Aditya Birla Health Insurance Company Ltd.

(A part of Aditya Birla Capital Ltd.)

ADITYA BIRLA CAPITAL

PROTECTING INVESTING FINANCING ADVISING

Activ Fit (Young Adult Product) - Prospectus

Section A. Coverage under the Product:

Section I: Basic Covers:

(1) In-patient Hospitalization
(1.a) Modern Treatment
(1.b) HIV / AIDS and STD
(1.c) Mental Care Cover
(2) Daily Cash Benefit (Shared Accommodation)
(3) Day Care Treatment
(4) Pre – Hospitalization Medical Expenses
(5) Post – Hospitalization Medical Expenses
(6.a.) Domiciliary Hospitalization
(6.b.) Home Treatment
(7) Road Ambulance Cover
(8) Organ Donor Expenses
(9) AYUSH Cover
(10) Binge Refill
(11) Maternity Expense

Section II: Additional Benefits

(12) No Claim Bonus
(13) Health Check Up Program
(14) Domestic Emergency Assistance Service

Section III: Value Added Benefits

(15) Health Assessment
(16) HealthReturns™
(17) Mental Health Assessment Program
(18) Upfront Good Health Discount

Section IV: Optional Covers

(19) Super NCB
(20) Travel Protect
(21) Premium Waiver
(22) EMI Protection
(23) Non- Medical Expense Waiver
(24) Reduction in Maternity Waiting
(25) OPD Expense

Activ Fit (Young Adult Product), Product UIN: ADIHLIP22008V012223.

Section I: Basic Covers:

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

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

Claims paid under this Section will impact the Sum Insured and eligibility for No Claim Bonus and Super No Claim Bonus (if opted).

(1) In-patient Hospitalization:

What is covered

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

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

1.a. Modern Treatment coverage

We shall cover the Medical Expenses for the following modern treatment procedures under section A .I. (1). In-Patient Hospitalization or section A. 1.(3) Day Care Treatment arising out of an Insured Person's Hospitalization following an Illness or Injury that's diagnosed during the Policy Period up to the Sum Insured specified in the Policy Schedule / Product Benefit Table of this Policy.

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
b. Balloon Sinuplasty
c. Deep Brain stimulation
d. Oral chemotherapy
e. Immunotherapy - Monoclonal Antibody to be given as injection
f. Intra vitreal injections
g. Robotic surgeries
h. Stereotactic radio surgeries
i. Bronchical Thermoplasty
j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
k. IONM - (Intra Operative Neuro Monitoring)
l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

1.b. HIV / AIDS and STD

We shall cover medical expenses incurred towards treatment taken during In-patient Hospitalisation (section I.1) of the insured person arising out of condition caused by or associated to HIV or HIV related illnesses, including AIDS or AIDS related Complex (ARC) and/or any mutant derivative or variations there of or sexually transmitted diseases (STD) up to the Sum Insured specified in the Policy Schedule / Product Benefit Table of this Policy.

1.c. Mental Care Cover

We shall cover the medical expenses incurred towards treatment taken during In-patient hospitalisation (section I.1) of the insured person arising out of a condition caused by or associated to a medical illness, stress, anxiety, depression or a medical condition impacting mental health of the insured person during the policy period up to the Sum Insured specified in the policy schedule/ product benefit table of this policy.

Conditions:

(i) The Hospitalization of the Insured Person is medically necessary and follows the written advice of a Medical Practitioner.
(ii) If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule / Product Benefit Table of this Policy, then the Insured Person shall bear a rateable proportion of the Room Rent (and the total Associated Medical Expenses, including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category to the Room Rent actually incurred.
(iii) Proportionate deductions are not applicable for ICU charges.
(iv) Such proportionate deductions, if any, will not be applied in respect of the Hospitals which do not follow differential billing, or for those Associated Medical Expenses in respect of which differential billing is not adopted based on the room category.

(2) Daily Cash Benefit (Shared Accommodation)

What is covered

If we have accepted a claim under section I. (1) (In-patient Hospitalization) and you have opted for a shared accommodation during hospitalisation then we shall pay the daily cash benefit specified in the Policy Schedule/Product Benefit Table, for each continuous and completed period of 24 hours of hospitalisation, during the Policy Period for treatment of an Illness/Injury.

What is not covered

Daily Cash Benefit for time spent by the Insured Person in an intensive care unit.

(3) Day Care Treatment

What is covered

We shall cover the Medical Expenses incurred on the Insured Person's Day Care Treatment, up to the Sum Insured as specified in the Policy Schedule / Product Benefit Table of this Policy, during the Policy Period following an Illness/Injury that diagnosed during the Policy Period.

Conditions

(i) The Day Care Treatment is medically necessary treatment and follows the written advice of a Medical Practitioner;
(ii) The medical expenses are incurred, including for any procedure undertaken by an insured person as Day Care Treatment which requires a period of specialized observation or care after completion of the procedure.

What is not covered

(i) OPD treatment is not covered under this Benefit.

(4) Pre – hospitalization Medical Expenses:

What is covered

We shall cover on a reimbursement basis, up to the Sum Insured for the number of days in accordance with the limits specified in the Policy Schedule / Product Benefit Table of this Policy, the Insured Person's Pre-Hospitalization Medical Expenses incurred in respect of an Illness/ Injury that's diagnosed during the Policy Period.

Conditions

(i) We have accepted a claim for In-patient Hospitalization under Section I.(1) or Day Care Treatment under Section I.(3) or Domiciliary Hospitalization under Section I. (6).(a) or Home Treatment I. (6) b. for the same Illness/Injury;
(ii) The date of admission to Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Illness/ Injury.

(5) Post – hospitalization Medical Expenses:

What is covered

We shall cover on a reimbursement basis, up to the Sum Insured for the number of days in accordance with the limits specified in the Policy Schedule / Product Benefit Table of this Policy, the Insured Person's Post-Hospitalization Medical Expenses incurred following an Illness/Injury that's diagnosed during the Policy Period.

Conditions

(i) We have accepted a claim for In-patient Hospitalization under Section I.(1) or Day Care Treatment under Section I.(3) or Domiciliary Hospitalization under Section I.(6).(a) or Home Treatment I. (6).(b) for the same Illness/Injury;
(ii) The date of discharge from Hospital for the purpose of this Benefit shall be the date of the Insured Person's discharge from Hospital in relation to the same Illness/ Injury.

(6) a. Domiciliary Treatment

What is covered

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

Conditions

(i) The Domiciliary Hospitalization continues for at least 3 consecutive days in which case we will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization;
(ii) The treating Medical Practitioner confirms in writing that Domiciliary Hospitalization was medically necessary and the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital OR the Insured Person satisfies Us that a Hospital bed was unavailable;
(iii) If a claim is accepted under this Benefit, then We shall pay Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses under Section I.(4) and Section I.(5) respectively for the same Illness/Injury.

(6) b. Home Treatment

What is covered

We shall cover the treatment expenses up to the limits as specified in the policy schedule/Product Benefit Table of this policy incurred by the insured person towards medically necessary treatment taken at his/her home for illnesses/injuries that's diagnosed during the policy period on cashless basis availed through Our Empanelled home care treatment providers. For the purpose of this section Home Treatment shall means Home Care Treatment means treatment availed by the Insured Person at home, which in normal course would require care and treatment at a hospital but is actually taken at home provided that

a) The Medical practitioner advices the Insured person to undergo treatment at home.
b) There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.
c) Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

Conditions

(i) Requisite pre-authorisation is obtained from our Empanelled homecare treatment provider for the said Illness/Injury.
(ii) OPD Treatment is not covered under this Benefit.
Condition specified in the section C.I.A (Inpatient hospitalization) shall also be applicable for this section f.b(Home Treatment)
(iii) Insured Person may avail a treatment in a network Hospital under Section I. (1) (In-patient hospitalisation) in case that Pre-Authorisation is not received by the Insured Person(s) from Empanelled home care treatment providers, as per the terms and conditions of Section I. (1) (In-patient hospitalisation)
(iv) We do not assume any liability towards, and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner and/or Empanelled homecare treatment provider or in any service under this Benefit or for any consequences of actions taken or not taken in reliance thereon.
(v) The exclusion no. 52 as specified in Annexure I – Non Medical Expenses are waived off to the extent of this Benefit(s) as specified in this Section I.(6).(b).
(vi) We do not assume any liability towards any additional or incidental charges/expenses, including but not limited to any charges towards breakage, damage, deposit for equipment, and equipment transportation. All such charges/expenses shall be borne by the Insured Person.
(vii) The foregoing home treatment services are provided through Empanelled homecare Treatment Provider in selected cities only. Please contact Us or refer to Our website for updated list of cities where home treatment service is provided.

(7) Road Ambulance Cover

What is covered

We shall cover the reasonable and customary charges incurred up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy, towards transportation of the Insured Person by road ambulance for any emergency illness/injury diagnosed during the policy period provided that

(i) The medical condition of the insured person requires immediate ambulance services from the place of occurrence of an Emergency to a nearest Hospital and/or
(ii) From the existing hospital, if the Medical Practitioner certifies in writing that It is medically necessary to transfer the Insured person to another hospital due to lack of super specialist treatment in the existing hospital or to a diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.

Conditions

(i) The Ambulance/ healthcare service provider is duly registered;
(ii) We have accepted a claim for In-patient Hospitalization under Section I.(1) and or (3) above for the same Illness/Injury;

What is not covered

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

(8) Organ Donor Expenses:

What is covered

We shall cover the Medical Expenses, up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy, incurred by or in respect of the organ donor, for an organ transplant Surgery accepted by Us under Section I.(1) solely towards the harvesting of the organ donated.

Conditions

(i) The organ donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;
(ii) The Insured Person is the recipient of the organ so donated by the organ donor;
(iii) The organ transplant is medically necessary for the Insured Person as certified by a Medical Practitioner;

What is not covered

(i) Pre-hospitalization Medical Expenses or Post-Hospitalization Medical Expenses of the organ donor.
(ii) Screening expenses of the organ donor.
(iii) Medical Expenses for treatment or any complication as a result of harvesting from the organ donor.
(iv) Costs associated with the acquisition of the donor's organ.
(v) Expenses related to organ transportation or preservation.

