneled Service Provider.
10) Medical Reports and all other information is shared with the chosen Hospital/ Clinic.
11) After the receipt of all medical information, a detailed Medical Opinion from the selected Hospital/ Treatment center would be delivered to You at the earliest.
12) Insured Person must notify Us of the willingness to take the treatment abroad and the country of choice.
13) On receipt of the Insured Person's confirmation of his/her decision to receive treatment abroad at the selected country for treatment, We/ Our Empaneled Service Provider will identify 3 Hospitals from our Network.
14) You may choose one of the Hospitals/ Treatment Centres out of the 3 Choices given by Us/ Our Empaneled Service Provider or you may choose from a fourth option from Our/Empaneled Service Provider's network Hospitals.
15) We will organize the necessary logistical, travel, accommodation and medical arrangements for the correct admission of the Insured Person and will issue a Preliminary Medical Certificate valid only for that Hospital.
16) We will provide coverage only in the indicated Hospital in the Preliminary Medical Certificate. Any expense incurred in a different Hospital from the one specified in the Preliminary Medical Certificate will not be covered.
17) Any expense incurred before the issuance of the Preliminary Medical Certificate will not be covered.
18) The list of recommended Hospitals and the Preliminary Medical Certificate are issued on the basis of the medical condition of the Insured Person at the time of issue of Preliminary Medical Certificate. Since the health condition of the Insured Person may change over time, both documents will have a validity of three months.
19) In the event that the Insured Person does not select a Hospital from the list of recommended Hospital or does not initiate treatment within 3 months of issuance of Preliminary Medical Certificate within 3 months of issue, We on the request of customer shall reinitiate the process of Pre-Authorisation for planned treatment based on the health condition of the Insured Person at that time.
20) Reimbursement of expenses is not available under B.I.(a), B.I.(c), B.I.(d), B.I.(e), as this benefit is meant to cover planned treatment outside India and does not cover Emergencies occurring while the Insured Person is overseas or within India.

(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. For Reimbursement Claims:

(i) For all claims under benefit B.I.(b) and B.I.(f) for which pre-authorization under Cashless Facility has not been accepted 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 72 hours of the Insured Person's admission to the Hospital or within 72 hours of 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 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/Our Empanelled Service Provider will be provided these documents by the Network Provider/ You (as the case may be) 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. invoice in 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) A valid ticket / proof of travel (such as Airline boarding pass) to the location the Insured Person is traveling as a bona fide passenger.
(18) 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.

Ambulance expenses under Section B.I.(d):

- 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:

(a) At Our discretion, We may investigate claims to determine the validity of a claim. This investigation shall be completed at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals/entities that are authorised by Us in writing.
If there are any deficiencies in the necessary claim documents which are not met or are partially met. We will send a maximum of 3 (three) reminders following which We will send a rejection letter or make apart-payment if we have not received the deficiency documents after 45 days from the date of the initial request for such documents.
(b) We may decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if We observe that such a claim is otherwise valid under the Policy. However documents/ details received beyond such period shall be considered, and the delay may be condoned if there are valid reasons for any delay which are proved to be for reasons beyond Insured Person's control.
(c) Payment for reimbursement claims will be made to You. In the unfortunate event of Your death, We will pay the Nominee named in the Policy Schedule or Your legal heirs or legal representatives holding a valid succession certificate.

For details on the claims process or assistance during the process, You may contact the 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.

C. 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

D. 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;

F. 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.

G. 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.

H. Alterations in the Policy

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

I. 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.

J. 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

K. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or the Policy Schedule, 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.

L. 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.

M. 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.

Refund			
In force Period-Up to	1 Year	2 Year	3 Year
1 Month	75.00%	85.00%	90.00%
3 months	50.00%	75.00%	85.00%
6 months	25.00%	60.00%	75.00%
12 months	Nil	50.00%	60.00%
15 months		30.00%	50.00%
18 months		20.00%	35.00%
24 months		Nil	30.00%
30 months			15.00%
30+ months			NIL

2. Automatic Cancellation:
   a. Individual Policy:
      The Policy shall automatically terminate on the death of all Insured Persons.
   b. 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.

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.

N. 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 Start Date or date of any subsequent Renewals of this Policy.

(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/Aadhaar/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^ (or 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 birth certificate / 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.

O. 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 Policy 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.

P. 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 disease/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) Alterations like increase/ decrease in Sum Insured or Change in Plan/Product, addition/deletion of Insured Persons (except due to /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.
(iii) Any Sum insured enhancement at the time of renewal would be applicable only up to maximum entry age under the product.
(iv) 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 below shall apply afresh for this enhanced limit from the effective date of such enhancement.
(v) Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as specified 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.
(vi) Where an Insured Person is added to this Policy, either by way of endorsement, all waiting periods under Section C(A) will be applicable considering such Policy Year as the first year of Policy with Us with respect to the Insured Person.

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.

Q. Communications & Notices

Any communication or notice or instruction under this Policy shall be in writing and will be sent to:

(i) The Policyholder, at the address/ E-mail ID as specified in the Policy Schedule/Proposal form or provided to Us by the Policyholder
(ii) To Us, at the address/E-mail ID 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.

R. Electronic Transactions

The Policyholder agrees to comply with all the terms and conditions of electronic transactions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as 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, in respect of this Policy and claim related details, shall constitute legally binding when done in compliance with Our terms for such facilities.

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 World Wide Web shall be maintained and such consent shall be subsequently validated / confirmed by the Policyholder.

S. Policy Disputes

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.

T. 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.

U. 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 claim under this Policy shall be contestable except for proven fraud and permanent exclusions specified in the Policy. The Policy would however be subject to all limits, sub limits, co-payments as per the terms and conditions of the Policy.

V. Redressal of Grievances
In case of a grievance, the Insured Person/ Policyholder can contact Us with the details through:
Our website: https://www.adityabirlacapital.com/healthinsurance
Toll Free : 1800 270 7000
Email: care.healthinsurance@adityabirlacapital.com
Address/Courier : 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 - 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@adityabirlacapital.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 A.

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

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

X. Disclosure of Information Duty of Disclosure
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)

Y. Territorial Jurisdiction
All benefits are available outside India only [except Section B.I.(b), B.II.(g) and B.II.(h)], and all claims shall be payable in India in Indian Rupees only.

Z. 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.

AA. 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.

BB. 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.

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** is the completed age as on his/her last birthday, and which means completed years as at the Start date.

3. **Ambulance** means a road vehicle operated by a licenced/authorised service provider only, and equipped for the transport and paramedical treatment of the person requiring medical attention.

4. **Annexure** means a document attached and marked as Annexure to this Policy.

5. **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.

6. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

7. **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.

8. **Co-payment** means a cost-sharing requirement under a health insurance policy that provides that the Policyholder/Insured shall bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum Insured.

9. **Country of Residence** means the country in which the Insured Person is currently residing and as specified in the Insured Person's corresponding address as specified in the Policy Schedule which for the purpose of this Policy shall be India.

10. **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.

11. **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:-
    1. has qualified nursing staff under its employment.
    2. has qualified Medical Practitioner/s in charge.
    3. has fully equipped operation theatre of its own where surgical procedures are carried out.
    4. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

12. **Dependent Child** means a child (natural or legally adopted or stepchild), who is financially dependent on You does not have his / her independent source of income, is up to the Age of 25 years.

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

14. **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)

15. **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.

16. **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.

17. **Empanelled Service Provider** means such person or person as may be appointed by Us or enlisted by Us, TPA or jointly by Us and TPA to provide assistance and OPD medical services to the Insured Person by a Cashless Facility available under this Policy. The updated list of Empanelled Service Providers (along with complete contact details) shall be available on Our website.

18. **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.

19. **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.
    Or
    Any equivalent institution established for in- patient care and day care and treatment of Injury or Illness and which has been registered as a Hospital or a clinic with the local authorities as per law rules and/or regulations applicable for the country where the treatment is being taken.

20. **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.

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

22. **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.

23. **Individual Policy** means a policy named as an Individual Policy in the Policy Schedule under which one or more persons may be covered as Insured Persons, if specified to be covered. The following relationships shall be covered in an Individual Policy: Self, legally married spouse as long as they continue to be married, son, daughter, mother, father, brother, sister, mother in-law, father in-law, grandfather, grandmother, grandson, granddaughter, son in-law, daughter in-law, brother in-law, sister in-law, nephew, niece.

24. **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.

25. **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.

26. **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.

27. **Inpatient Care** means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.

28. **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.

29. **Major Illness** means any of the Illnesses, medical events or Surgical Procedures as specifically defined and listed under Section B.I.(a).

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

31. **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.

32. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    1. is required for the medical management of the illness or injury suffered by the Insured.
    2. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity.
    3. must have been prescribed by a Medical Practitioner.
    4. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

33. **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 or the appropriate authority for the same in the relevant jurisdiction, and is thereby entitled to practice medicine within its jurisdiction per the scope of its registration/license.

34. **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.

35. **New Born Baby** means baby born during the Policy Period and is aged upto 90 days.

36. **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.

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

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

39. **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.

40. **Policy** means this terms & conditions document, the Proposal Form, Policy Schedule, Benefit and Additional Benefit details (if applicable) and any 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.

41. **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.

42. **Policy Year** means a period of 12 consecutive months commencing from the Start date or any subsequent Policy anniversary.

43. **Policy Schedule** means Schedule attached to and forming part of this Policy specifying the details of the Insured Persons, the Sum Insured, the Policy Period and the sub-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.

44. **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.

45. **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.

46. **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.

47. **Portability** means, the right accorded to individual health insurance Policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one Insurer to another Insurer.

48. **Qualified Nurse** means a person who holds a valid registration of nursing in the country of treatment, or from the Nursing Council of India or the Nursing Council of any state in India.

49. **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.

50. **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.

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

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

53. **Sum Insured** means 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 Benefit/Additional Benefits during a Policy Year in respect of any and all Insured Persons named in the Policy Schedule.

54. **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.

55. **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.

56. **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.

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

58. **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: Global Health Secure, Product UIN: ADIHLIP21069V022021.
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. For more details on risk factors, terms and conditions please read terms and conditions carefully before concluding a sale. Trademark/Logo Aditya Birla Capital is owned by Aditya Birla Management Corporation Private Limited. These trademark/Logos are being used by Aditya Birla Health Insurance Co. Limited under licensed user agreement(s).