(9) AYUSH Cover

What is covered

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

What is not covered

(i) The Pre-hospitalization Medical Expenses and Post- hospitalization Medical Expenses related to AYUSH Treatments are not covered in this Benefit;
(ii) Outpatient Treatment;
(iii) Treatment taken outside India.

(10) Binge refill

What is covered

If the Policy Sum insured along with accumulated No Claim Bonus (if any), Super No Claim Bonus (if any), is completely exhausted or is insufficient for covering a claim as a result of previous claims than We shall provide for a Refill of the Sum Insured, unlimited times during the Policy Year up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy.

Conditions

(i) A claim shall be admissible under this Benefit only if the claim is admissible under In-patient Hospitalization under Section I.(1) or Day Care Treatment under Section I.(3) or Section I.(9) (AYUSH Cover) or Section I.(6).(a) (Domiciliary Hospitalization) & .(6).(b) Home Treatment or Section I.(8) (Organ Donor Expenses) arising in that Policy Year for any or all Insured Person(s).
(ii) The Refill of Sum Insured shall be available for all subsequent claims also and to any Illness/ Injury (including its complications) for which a claim has been admitted for the Insured Person during that Policy Year
(iii) The Refill of the Sum Insured shall apply to the first claim in the Policy Year
(iv) Our total, maximum liability under a single claim under this Benefit shall not be more than the Sum Insured
(v) The Refill Sum Insured shall not be considered while calculating the No Claim Bonus or the Super No Claim Bonus.
(vi) In case of an Individual Policy, Refill of the Sum Insured is available to each Insured Person and can be utilised by Insured Persons who are covered under the Policy.
(vii) In case of a Family Floater Policy, the refill of Sum Insured shall be available on a floater basis for all Insured Persons in the family that are covered under the Policy.
(viii) If the Refill of Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

(11) Maternity Expense

What is covered

We shall cover Maternity Expenses up to the limit specified in the Policy Schedule / Product Benefit Table of this Policy after a waiting period of 36 months from the inception of the 1st policy where Maternity cover is available & renewed without any break. The coverage under this benefit will be over and above the base policy Sum Insured.

Coverage under this Benefit shall include:

(i) Medical Expenses for a delivery of a child (including caesarean section) or lawful medical termination of pregnancy up to a maximum of 2 events in the lifetime of the insured including
  (a) 2 deliveries (including twins) or
  (b) 2 terminations or
  (c) 1 delivery (including twins) and 1 termination
(ii) Pre or Post - Natal Maternity Expenses;
(iii) The coverage under this Benefit will be over and above the base policy Sum Insured. Any claim under this Benefit shall not impact the Opted Sum Insured, No Claim Bonus & Super No Claim Bonus (if opted).

Conditions

- This benefit is available for You or Your spouse provided You and Your spouse, both are covered under the same Policy for a continues period of 36 months.
- Minimum Age at entry of the female insured is 18 to 45 Years, however claims can be made at any age even after 45 Years.
- Our maximum liability per pregnancy will be subject to the limits specified in the policy Schedule.

What is not covered

(i) Medical expenses for ectopic pregnancy. However, these expenses will be covered under In-patient Treatment under section I (1).
(ii) Any Pre-Hospitalization Medical Expenses or Post – Hospitalization Medical Expenses under Section .I.(4) and I. (5), above will not be covered under this Benefit,
(iii) Any Refill of Sum Insured under binge refill benefit (Section. I. 10) will not be available for coverage under this Benefit.
Note: Section e.I .18 is not applicable.

(i) New Born Baby Expenses

What is covered

We shall cover medical expenses towards the treatment of the New Born Baby as an In-patient, within the limit of the Maternity Sum Insured, while the Insured Person is Hospitalised as an in-patient for delivery, subject to a valid claim being accepted under Maternity Expenses.

(i) This would include in-patient hospitalisation expenses incurred on the New Born Baby while the Insured Person is Hospitalised as an in-patient for delivery.
(ii) Charges incurred on the New Born Baby during and post birth up to 90 days from the date of delivery, within the limits of Maternity Expenses.

(iii) A New Born Baby beyond 90 days can be covered under the Policy by way of an endorsement or at the next Renewal whichever is earlier, on payment of requisite premium.

Conditions
Any Refill of Sum Insured (Binge Refill Section I.10) will not be available for coverage under this Benefit

(ii) Vaccination Expenses
What is covered
We will cover vaccination expenses listed below of a New Born Baby from birth to until the New Born Baby completes two years.

Sr. No.	Name of Vaccine	Time to be given
1	Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed	6 wks, 10 wks, 14 wks; 16-18 months;
2	Varicella Vaccine, live attenuated	15 months,
3	Human Rotavirus Vaccine, Live Attenuated	6 wks, 10 wks, 14 wks
4	Combined Measles, Mumps, and Rubella Vaccine (live attenuated)	9 months, 15 months,
5	BCG Vaccines	At Birth,
6	OPV	At Birth, 6 months, 9 months
7	Hepatitis B	At Birth, 6 wks, 6 months
8	Haemophilus influenzae type b Vaccine (Hib)	6 wks, 10 wks, 14 wks; 16-18 months
9	Inactivated Hepatitis A virus Vaccine	12 months, 18 months
10	Pneumococcal Polysaccharide and Non-Typeable Haemophilus influenzae (NTHi) Protein D Conjugate Vaccine, Adsorbed	14 wks, 15 months
11	Typhoid	9-12months, 18-2 yrs
12	IPV	6 wks, 10 wks, 14 wks

Conditions
(i) Coverage will be subject to claims admitted under Maternity Expenses cover and will be within the limits of Maternity Sum Insured.
(ii) Vaccination expenses will be covered only if the Insured Person whose maternity claim has been accepted by Us continues to Renew the Policy with Us during the period.
(iii) Reimbursement claims for vaccination expenses can be submitted quarterly in a Policy Year.
(iv) Section e.II.21. d is not applicable.

Note:
(i) Our total liability under Maternity Expenses inclusive of New born baby expenses and vaccination expenses will be ₹40,000 per event subject to maximum of 2 events during the lifetime, if the insured person has a normal delivery.
(ii) Our total liability under Maternity Expenses inclusive of New born baby expenses and vaccination expenses will be ₹60,000 per event subject to maximum of 2 events during the lifetime, if the insured person has a C-Section delivery.

(iii) Stem cell preservation
What is covered
We will cover onetime Medical Expenses up to the limit specified in the Policy Schedule towards the harvesting and storage of stem cells of the New Born Baby.

Conditions
(i) The harvesting and storage of the stem cells of the New Born Baby is carried out as a preventive measure against possible future Illnesses.
(ii) The stem cells of the New Born Baby are preserved in an India based Stem Cell Bank only.
(iii) The payment under this Benefit is subject to a valid claim being accepted by Us under Maternity Expenses under section I.(11)
(iv) The coverage under this Benefit will be within the limits of Maternity Sum Insured as Specified in the Policy Schedule and Product Benefit Table.
(v) We shall be covering stem cell preservation for a maximum up to 2 New Born Baby(s) during the lifetime of an Insured Person.

Section II: Additional Benefits

The Benefits listed below are additional Policy benefits and shall be available with applicable limits, if any to all Insured Persons as specified in the Policy Schedule / Product Benefit Table of this Policy.

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

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

(12) No Claim Bonus
We shall apply a cumulative bonus in the form of No Claim Bonus at such 10% of the Sum Insured of the expiring policy year, provided that the insured person(s) has not made any claim under Section I in a policy year, and has successfully renewed the policy with us continuously and without any break on or before the Grace Period. The accumulated No Claim Bonus shall not exceed 100% of the Sum Insured on the Renewal Policy.

Conditions
(i) If the Policy is a Family Floater Policy, then No Claim Bonus will accrue only if no claims have been made in respect of the Insured Person(s) in the expiring Policy Year. No claim Bonus which is accrued during the claim free Policy Year, will only be available to those Insured Person(s) who were insured in such claim free Policy Year and continue to be Insured Person(s) in the subsequent Policy Year.
(ii) If the Policy Period is two or three years, any No Claim Bonus that has accrued for the first/second Policy Year will be credited at the end of the first/second Policy Year as the case may be and will be available for any claims made in the subsequent Policy Year.
(iii) The No Claim Bonus can be utilised for Benefits covered under Section I.(1) (In-patient Hospitalization), I.(4) (Pre-hospitalization Medical Expenses), I.(5) (Post-hospitalization Medical Expenses), I.(3) (Day Care Treatment), I.(6).(a) (Domiciliary Hospitalization), I.(6).(b) (Home Treatment), I.(7) (Road Ambulance Cover), I.(8)Organ Donor & I.(9) AYUSH Cover.
(iv) The accumulated No Claim Bonus can be utilised only when Sum Insured specified in the Policy Schedule/ Product Benefit Table have been completely exhausted.

(v) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated No claim bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater Policy basis then the No claim Bonus to be carried forward for credit in such Renewed Policy shall be the lowest accrued amongst all the Insured Persons.
(vi) If the Insured Persons in the expiring Policy are covered on a Family Floater Policy basis and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater Policies/Individual Policies, then the No Claim Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
(vii) If the Sum Insured has been reduced at the time of Renewal, the applicable No Claim Bonus shall be reduced in the same proportion to the Sum Insured.
(viii) If the Sum Insured under the Policy has been increased at the time of Renewal the No Claim Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
(ix) The No Claim Bonus is provisional and is subject to revision if a claim is made in respect of the expiring Policy Year, which is notified after the acceptance of Renewal premium. Such awarded No Claim Bonus shall be withdrawn only in respect of the expiring Policy Year in which the claim was admitted.
(x) In case of Family Floater Policies, Dependent Children attaining Age 25 years at the time of Renewal will be moved out of the Family Floater Policy into an Individual Policy. However, all continuity benefits for such Insured Person on the Policy will remain intact. No Claim Bonus earned on the Policy will stay with the Insured Person(s) covered under the original Policy.
(xi) In the event of a claim impacting the eligibility of a No Claim Bonus, the accumulated No Claim Bonus shall be reduced by the percentage of Sum Insured as accumulated in the previous Policy Year and as mentioned in Policy Schedule/ Product Benefit Table of this Policy.

(13) Health Check Up Program

What is covered

Insured Person(s) Aged 18 years and above on the Start date of the Policy may avail a comprehensive health check-up once in a Policy Year in accordance with the table below and as specified in the Policy Schedule/Product Benefit Table of this Policy:

Medical tests covered in the Health Check-up Program are as follows:

List of Tests - During Annual Health Check up	Sum Insured
MER, CBC with ESR, Urine routine, Blood Group, Blood Sugar, Serum Cholesterol, SGPT, Serum Creatinine, ECG	Up to 4 Lacs
MER, CBC with ESR, Urine routine, Blood Group, Blood Sugar , Lipid Profile, Kidney Function Test, ECG	5 Lacs -10 Lacs
MER, CBC with ESR, Urine routine, Blood Group, Blood Sugar , Lipid Profile, TMT, Kidney Function Test	15 Lacs -75 Lacs
MER, CBC with ESR, ABO Group & Rh type, Urine routine, Stool routine, S Bilirubin(total/direct), SGOT, SGPT, GGT, Alkaline phosphatase, Total Protein, Albumin: Globulin, Liver Function Test, TMT, ECG, Cholesterol, LDL, HDL, Triglycerides, VLDL, Creatinine, Blood Urea Nitrogen, Uric acid, Hba1C, Chest X ray, USG Abdomen	Above 75 Lacs

Reference:
MER - Medical Examiner's Report stamped and signed by a Medical Practitioner who is an MD physician,
BMI - Body Mass Index,
CBC - Complete Blood Count,
ESR – Erythrocyte Sedimentation Rate,
ECG – Electrocardiogram,
TMT - Treadmill Test,
SGPT - Serum Glutamic Pyruvic Transaminase,
SGOT - Serum Glutamic Oxaloacetic Transaminase,
GGT - Gamma-Glutamyl Transferase,
LDL – Low Density Lipoprotein,
HDL – High Density Lipoprotein,
VLDL – Very Low Density Lipoprotein,
Hba1c - Glycated Hemoglobin Test,
USG – Ultrasonography.

Conditions

(i) The health check-ups shall be arranged by Us only on cashless basis at Our Network Providers / Empanelled Service Providers.
(ii) The Network Provider /Empanelled Service Provider shall be assigned by us post receiving customer's request to avail this Benefit;
(iii) The Insured Person will be eligible to avail a health check-up every Policy Year.
(iv) Annual Health Check Up will have to be carried out at one go (together)
(v) Section e.II.21.a, is not applicable in respect of coverage under this Benefit.
(vi) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider in relation to the health check-up.

(14) Domestic Emergency Assistance Service

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

(i) Emergency Medical Evacuation: When a Hospital with adequate medical facility is not available in the proximity of the Insured Person, as determined by Our Empanelled Service Provider for providing Emergency Services, Air ambulance under appropriate medical supervision will be arranged by Our Empanelled Service Provider, through an appropriate mode of transport to the nearest Hospital with adequate medical facility which is able to provide the required care.
(ii) Medical Repatriation (Transportation): When medically necessary as determined by Empanelled Service Provider and the consulting Medical Practitioner transportation under medical supervision shall be provided in respect of the Insured Person to the residential address as mentioned in the Policy Schedule, provided that the Insured Person is medically cleared for travel via commercial carrier, and provided further that The transportation can be accomplished without compromising the Insured Person's medical condition.

Conditions

(i) No claims for reimbursement of expenses incurred for services arranged by Insured Person will be allowed unless agreed by Us or Our authorized representative. However in a situation where it is an emergency and when our service provider is unable to provide the service or in case of an emergency where the insured person is unable to inform the empanelled service provider, the Insured person can arrange for air ambulance service and can claim the same with Us.
(ii) Please call Our call centre with details on the name of the Insured Person and/ or Policyholder and Policy number, on the toll free number specified in the Policy Schedule for availing this Benefit.

What is not covered

We will not provide services in the following instances:

(i) Travel undertaken specifically for securing medical treatment.
(ii) Injuries resulting from participation in acts of war or insurrection.
(iii) Commission of an unlawful act(s).
(iv) Attempt at suicide.
(v) Incidents involving the use of drugs unless prescribed by a Medical Practitioner.
(vi) Transfer of the Insured Person from one medical facility to another medical facility of similar capabilities which provides a similar level of care.

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

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

Section III: Value Added Benefits

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

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

(15) Health Assessment

What is covered

Health Assessment measures MER including BP (Blood Pressure), BMI (Body Mass Index), HWR (Height –to- Weight Ratio), smoking status, Blood Sugar and Total Cholesterol. Charges for the same shall be borne by Us once in a policy year. Insured can undergo health assessment anytime during the Policy Year. All tests mentioned as a part of Health Assessment shall be conducted together.

Conditions

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

(16) Health Returns™

I. What is Health Returns™

Health Returns is a percentage of premium calculated by means of Healthy Heart Score which can be earned by an Insured Person by looking after his/her health and being physically active on a regular basis which is determined by the following Health Activities:

1. Activ Dayz™ .
2. Fitness Assessment

A Healthy Heart Score can be calculated by undergoing one of the following Medical Assessment:

i. Pre Policy Medical Check Up before the start of the policy OR
ii. Health Assessment (Section III.15) during the policy year OR
iii. Health Check Up Program (Section II.13)

Please note:

- Health Assessment ((Section III.15)) and Health Check-up Program (Section II.13) can be done once a year.
- If an insured has done HA first, then insured can undergo AHC for all the listed medical tests. However, if an Insured has done AHC first then HA is not mandatory and HHS can be calculated basis the AHC also.

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

(i) One Active Dayz™ can be earned by:
   a. Completing a Fitness centre or yoga centre activity for a minimum of 30 minutes at Our panel of Fitness or yoga centre, OR;
   b. Recording 10,000 steps or more in a day for all Insured Persons (tracked through Our mobile application or a wearable device linked to the Policy number) OR;
   c. Burning 300 calories or more in one exercise session per day OR;
   d. Participating in a recognized marathon/ walkathon/ cyclothon or a similar activity which offers a completion certificate with timing.

Once Activ Days are earned, Healthy Heart score is calculated basis the Medical assessment done and Health returns are allotted to the Insured Person.

Bonus Activ Dayz:

In case the insured person is unable to earn Activ Dayz we offer bonus active days to pass on the benefit for days engaged in maintaining good health.

Bonus Activ days will be calculated basis details below

<table>
<tr><th></th><th>Bonus Activ Dayz calculation</th><th>Range</th><th>Bonus Activ Dayz</th><th>Maximum % of Health Returns earned</th></tr>
<tr><td rowspan="3">Grid 1 – Monthly Earning Slabs</td><td>No of steps completed in a month / No of days in a calendar month</td><td>5000-7499</td><td rowspan="3">4 Bonus Activ Dayz</td><td rowspan="3">Upto 30% of the premium excluding premium for optional benefit(s) & taxes</td></tr>
<tr><td colspan="2">OR</td></tr>
<tr><td colspan="2">Burnt 150-200 calories on an average in one exercise session per day at the end of the month</td></tr>
</table>

Grid 2 – Monthly Earning Slabs	No of steps completed in a month / No of days in a calendar month	= or > 7500	6 Bonus Activ Dayz	
	OR			
	Burnt more than 200 calories on an average in one exercise session per day at the end of the month			
Grid 3 – Yearly Earning Slabs	13 Activ Dayz or more every month in a Policy Year		275 Active Dayz™ (including Bonus Activ Dayz) in the same Policy Year	Upto 50% Health Returns™ (30% accumulated every month + 20% on achieving 275 Active Dayz)

Please refer example in Annexure A for Bonus Activ Dayz calculation.

If an Insured Person has completed less than 10000 steps per day but however if monthly average step count is between 5000-7499 OR has burnt 150-200 calories on an average in one exercise session per day at the end of the month, then We shall reward 4 bonus Activ Dayz.

In case if an Insured Person has earned Activ Dayz, then he will be rewarded bonus Activ Dayz in addition to the Active Dayz earned during the month.

Similarly, If an Insured Person If an Insured Person has completed less than 10000 steps per day but however if monthly average step count is equal to or greater than 7500 per day OR has burnt more than 200 calories on an average in one exercise session per day at the end of the month, then We shall reward 6 bonus Activ dayz.

In case if an Insured Person has earned Activ Dayz, then he will be rewarded bonus Activ Dayz in addition to the Active Dayz earned during the month.

The grid above is calculated on the Monthly Premium. The Insured Person can earn up 30% Of their Monthly Premium as HealthReturns™ based on the grid above.

In addition to the above monthly earning slabs, the Insured Person will earn additional HealthReturns™ based on the Healthy Heart Score™ and the number of Active Dayz™ recorded based on the below grid which shall be calculated basis the number of Active Dayz™ achieved on yearly basis.

Note -Fitness Assessment Results shall not be considered for earning the following annual Slabs. The below mentioned slabs are in addition to the monthly slabs, and are independent of the monthly slabs. e.g. Insured Person with Healthy Heart Score™ who on a monthly basis has accomplished 13 Activ Dayz or more every month in a Policy Year, and has achieved at least 275 Active Dayz™ (including Bonus Activ Dayz) in the same Policy Year then shall be rewarded with 50% Health Returns™ (30% accumulated every month + 20% on achieving 275 Active Dayz)

No of Active Dayz™ in a year	Healthy Heart Score™		
	Red	Amber	Green
275	4.0 %	8.0%	20.0%

The sum total earning under this benefit shall not exceed 50% of the premium excluding premium for optional benefit(s) & taxes.

2. Fitness Assessment

Cardiorespiratory fitness is an element of physical fitness requiring a combination of the circulatory, respiratory, and muscular systems to supply oxygen to the working tissues during physical activity. An Insured Person needs to undergo fitness tests under following 4 components to assess Cardiorespiratory fitness:

a. Cardiovascular Endurance
b. Muscular Endurance and Strength
c. Flexibility
d. Body Composition

Fitness Score Methodology

i. An insured person is then instructed to undergo fitness test (as defined in Annexure A) under each component as per their age.

Fitness Components	Perform Test as per the Age criteria
Body Composition:	18 yrs to 80 yrs:
	Waist Hip circumference measurement
Cardio-Vascular Endurance (Stamina) Level (Any one of the given test option to be conducted & result to be recorded)	18 yrs to 65 yrs:
	Modified 3 – minutes Step test
	Modified Spot Jogging Test
Muscular Strength & Endurance Level (Any one of the given test option to be conducted & result to be recorded)	18 yrs to 55 yrs:
	Knee Push-ups
	Plank
Flexibility Level Any one of the given test option to be conducted & result to be recorded)	18 yrs to 65 yrs:
	V Sit & Reach
	Shoulder Reach Stretch

i. Post completion of Test, result is recorded and Individual Level is allotted as per the normative reference table.
ii. The final total Fitness level is generated based on weighted average score from the result of individual parameters
iii. Once Fitness Assessment is completed by the Insured Person, Healthy Heart score is calculated basis the Medical assessment done and Health returns are allotted to the Insured Person as per the final level achieved.

Please Note:

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

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

   Kindly refer to Annexure A for complete details and Illustration.

II. Healthy Heart Score (HHS) and its calculation

Coronary artery disease (CAD) is one of the leading causes of mortality and morbidity in cardiovascular disease (CVD) in India. The HHS is a simplified scientific tool for the assessment of risk level of CAD over 10 years created on the basis of the individual and multi-factorial risk assessment done by monitoring following medical test based parameters:

S. No.	Parameter
1	Age:
2	Gender:
3	Total Cholesterol
4	Systolic blood pressure:
5	Smoking Status:
6	Random Blood Sugar:

Healthy Heart Score Methodology:

i. Once an Insured person completes the medical test based parameters as given above, the actual value received for these parameters is compared with the cut off value of each parameter. Kindly refer to Annexure A for complete details and illustration.
ii. Based on the actual value received for each tests compared to the cut off value, Individual Points are allocated to each parameter
iii. The calculated risk score (Sum of individual Points) is then converted into an absolute risk probability in percentage of developing coronary heart disease (CHD) events separately for men and women.
iv. The risk probability estimate is then categorized into Red, Amber and Green for different age and gender

Kindly refer to Annexure A for cut –off values, complete details and Illustration

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

III. How to calculate Health Returns

Step 1 –The first step in Earning Health Return is to generate Healthy Heart Score. Each Insured Person in the Policy should complete Medical Assessment TM by undergoing any of the following

i. Health Assessment (Section III.15) during the policy year OR
ii. Health Check Up Program (Section II.13)
iii. Pre Policy Medical Check Up before the start of the policy

Basis the medical assessment, an Insured Person will be categorised into one of the three HHS categories:

1. Red
2. Amber
3. Green

Once categorised, an Insured Person needs to undergo Physical Assessment as mentioned in Step 2 to earn Health Returns.

Step 2 – Post completion of Medical Assessment , an Insured Person should earn Active Dayz™/ Bonus Active Days, by achieving daily step count goal on monthly basis or can achieve fitness level by completing the Fitness Assessment , twice in a Policy Year after a gap of 6 months. The health return accrued post completion of Fitness Assessment will stay applicable every month for next 6 months only

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

Step 3 - Health Returns Grid

The Insured Person will earn HealthReturns™ based on the Healthy Heart Score™, the fitness assessment result and the number of Active Dayz™ recorded.
HealthReturns™ is accrued on a monthly basis according to the following grid.

			Healthy Heart Score™		
No of Active Dayz™ in a calendar month	OR	Fitness Assessment Result*	Red	Amber	Green
			Health Returns accrued		
13 or more		Level 5	6.0%	12.0%	30.0%
10 – 12		Level 4	3.6%	7.2%	18.0%
7- 9		Level 3	2.4%	4.8%	12.0%
4 – 6		Level 2	1.2%	2.4%	6.0%
0 – 3		Level 1	0%	0%	0%

Note: Please refer Annexure A for Measurement of Fitness Assessment level and Healthy Heart Score Status

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

IV. Health Returns Eligibility

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

The following relations up to Age of 18 years shall not be eligible for earning HealthReturns™ /Health Assessment (Section III.15) namely son, daughter, brother, sister, grandson, granddaughter, brother in-law, sister in-law, nephew, niece.

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

Dependent Children up to 25 years of Age are not eligible for HealthReturns™/Health Assessment™ (Section III.15) .

Family size	Weightage
Self, Spouse and Dependent Children (upto 25 yrs)	1:1:0:0
Self and Spouse	1:1

V. Utilization Of HealthReturns™

Health Returns can be utilized by any covered member under a Policy towards the following expenses:
- payment of Renewal Premium/EMI or payment of premium for any retail policy with Us.
- For hospitalization expenses not payable as per the Policy terms and conditions
- For non-payable expenses in case of an In-patient Hospitalization or Day Care Treatment
- Non-Medical expenses listed in Annexure I 'Non-Medical Expenses' that would not otherwise be payable under the Policy.
- Out-patient expenses up to the value of accrued funds
- Reimbursement claims for Outpatient can be submitted quarterly in a Policy Year.

Note:
- Funds earned as HealthReturns™, can be carried forward each month as long as the Policy is Renewed with Us in accordance with the Renewal Terms under the Policy.
- Permanent Exclusions and Waiting Periods do not apply under this Benefit.
- The claim for accumulated HealthReturns™ can be made a maximum 4 times in a Policy Year. If You /Insured Person wish to know the present value of the funds earned as HealthReturnsTM, then You may contact Us at our toll free number or through Our website or through Our mobile application, which is available on installing the same

There will no change in the parameter and scoring mechanism. However there may be changes in cut off values arriving at the scoring mechanism based on the emerging medical experience. Please refer our website for updated Annexure.

(17) Mental Health Assessment Program

What is covered

You may avail a confidential professional assistance based Mental Health Assessment program to assess Your current mental health & wellbeing, supported by mental health coaching.

Mental Health Assessment includes

1. Guidance on knowing Your Mental Health status
The Insured Person will be guided to take an online mental health assessment tool.
The result of this assessment will be given on a scale of 'healthy' to 'extremely severe' risk for anxiety, depression and stress.
   - Healthy: Needs sustenance support
   - Mild: Needs Self-care support
   - Moderate: Needs intervention and support
   - Severe: Needs intervention and support
   - Extremely Severe: Needs intervention and support

2. Guidance on Improving Your Mental Health
Based on the Based on the result of the mental health assessment under point 1 above, the Insured Person(s) will be eligible for a screening for mental health status and consultation sessions as mentioned below.

Know your mental health status	Eligibility
Moderate	1 screening for mental health status followed by 2 consultation sessions
Severe to Extremely Severe	1 screening for mental health status followed by 4 consultation sessions

Conditions applicable to Mental Health Coaching

(i) These coaches shall be available over a telephonic discussion as a call back service/feasible mode of communication. The request for call back may be placed through Digital self-servicing mediums of mobile app/website.
(ii) It is agreed and understood that Our coaches are not providing and shall not be deemed to be providing any medical advice. They shall only provide a suggestion for the Insured Person's consideration and it is the Insured Person's sole and absolute choice to follow the suggestion for any health related advice.
(iii) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this Benefit.
(iv) Mental health coaching services will render general support for issues concerning stress, anxiety and depression. This will not include support for clinically established mental health conditions like bipolar disorder, schizophrenia, dementia, Alzheimer's disease and/or any other pre diagnosed condition. Our support includes grief/ bereavement counselling, support on mental health issues arising from rape/ gender based violence, HIV, parenting and inter personal relationships. We do not offer any medical or legal/financial advice, in any manner whatsoever.

(18) Upfront Good Health Discount:

If You are above 18 Years of Age and not a Dependent Child under this Policy, You can earn Good Health discount by undergoing a Health Risk Assessment. It is a dynamic screening tool based on series of lifestyle and health based questions to assess Your lifestyle habits and health history to determine your current Health Status. Provided that:
You opt to complete the Health Risk Assessment(HRA) at the time of buying the Policy
(Note: If Your HRA outcome is good as defined below which is determined by the screening Tool)
(i) You will eligible for 10% discount on premium if opted at the time of buying the policy

HRA Outcome	Description
Good Risk	No risk or History of any disease compared to peers in the same age and gender group
Moderate / High Risk	Moderate to High risk or Positive history of any disease compared to peers in the same age and gender group

(i) Once you completed the HRA, you will receive a report which contains a health score based on the assessment of your current health.
(ii) Discount applicable only on first policy year.
(iii) Discount is applied on the Premium of the Individual Insured Person who is eligible for HRA discount
(iv) In case of Family Floater risk of each Adult insured will be evaluated and average discount need to be calculated.

Weightages for allowed family combination is described in the table below.

Family size	Weightage
Self and Spouse	1:1
Self, Spouse and Dependent Children	1:1:0

Please refer Annexure B for Illustration on HRA Parameters.

Section IV: Optional Covers

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

Benefits under this Section IV are subject to the terms, conditions and exclusions of this Policy. The sub-limit for each Benefit is specified against that Benefit in the Policy Schedule /Product Benefit Table of this Policy. Payment of the Benefit shall be subject to the availability of the applicable sub-limit for that Benefit.

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

(19) Super NCB

What is covered

We shall apply a Super No Claim Bonus (Super NCB) (over and above) No Claim Bonus as Specified under Section II. (12) at such rates as specified in the Policy Schedule/ Product Benefit

Table of this Policy on the Sum Insured of the expiring Policy as specified for Section I.1 in the Policy Schedule on a cumulative basis, provided that the Insured Person(s) has not made any claim under Section I.1 in a Policy Year and has successfully Renewed the Policy with Us continuously and without any break. The accumulated Super No Claim Bonus shall not exceed 100% of the Sum Insured on the Renewed Policy. In the event of a claim impacting the eligibility of Super No Claim Bonus, the accumulated Super No Claim Bonus shall be reduced by 50% of the Sum Insured at the commencement of subsequent Policy Year.

Conditions

(i) "Super NCB" is an extension to the Benefit mentioned in Section. II.(12) (No Claim Bonus) and therefore all the conditions and provisions stated under Section II.(12) shall also be valid and applicable in relation to for this Section .IV.(19).
(ii) At the time of Renewal of this Policy, if the Policyholder chooses not to renew this optional cover, then the Super NCB under the expiring Policy shall be forfeited.
(iii) The Binge Refill & accumulated No Claim Bonus shall not be considered while calculating the Super NCB.

(20) Travel Protect

We shall pay fixed benefits amount specified in the Policy Schedule/ Product Benefit Table of this policy only once in a policy year irrespective of the claim amount, where the Insured Person travels by a common Carrier within the territory of India.
The cover under this benefit shall cease for that policy year post claim settlement under this benefit.

Definition applicable to this section

Common Carrier Shall means any commercial public airline operating under license issued by the Appropriate authority for transportation of passengers.

Period of Insurance shall mean a period within the Policy Period which commences when the Insured Person crosses the City of Residence and expires automatically on the earliest of:
a) the Insured Person returning to the City of residence OR
b) the expiry of the period specified in the Policy Schedule / Product benefit Table of this Policy from the commencement of the Period of Insurance; OR
c) the Policy Period End Date.

Place of Origin Shall mean the starting point/ place from where the Insured Person's trip is scheduled to be undertaken through a Common Carrier by which he leaves the City of Residence.

This optional cover will be applied on individual basis for Individual Policies, Multi Individual & Family Floater policy.

t.(a) Total Loss of Checked-in Baggage Benefit

What is covered

We shall pay the fixed benefit amount specified in the Policy Schedule/ Product Benefit Table Of this Policy against this Optional Benefit in the event of total and complete loss of the Insured Person's Checked- in baggage whilst the Insured Person was travelling within India by a common Carrier provided that:
(i) Coverage under this Optional Benefit shall commence only after the Checked-in Baggage is in the custody of the Common Carrier and a receipt is obtained by the Insured Person.
(ii) Coverage under this Optional Benefit is only available for 24 hours after the common carrier reaching the Place of Destination specified in the Insured Person's valid ticket and shall terminate automatically thereafter.

What is not covered

Any claim in respect of any Insured Person for, arising due to any of the following shall not be admissible under this Optional Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(i) Any loss arising from any delay, detention, confiscation by customs officials or other public authorities;
(ii) Any loss due to damage to the Checked-In Baggage;
(iii) Valuables
(iv) Any item that the Common Carrier's policy or rules specifies should not have been carried.

For this Optional Benefit only:
Valuables shall mean and include photographic, audio, video, painting, cash, computer and any other electronic equipment, telecommunications, telescopes, binoculars, antiques, watches, jewellery and gems, furs and articles made of precious stones and metals.

t.(b) Delay of Checked-in Baggage

What is covered

We shall pay the fixed benefit amount specified in the Policy Schedule/Product Benefit Table of this Policy against this Optional Benefit if the delivery of the Insured Person's Checked-In baggage which has been entrusted with the Common Carrier is delayed by a period equal to or exceeding the first six hours as specified in the policy schedule/product benefit Table of this Policy, from the Insured Person's arrival at the Place of Destination specified on his/her valid ticket during the Policy Period of Insurance.

What is not covered

Any claim in respect of any Insured Person for, arising due to any of the following shall not be admissible under this Optional Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(i) Any delay which does not exceed the time period specified in the Policy Schedule/Product benefit Table of this Policy for this Optional Benefit;
(ii) Detention or confiscation of the Check-in baggage by the Common Carrier or customs or any government or other agencies;
(iii) Any delay attributable to damage to the Checked-In Baggage warranting an examined delivery by the Common Carrier;

t.(c) Trip Cancellation & Interruption

A. Trip Cancellation:

What is covered

If the Insured Person's outward trip as a fare paying passenger from the City of Residence to a Place of Destination on a Common Carrier is unavoidably cancelled before the commencement of the Period of Insurance solely and directly due to one of the reasons below, then We shall pay the benefit amount specified in the Policy Schedule/ Product Benefit Table of this Policy.

(i) Earthquake, storm, flood, inundation, cyclone or tempest provided that the peril takes Place prior to the commencement of the Period of Insurance at or in the vicinity of the Place of Origin of the Trip, the ultimate scheduled Place of Destination or any intermediate place which is involved in or related to the proposed journey;
(ii) Terrorism provided that the peril takes place prior to the commencement of the Period of Insurance at or in the vicinity of the Place of Origin of the trip, the ultimate scheduled Place of Destination or any intermediate place which is involved in or related to the proposed Trip
(iii) The Insured Person's Immediate Family Member dies or is Hospitalized in an Emergency Due to an unforeseen Illness or Injury for at least 2 consecutive days provided that such Illness or Injury shall be diagnosed not earlier than 10 consecutive days from the scheduled commencement of the Trip;
(iv) The Insured Person is Hospitalized in an Emergency due to an unforeseen Illness or Injury (in case this Optional Benefit is applicable to the Insured Person along with Section C.1(a)) and such Hospitalization commences within 10 days from the scheduled commencement of the trip and continues for at least 2 consecutive days and the treating Medical Practitioner certifies in writing that the insured person is not fit to undertake Travel.

B. Trip Interruption:

What is covered

If the Insured Person's stay is unavoidably curtailed after the commencement of the Period of Insurance solely and directly due to one of the reasons below, then We shall pay the benefit amount specified in the Policy Schedule/ Product Benefit Table of this policy.

(i) Earthquake, storm, flood, inundation, cyclone or tempest provided that the peril takes place within the Period of Insurance at or in the vicinity of the Place of Origin of the trip, the ultimate scheduled Place of Destination or any intermediate place which is involved in or related to the proposed trip.
(ii) Terrorism provided that the peril takes place within the Period of Insurance at or in the vicinity of the Place of Origin of the trip the ultimate scheduled Place of Destination or any intermediate place which is involved in or related to the proposed Trip;
(iii) The Insured Person's Immediate Family Member dies or is Hospitalized in an Emergency due to an unforeseen Illness or Injury and such Hospitalization continues for at least 5 consecutive days;

What is not covered

Any claim in respect of any Insured Person for, arising due to any of the following shall not be admissible under this Optional Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(i) Negligence or fault of the travel agent
(ii) Any advance intimation given to the Insured Person of a possible delay of the Common Carrier by the way of sources such as travel advisories issued by competent /Government authority(s) etc in a public domain that might result in the cancellation or curtailment of the trip.

t.(d) Trip Delay

What is covered

If the departure of a Common Carrier in which the Insured Person is scheduled to travel on a valid ticket during the Period of Insurance is delayed from city of residence from the schedule departure time for more than the number of consecutive and completed hours/minutes as specified in the Policy Schedule/Product Benefit Table from the later of the declared time of departure or expected time of departure due solely and directly to any one of the following:

(i) Earthquake, flood, rains, storm, cyclone or tempest; or
(ii) Terrorism
(iii) Delay of a scheduled Common Carrier caused by inclement weather.
(iv) Delay due to a sudden strike or any other action by employees of the Common Carrier.
(v) Delay caused by equipment failure of the Common Carrier.
(vi) Delay caused by operational problem at the Common Carrier end (like crew / staff scheduling issues etc).
(vii) Cancellation or rescheduling of flights done at the instance of the Common Carrier that causes delay.

We shall pay the benefit amount specified in the Policy Schedule/ Product Benefit Table against this Optional Benefit provided that We or the Assistance Service Provider is given written notice of the delay immediately and in any event within 30 days of the commencement of the delay and immediate alternative arrangements are made by the Insured Person for progressing the trip as scheduled

What is not covered

Any Claim in respect of any Insured Person for, arising due to any of the following shall not be admissible under this Optional Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(i) Any contingencies other than those specifically named above;
(ii) The Common Carrier is taken out of service on the instructions of the Civil Aviation Authority or any similar authority;
(iii) Delay caused by strike or industrial action if already notified at the time the Insured Person booked his/her ticket or paid or committed to other travel and accommodation expenses.
(iv) The failure to arrive for the Common Carrier's departure in sufficient time to complete all departure formalities in accordance with the Common Carrier's published time schedule.
(vi) Rescheduling of the flight by the flight operator minimum 10 hours prior to the original departure date & time of the booked Common Carrier is not covered.

t.(e) Missed Flight Connection

What is covered

If the Insured Person misses the connecting flight during the Period of Insurance solely and directly due to the delayed arrival of the Common Carrier in which the Insured Person was traveling on a valid ticket, We pay the benefit amount specified in the Policy Schedule/ Product Benefit Table of this Policy for the costs incurred by the Insured Person to continue the journey to the Scheduled Place of Destination provided that the time gap between the scheduled arrival of the Common Carrier and the connecting flight is more than the number of consecutive hours specified in the Policy Schedule/ Product Benefit Table of this Policy.

What is not covered

Any claim in respect of any Insured Person for, arising due to any of the following shall not be admissible under this Optional Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(i) Missing of the flight is the result of any deviation from the originally scheduled route at the instance of the Insured Person for any reason whatsoever;
(ii) Any advance intimation given to the Insured Person of a possible delay of the Common Carrier by the way of sources such as travel advisories issued by competent /Government authority(s) etc in a public domain that might lead to missing of the connecting flight;

(21) Premium Waiver

What is covered

If an Insured Person is diagnosed for the first time during the policy year with any of the below listed Critical Illnesses OR suffers an Injury due to an Accident resulting in the Permanent Total Disablement of the Insured Person which is of the nature specified in the table below within 365 days from the date of the Accident which occurred during the Policy Period, then the premium will be waived off for 1 Policy year.

List & Definition of Critical Illnesses as applicable: The Critical Illness first diagnosed during the Policy Period and after completion of 90 days from the inception of the First Policy with Us.

Critical Illnesses	Definition
1 Cancer of Specified Severity:	I. 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 includes leukaemia, lymphoma and sarcoma. II. The following are excluded- i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3. ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond; iii. Malignant melanoma that has not caused invasion beyond the epidermis; iv. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0 v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below; vi. Chronic lymphocytic leukaemia less than RAI stage 3 vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification, viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs; ix. All tumours in the presence of HIV infection.
2 Myocardial Infarction (First Heart Attack of specific severity)	I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria: i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain) ii. New characteristic electrocardiogram changes iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers. The following are excluded: i. Other acute Coronary Syndromes ii. Any type of angina pectoris iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3	Open Chest CABG	I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive key hole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. II. The following are excluded: i. Angioplasty and/or any other intra-arterial procedures
4	Open Heart Replacement Or Repair of Heart Valves	I. The actual undergoing of open-heart valve Surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.
5	Kidney Failure Requiring Regular Dialysis	I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.
6	Stroke Resulting In Permanent Symptoms	I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced. II. The following are excluded: i. Transient ischemic attacks (TIA) ii. Traumatic Injury of the brain iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.
7	Major Organ / Bone Marrow Transplant	I. The actual undergoing of a transplant of: i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner. II. The following are excluded: i. Other stem-cell transplants ii. Where only islets of langerhans are transplanted
8	Permanent Paralysis of Limbs	I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.
9	Multiple Sclerosis With Persisting Symptoms	I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following: i. investigations including typical MRI findings, which unequivocally confirm the diagnosis to be multiple sclerosis and ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months. II. Other causes of neurological damage such as SLE and HIV are excluded.
10	Coma of Specified Severity	I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following: i. no response to external stimuli continuously for at least 96 hours; ii. life support measures are necessary to sustain life; and iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma. II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.
11	Motor Neuron Disease With Permanent Symptoms	I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.
12	Third Degree Burns	I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

13	Deafness	I. Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.
14	Loss of Speech	I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by and Ear, Nose, Throat (ENT) specialist. II. All psychiatric related causes are excluded.
15	Aplastic Anemia	Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following: a. Blood product transfusion; b. Marrow stimulating agents; c. Immunosuppressive agents; or d. Bone marrow transplantation. The diagnosis must be confirmed by a haematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following: a. Absolute neutrophil count of 500/mm^3 or less b. Platelets count less than 20,000/mm^3 or less c. Absolute Reticulocyte count of 20,000/mm^3 or less Temporary or reversible Aplastic Anaemia is excluded. In this condition, the bone marrow fails to produce sufficient blood cells or clotting agents.
16	End Stage Liver Failure	I. Permanent and irreversible failure of liver function that has resulted in all three of the following: i. Permanent jaundice; and ii. Ascites; and iii. Hepatic encephalopathy. II. Liver failure secondary to drug or alcohol abuse is excluded.
17	End Stage Lung Failure	I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following: i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and iii. Arterial blood gas analysis with partial oxygen pressures of 55mmHg or less (PaO2 <55 mm Hg); and iv. Dyspnea at rest.
18	Bacterial Meningitis	Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal chord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks resulting in permanent inability to perform three or more Activities for Loss of Independent Living. This diagnosis must be confirmed by: a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and b. A consultant neurologist certifying the diagnosis of bacterial meningitis. Bacterial Meningitis in the presence of HIV infection is excluded.
19	Fulminant Hepatitis	A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following: a. Rapid decreasing of liver size; b. Necrosis involving entire lobules, leaving only a collapsed reticular framework; c. Rapid deterioration of liver function tests; d. Deepening jaundice; and e. Hepatic encephalopathy. Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.
20	Muscular Dystrophy	A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist acceptable to Us, with confirmation of at least 3 of the following 4 conditions: a. Family history of muscular dystrophy; b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction; c. Characteristic electromygrom; or d. Clinical suspicion confirmed by muscle biopsy. The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months.

Type of Permanent Total Disablement	
i)	Total and irrecoverable loss of sight of both eyes
ii)	Loss by physical separation or total and permanent loss of use of both hands or both feet
iii)	Loss by physical separation or total and permanent loss of use of one hand and one foot
iv)	Total and irrecoverable loss of sight of one eye and loss of a Limb
v)	Total and irrecoverable loss of hearing of both ears and loss of one Limb/loss of sight of one eye
vi)	Total and irrecoverable loss of hearing of both ears and loss of speech
vii)	Total and irrecoverable loss of speech and loss of one Limb/loss of sight of one eye
viii)	Permanent total and absolute disablement (not falling under the above) disabling the Insured Person from engaging in any employment or occupation or business for remuneration or profit, of any description whatsoever which results in Loss of Independent Living.

(i) This Benefit is available once in the lifetime of the Policy, regardless of the number of Years the Policy has served with Us.
(ii) Waiver of premium for 1 year shall be excluding with respect to the premium payable towards optional covers opted, if any
(iii) In case of Individual/multi individual Policy, each individual Insured Person can opt this optional covers as per their requirements. In case of Family Floater Policy, once selected, the optional covers shall apply to all Insured Persons without any individual selection.
(iv) This optional cover can be opted only at inception of the Policy and not applicable for Renewal/Portability & Migration cases.

22. EMI Protection

What is covered

We shall pay equated monthly instalment due under existing loan account as specified in the Policy Schedule / Product Benefit Table of this Policy where the insured is hospitalized due to any illness/injury in excess of 6 consecutive days during the Policy Period while the policy is in force and provided that claim under In-patient Hospitalization under I.(1) or Day Care Treatment under Section I.(3) or Section I.(9) AYUSH Cover or Section I. (6) (a) Domiciliary Hospitalization or (6) (b) Home Treatment is admitted by Us. The benefit amount will be paid as a lump sum amount post the insured Person discharge from the hospital

This Benefit is available once in the lifetime in the Policy regardless of the number of years the Policy has served with Us. This optional cover will be applied on individual basis for Individual, Multi Individual & Family Floater policy.

What is not covered

Any penalty or arrears which may have accumulated due to delayed or missed EMI's prior to the date of hospitalization.

23. Non- Medical Expense Waiver

What is covered

We shall cover cost of Non-Medical Items, listed under Annexure I of this Policy, which are necessarily incurred towards Hospitalization of the Insured Person, arising out of Illness or Injury contracted or sustained during the Policy Period. The Benefit is available subject to claim being admissible under the In-patient Hospitalization Benefit (I.1) and/ or Day Care Treatment (I.3) Benefit under the Policy and provided that the expenses on Non-Medical Items pertain to the same Illness/injury admitted by US. The total, cumulative and maximum claim pay out under this Benefit shall be limited to applicable policy Sum Insured specified in the Policy Schedule/Product Benefit table of the Base Policy.

24. Reduction in Maternity Waiting

What is covered

We will provide for a waiver of waiting period for Maternity Expenses (Section I.11) from 36 months to 24 months from the date of inception of first Policy with Us. New Born Baby Expense, Vaccination Expense & Stem Cell Preservation will follow reduction in waiting period under Maternity Expenses Cover. All other terms, conditions and exclusions under Maternity Expenses Cover (Section I.11) shall apply.

This optional cover can be opted only at inception of the Policy. Not applicable for Renewal/Portability & Migration cases.

25. OPD Expense

What is covered

We shall cover medical expenses incurred during the policy period for outpatient consultation as specified in the policy schedule/Product Benefit table of the policy in relation to any illness/ injury diagnosed during the policy period. These services can be availed via our application or through toll free number of empanelled service provider specified in the Policy Schedule on cashless basis in selected cities.

This cover includes
(a) Physical Outpatient consultations given by a General Medical Practitioner or AYUSH Medical Practitioner during the policy year.
(b) Teleconsultation given by a General Medical Practitioner or AYUSH Medical Practitioner for any telephonic/ virtual consultations and recommendations.

For the purpose of this Benefit, telephonic/virtual consultation shall mean consultation provided by a Medical Practitioner through various mode of communication like audio, video, online portal, chat or mobile application.

Conditions:

Benefits under this Section shall be available on an individual basis to each eligible Insured Person up to the limit specified in the Policy Schedule for an Individual Policy and Family Floater Policies. Any claim under this Benefit shall not impact the Opted Sum Insured, No Claim Bonus & Super No Claim Bonus (if opted).

Section B. Terms and Conditions:

A. Eligibility and Coverage:

a) Minimum Age at Entry:
i) Family Floater Policy: 91 days (for dependent child) and 18 years (for adults).
ii) Individual Policy: Minimum age at entry is 5Yrs

b) Maximum age at entry:
Maximum age at entry - 45 Years (for adults). Lifetime renewability is allowed.

Note:
1. Children up to 25 years can be covered under the floater as dependents.
2. Age is calculated as no. of years completed as on last birthday.
3. Individual Policy: Children beyond 25 years if dependent on the parents can be covered under an individual policy.

B. 1. Policy Type:

The policy can be purchased on an Individual basis or a Family floater basis.

a) In case of an Individual policy, each Insured Person under the policy will have a separate Sum Insured.
b) Individual/Multi individual policies not applicable for preferred plan.
c) In case of a floater Policy, one family will share a single Opted Sum Insured.

2. Relationships covered:

Family Floater Policy: Self & legally wedded spouse, dependent children up to 4 (i.e. natural or legally adopted) between the age 3 months to 25 years.

Individual Policy: Self, legally married spouse as long as they continue to be married, son, daughter, brother, sister, grandson, granddaughter, son in-law, daughter in-law, brother in-law, sister in-law, nephew, niece. (Note: Son/Daughter/Child will include legally adopted Child and Step Child).

3. Sum Insured -

1 lac, 2 Lac, 3lac, 4Lac, 5 Lac, 7 Lac, 10 Lac, 15 Lac, 20 Lac, 25 Lac, 30 Lac, 40Lac, 50 Lac, 75 Lac, 1 Cr.

4. Policy Period option -

You can buy the policy for one, two or three continuous years at the option of the Insured. 'One Policy Year' shall mean a period of one year from the start date of the policy.

5. Discounts under the Policy

You can avail of the following discounts on the premium on Your policy.

1. **Upfront Good Health Discount** - 10% basis good health risk classified. We will allow this discount once at the time of obtaining first Policy from Us.
   (In case of Family Floater risk of each insured will be evaluated and average discount need to be calculated. Explanation for this benefit is detailed in Section III.(18).
2. **Early Bird Discount** - Applicable if Insured Persons age at entry is less than 35 years at the time of inception of first policy. This discount will be available at renewal.5% discount from 4th policy year to 7th policy year and 10% discount from 8th Policy year onwards.
   If the Insured Persons in the expiring Policy are covered on a Family Floater Policy basis and such Insured Persons Renew their expiring Policy with Us by splitting into Individual Policy/ policies, in such cases the accrued discount of 5% will be applicable from 4th policy year to 7th policy year and 10% discount from 8th Policy year onwards, provided the Insured person was less than 35 at the time of inception of the first policy.
   If the Insured Persons in the expiring Policy are covered on Individual Policy basis and such Insured Persons Renew their expiring Policy with Us into family floater policies, in such cases the accrued discount of 5% will be applicable from 4th policy year to 7th policy year and 10% discount from 8th Policy year onwards, provided the of the proposer was less than 35 at the time of inception of the first policy.
3. **Family Discount on multi individual policy:**
   This discount will be applicable on both New Business and Renewal policy premium.
   - 2 members in a policy – 5% Discount
   - 3 or more members in a policy – 10% Discount
4. **Long term discount:**
   This discount will be applicable on both New Business and Renewal Policy premium only in case of Single Premium Policies. A long term discount of 7.5% and 10% On selecting a 2 and 3 years Policy respectively.
5. **Standing Instruction Discount -** Discount of 2.5% on the premium from 1st renewal, if The premium is received through NACH or standing instruction (where payment is made either By direct debit of bank account or credit card)
6. **Direct Purchase Discount -** 10% Discount would be offered on both New Business and Renewal policies which are purchased directly from the insurer without any intermediary involved.
7. **Online Intermediary Discount -** 10% Discount would be offered on both New Business and Renewal policies if the insured member opts to purchase the policy using an online intermediary.
8. **Affiliate Emplo yee Discount -** 10% Discount would be offered on both New Business and Renewal policies which are purchased by employees of intermediaries of Aditya Birla Health Insurance Co. Ltd.
9. **Employee Discount -** 10% Discount would be offered on both New Business and Renewal Policies covering employees and/or family members of employees of Aditya Birla Group.

Note - Online Intermediary Discount, Employee Discount, Affiliate Emplo yee Discount and Direct Purchase Discount are available on mutually exclusive basis.

C. Pre-policy Medical Examination

Pre-Policy medical check- up may be required based on cover(s) chosen, Sum Insured, Age and/or any health declaration. Medical tests will be facilitated by Us and conducted at Our network of diagnostic centres. Full cost of all such tests will be borne by Us for all accepted proposals. In case of rejected proposals or where a counter offer is not accepted by the customer We will bear only 50% of the cost for such tests.

D. Underwriting and Loadings

i. We may apply a risk loading (additional premium) on the premium payable (excluding statutory levies and taxes) based on the details of the Insured Person, including the health status, habits and lifestyle, past medical records, declarations on the Proposal Form and the results of the pre-Policy medical examination.
ii. The maximum risk loading applicable for an individual shall not exceed above 100% per Insured Person. Loadings will be applied from the Inception Date of the first Policy including subsequent Renewal. There will be no loadings based on individual claims experience on Renewals for the Policies Renewed with Us continuously without any break.
iii. We will inform You about the applicable risk loading through a counter offer letter and We will only issue the Policy Once We receive your consent and applicable additional premium. In case, you neither accept the counter offer nor revert to Us within 10 working days, We shall cancel Your application and refund the premium paid.
iv. Your Policy shall not be issued unless We receive Your consent.

E. Waiting Periods and Permanent Exclusions

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

I. Standard Exclusions

1. 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 months as specified in the Policy Schedule / Product Benefit Table of this Policy of continuous coverage after the date of inception of the first policy with Insurer.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of months as specified in the Policy Schedule / Product Benefit Table of this Policy for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. 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**
1	Eye	Cataract	Cataract Surgery
		Glaucoma	Glaucoma Surgery
		Refractive Error Correction	Correction Surgery
2	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
3	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
4	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
5	Gastroenterology (Alimentary Canal and related Organs)	Stone in Gall Bladder, Bile duct & other parts of Biliary System	Medical & Surgical treatment
		Cholecystitis	Surgical treatment
		Pancreatitis	Surgical treatment
		Fissure, Fistula in ano, hemorrhoids (piles), Pilonidal Sinus, Ano-rectal & Perianal Abscess	Medical & Surgical treatment
		Rectal Prolapse	Medical & Surgical treatment
		Gastric or Duodenal Erosions or Ulcers, Gastritis, Duodenitis & Colitis	Medical & Surgical treatment
		Gastro Esophageal Reflux Disease (GERD)	Medical & Surgical treatment

		Cirrhosis	Medical & Surgical treatment
		Chronic Appendicitis	Surgical treatment
		Appendicular lump, Appendicular abscess	Medical & Surgical treatment
6	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
7	Skin	Skin tumour (unless malignant)	Medical & Surgical treatment
		All skin diseases	Medical & Surgical treatment
8	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 e.I.1 .

Specified disease / procedure waiting period: (Code- Excl02)

g) 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.
h) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
i) 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.
j) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
k) 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.
l) List of specific diseases/procedures:
   1. Genetic Disorders

3. 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.

4. 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.

5. 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:
b) 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.
c) Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6. 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

7. 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.

8. 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.

9. 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.

10. **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.
11. **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 II 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.
12. **Treatment for, Alcoholism, drug or substance abuse or any addictive condition** and consequences thereof. **(Code- Excl12)**.
13. **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)**
14. **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)**
15. **Refractive Error:(Code- Excl15)** - Expenses related to the treatment for correction of eye sight due to refractive error less than 7 .5 dioptres.
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. **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
18. **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.

II. Specific Exclusions

19. **Circumstantial Exclusion**
    a. 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 participation or involvement in naval, military or air force operation
    b. usurped acts, nuclear weapons / materials, chemical and biological weapons, ionizing radiation, contamination by radioactive material or radiation of any kind, nuclear fuel, nuclear waste.
    c. The Insured Person's direct participation in terrorist acts;

20. **Behavioural Exclusions**
    a. Suicide or attempted suicide, wilfully self-inflicted injury;
    b. Illegal act of the Insured Person or an Insured Person's executors or administrators, legal heirs or personal representatives;
    c. Any treatment for Injury resulting from the consumption of alcohol or any intoxicating substance, its intake or abuse thereof
    d. The use of drugs (other than drugs taken under treatment prescribed and directed by a Medical Practitioner but not for the treatment of drug addiction);

21. **Medical Exclusions**
    a. All routine examinations and preventive health check-ups;
    b. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment);
    c. Conditions for which treatment could have been done on an outpatient basis without any Hospitalization;
    d. Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing
    e. 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.
    f. External Congenital Anomalies or diseases or defects.
    g. Stem cell therapy except Hematopoietic stem cells for bone marrow transplant for haematological conditions) or Surgery, or growth hormone therapy or Hormone Replacement Therapy.

22. **Prosthesis and Devices**
    a. Hearing aids, spectacles or contact lenses including optometric therapy, multifocal lens
    b. Wigs, or toupees, and related expenses.
    c. Any expenses incurred on prosthesis, corrective devices external durable medical equipment wheelchairs crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.), devices used for ambulatory monitoring of blood pressure, blood sugar, glucometers, nebulizers and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Cost of artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment. Sleep-apnea and other sleep disorders.

23. **Non-Medical expenses**
As mentioned under Annexure (1) List II, III & IV will be excluded unless forms a part of In-patient hospitalization.

24. **Specific treatment Exclusion**
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 Radio Frequency (RF) probe for ablation.

25. Activities and Profession Exclusions

a. 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.
b. Treatment charges or fees charged by any Medical Practitioner acting outside the scope of license or registration granted to him by any medical council.
c. 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.

26. Geographical Exclusion

Treatment taken outside India

f. 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://wwwww.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987&flag=1]

g. 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 at least 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://wwwww.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987&flag=1]

h. 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;

I. 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.

Provided that in case there is a request for Refund where claim has been made only under Health Assessment™ and / Health Check-up Program we shall process the refund in accordance with the grid below provided and after deduction of the charges for the claims made under the Sections referred hereinabove.

	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 & Family 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.

4. Treatment of HealthReturns™ on Cancellation
All coverage, benefits, earning on HealthReturns™, shall automatically lapse upon cancellation of the Policy. However, any unclaimed and accrued HealthReturns™ (from previous Policy Year/ month) shall be available for a claim over the next 12-month period from the date of cancellation/termination.

j. Grace Period

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

k. 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) Any unutilised funds under HealthReturns™ (from the previous Policy year/ month) will be available for claims during the Grace Period.
(iii) You shall not be able to earn HealthReturns™ during the Grace Period.
(iv) In case the Policy is not renewed before the end of the Grace Period, any unutilized funds under HealthReturns™ shall be available for a claim as up to a period of 3 months from the date of expiry of the Policy.
(v) If the Insured Persons in the expiring Policy are covered in an Individual Policy, and such expiring Policy has been Renewed with Us on a Family Floater Policy basis then the accumulated amount under HealthReturns™ that will be carried forward in such Renewed Policy shall be the total of all the Insured Persons moving out and shall be maintained on an Individual Policy basis.
(vi) If the Insured Persons in the expiring Policy are in a Family Floater Policy and such Insured Persons renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater Policy/ Individual Policies then the accumulated amount under HealthReturns™ shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
(vii) Alterations like increase/ decrease in Sum Insured or Change in Plan/Product, addition/deletion of Insured Persons (except due to child Birth/Marriage or Death) will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the Proposal Form before the expiry of the Policy. We reserve Our right to carry out underwriting in relation to acceptance of request for changes on Renewal. The terms and conditions of the existing Policy will not be altered.
(viii) Any 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 mentioned below shall apply afresh for this enhanced limit from the effective date of such enhancement.
(ix) Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned in the Policy Schedule shall be waived only up to the lowest Sum Insured as applicable to the relevant waiting periods of the Plan in force.
(x) Where an Insured Person is added to this Policy, either by way of endorsement, all waiting periods under Section e.(I) (1), (2) & (3) will be applicable considering such Policy Year as the first year of Policy with Us with respect to the Insured Person.
(xi) Applicable Cumulative Bonus shall be accrued on each Renewal as per eligibility under the plan in force.
(xii) In case of Family Floater Policies, Dependent Child attaining 25 years of Age at the time of Renewal will be moved out of the floater into an individual policy. However, all continuity benefits for such Insured Person on the Policy will remain intact. No Claim Bonus(if any), Super NCB (if any) earned on the Policy will stay with the Insured Persons(s) covered under the original Policy.

3. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Policy holder 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 No Claim 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.

L. Claims Administration & Process

1. Claims Administration & Process

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

(1) On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed.
(2) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
(3) We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

I. Claims Procedure

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

a. For Availing Cashless Facility

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

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

(i) We must be contacted to pre-authorize Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Each request for pre-authorization must be accompanied with all the following details:
   (1) The health card issued by Us to the Insured Person, along with the Insured Person's KYC documents.
   (2) The Policy Number;
   (3) Name of the Policyholder;
   (4) Name and address of Insured Person in respect of whom the request is being made;
   (5) Nature of the Illness/Injury and the treatment/Surgery required;
   (6) Name and address of the attending Medical Practitioner;
   (7) Hospital where treatment/Surgery is proposed to be taken;
   (8) Proposed date of admission.

(ii) If these details are not provided in full or are insufficient for Us to consider the request, we will request additional information or documentation in respect of that request.

(iii) When we have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.

(iv) The Authorization letter shall be issued to the Network Provider within 24 hours of receiving the complete information.

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

(i) We must be contacted to pre-authorise Cashless Facility within 24 hours of the Insured Person's Hospitalization if the Insured Person has been Hospitalized in an Emergency. Each request for pre-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) Hospital where treatment/Surgery is to be taken;
   (8) Date of admission.

(ii) If these details are not provided in full or are insufficient for Us to consider the request, we will request additional information or documentation in respect of that request.

(iii) When we have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.

(iv) Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, Hospital and locations, match with the details of the actual treatment received. For Hospitalization where Cashless Facility is pre-authorised by Us, We will make the payment of the amounts assessed to be due directly to the Network Provider.

(v) The Authorization letter shall be issued to the Network Provider within 24 hours of receiving the complete information.

d. For Reimbursement Claims:

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

(ii) If the claim is not notified to Us within the earlier of 48 hours of the Insured Person's admission to the Hospital or before the Insured Person's discharge from the Hospital, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

II. Claims Documentation:

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

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

(ii) For those claims for which the use of Cashless Facility has been authorised, we will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:
   1. Duly signed, stamped and completed Claim Form
   2. Photo ID & Age Proof
   3. Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents)
   4. Copy of the Network Provider's Registration Certificate / Copy of Form C in case of Hospitalization
   5. Original Discharge Card / Day Care Summary / Transfer Summary
   6. Original final Hospital Bill with all original deposit and final payment receipt
   7. Original invoice with payment receipt and implant stickers for all implants used during surgeries i.e. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery.
   8. All previous consultation papers indicating history and treatment details for current ailment
   9. All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription and invoice / bill with receipt from diagnostic center
   10. All original medicine / pharmacy bills along with Medical Practitioner's prescription
   11. MLC / FIR Copy – in Accidental cases only
   12. Copy of Death Summary and copy of Death Certificate (in death claims only)
   13. Pre and Post-Operative Imaging reports – in Accidental cases only
   14. Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress (if available).
   15. Original invoice for Vaccination and payment receipt
   16. KYC documents

17. Additional Claim documents for Section.I.(7) Road Ambulance
    - o Photocopy of discharge card
    - o Original Ambulance invoice & paid receipt

18. Additional Claim documents for Section IV: Optional Covers (20) Travel Protect

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

19.(a) Total Loss of Checked-in Baggage Benefit
    - (i) Property irregularity report issued by the appropriate authority
    - (ii) A valid ticket / proof of travel to the location the Insured Person is traveling as a bona fide passenger.
    - (iii) Voucher of the Common Carrier for the compensation paid for the non-delivery/short delivery of the Checked-In Baggage; / short delivery of the Checked-In Baggage

19.(b) Delay of Checked-in Baggage
    - (i) Property irregularity report issued by the appropriate authority stating the scheduled time of delivery and actual time of delivery of the Checked-In Baggage
    - (ii) Copies of correspondence exchanged, if any, with the Common Carrier in connection with the delay in delivery of the Checked-In Baggage;
    - (iiii) A valid ticket / proof of travel to the location the Insured Person is traveling as a bona Fide Passenger
    - (iv) Voucher of the Common Carrier for the delay in delivery of the Checked-In Baggage

19.(c) Trip Cancellation & Interruption
    - (i) Confirmation in writing of cancellation of the journey from the Common Carrier detailing he circumstances of cancellation/interruption;
    - (ii) Ticket / boarding pass issued by the Common Carrier indicating the cost of ticket of the journey indicating cancellation charges retained by the Common Carrier.
    - (iii) A declaration from the Insured Person furnishing the circumstances that compelled him/her to cancel the journey;
    - (iv) Medical evidence as may be required in case of the cancellation of the journey arising out of personal contingencies of the Insured Person or his/her Immediate Family Member;
    - (v) Death certificate (if applicable).

19.(d) Trip Delay
    - (i) Certificate from the Common Carrier confirming the delay and detailing the circumstances of delay.
    - (ii) Copy ticket for the common carrier

19.(e) Missed Flight Connection
    - (i) Confirmation from the Common Carrier of the delay as to the expected time of arrival and the actual time of arrival at Place of Destination;
    - (ii) Copy of unused ticket for the missed common carrier
    - (iii) Certificate from the Common Carrier of the missed common carrier that the fare for the part of the Journey covered by the missed flight is forfeited in full or in part together with the amount of forfeiture;
    - (iv) Original used ticket obtained afresh towards the alternative common carrier for the part of the journey covered indicating the amount paid as fare.

20. Additional Claim documents for Section IV: Optional Covers (21) Premium Waiver

    A. If an Insured Person is diagnosed for the first time with or for any of the listed (20) Critical Illnesses during the policy period, the following document need to be submitted if Premium waiver optional cover is opted.
        - (i) Claim Form (in original) duly completed and signed as prescribed by Us
        - (ii) Photo ID and Age proof of Insured Person / Nominee (if Insured Person is not alive)
        - (iii) Copy of the claim intimation, if any
        - (iv) Final Hospital bill
        - (v) Hospital discharge summary / day care summary / transfer summary
        - (vi) Operation theatre notes
        - (vii) Investigation reports (Including CT scan/ MRI /USG / Histopathology or Biopsy report)
        - (viii) Doctor's prescriptions
        - (ix) Cancelled cheque for NEFT
        - (x) Others

    B. If the insured person suffers an Injury due to an Accident resulting in the Permanent Total Disablement of the Insured Person which is of the nature specified within 365 days from the date of the Accident, then submit following document
        - (i) Attested copy of disability certificate issued by civil surgeon of district Hospital mentioning the type and percentage of disability.
        - (ii) Original photograph of the Insured Person reflecting the disablement or injured part for which the claim is made
        - (iii) Leave records with seal and signature of authorized signatory of the organization (if employed)
        - (iv) Salary slips for last 3 months with seal and signature of authorized signatory of the organization (if employed)
        - (v) Last 3 years financial years income tax return for self-employed persons
        - (vi) Copies of medical documents towards treatment taken during disability period, including discharge summary of the Hospital
        - (vii) Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details and patient's progress (where the discharge summary is not detailed) (if available)

21. Additional Claim documents for Section IV: Optional Covers (IV.22) EMI Protection
    - (i) Claim Form (in original) duly completed and signed as prescribed by Us
    - (ii) Photo ID and Age proof of Insured Person / Nominee (if Insured Person is not alive)
    - (iii) Claim intimation or claim reference number
    - (iv) Current Outstanding Loan Certificate from financer, along with copies of documents submitted
    - (v) Loan disbursement letter along with payment record till the date of Accident
    - (vi) Repayment schedule showing the EMI details

22. 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

Note - For acceptance of claims in electronic mode, the documents shall be submitted in such form (Soft copy or Hard copy) and in manner as may be specified by Us.
For the following Claims, please notify the same at our call centre/website/e-mail
- Health Assessment™ Section III.(15)
- HealthReturns™ Section III.(16)
- Health Check-up Program Section II.(13)

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

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

n. 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 the 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.

o. Redressal Procedure
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 World Centre, Jupiter Mills Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai 400013.

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

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at

For updated details of grievance officer, refer the link https://www.adityabirlacapital.com/healthinsurance/#!/homepage

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 as per Annexure III.

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

Statutory Warning - Prohibition of Rebates
(Under Section 41 of Insurance Act 1938)
1) No person shall allow or offer to allow, either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property, in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the Insurer.
2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Annexures to Prospectus:
- Annexure A: Measurement of Fitness Assessment and Healthy Heart Score
- Annexure B: HRA Parameters
- Annexure I: List of Non-Medical Expenses
- Annexure II: Non Preferred Providers
- Annexure III: Insurance Ombudsman Offices
- Annexure IV: Product Benefit Table
- Annexure V: Rate Chart

Activ Fit (Young Adult Product), Product UIN: ADIHLIP22008V012223.