ADITYA BIRLA CAPITAL
HEALTH INSURANCE

Activ Assure
Prospectus

Section A. Key Highlights

A Health Insurance Indemnity Product to cater to ever changing health and protection need. key features includes coverage for Modern Treatment methods, Reload of Sum Insured, HealthReturns, Super No Claim Bonus, Accidental and Cancer Hospitalisation Booster.

Section B. Eligibility and Terms

A. Eligibility and Coverage:
minimum Age at entry:
a. Dependent Children from Age - 91 days to 5 years will be covered only if one adult is covered under family floater Policy. In case of an Individual policy, minimum age at entry is 5Yrs.
b. Children up to 25 years can be covered under the floater as dependents

Maximum age at entry: No Maximum age at entry.
Age is calculated as no. of years completed as on last birthday.

B. 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 for them. Relationships covered (Proposer's relationship with the Proposed Insured Member): Self, legally married spouse as long as they continue to be married, son, daughter, mother, father, brother, sister, mother in-law, father in-law, grandfather, grandmother, grandson, granddaughter, son in-law, daughter in-law, brother in-law, sister in-law, nephew, niece.

b. In case of a floater Policy, one family will share a single Opted Sum Insured. Relationships covered - Self, legally married spouse as long as they continue to be married, dependent children (upto 4)
Maximum floater cover can be offered to 2 Adults + 4 children.
Note: Son/Daughter/Child will include legally adopted Child and Step Child

C. Base Sum Insured and Optional Benefit
Sum Insured Options : Rs 2 Lakh, 3 Lakh, 4 Lakh, 5 Lakh, 7 Lakh, 10 Lakh, 15 Lakh, 20 Lakh, 25 Lakh, 30 Lakh, 40 Lakh, 50 Lakh, 75 Lakh, 100 Lakh, 150 Lakh, 200 Lakh

Optional covers under family floater policies, if chosen, will be applicable to all members in the Policy.

Cancer Hospitalization Booster is available for the following adult members (above the age of 18 yrs.)
a. Family Floater: All members above the age of 18 yrs.
b. Individual / multi Individual: all relations above the age of 18 yrs.

D. Policy Period option
You can buy the Policy for one, two or three continuous years at the option of the Insured Person. 'One Policy Year' shall mean a period of one year from the Start Date of the Policy.

E. Discounts under the Policy
You can avail of the following discounts on the premium on Your policy.
- Family Discount on multi individual policy: 2 or 3 members in a policy – 5% discount on premium applicable, 4 or more members in a policy
- 10% discount on premium applicable.
- A long term discount of 7.5% and 10% on selecting a 2 and 3 years Policy respectively. Long term discount will apply only in case of Single Premium Policies
- A 10% discount is applicable for employees of Aditya Birla Group upon purchase of this product.
- A 10% discount is applicable for employees of intermediaries of Aditya Birla Health Insurance Company Limited upon purchase of this product.
- A loyalty Discount of 5% maximum up to Rs.2500 on the applicable Premium of the subsequent Policy for Customers buying a subsequent Retail Policy in the same Policy Year from Aditya Birla Health Insurance Company Limited.
- A 10% discount is applicable by selecting PPN (preferred provider network) for treatment. Insured member has to bear a co-pay of 10% in case he/she will decide to take treatment outside PPN. This co-payment will apply over and above mandatory co-payment mentioned in the policy.

F. 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.

H. 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.

Section C. Benefits Covered Under the Policy

Section I: Basic Covers:

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

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

All claims must be made in accordance with the procedure set out in Section F.1. Claims paid under this Section will impact the Sum Insured and eligibility for No Claim Bonus and Super NCB.

(a) In-patient Hospitalization:

What is covered

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

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

Conditions

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

Proportionate deductions are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

a.1. Modern Treatment coverage

We shall cover the Medical Expenses for the following modern treatment procedures under section C .I. a. In-Patient Hospitalization or C.1.d 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.

(b) 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 limit as specified in the Policy Schedule / Product Benefit Table of this Policy, the Insured Person's Pre-hospitalization Medical Expenses incurred in respect of an Illness or Injury that occurs during the Policy Period.

Conditions

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

(c) Post – hospitalization Medical Expenses:

What is covered

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

Conditions

(i) We have accepted a claim for In-patient Hospitalization under Section C.I.(a) or Day Care Treatment under Section C.I.(d) or Domiciliary Hospitalization under Section C.I.(e) or Ayush (In-patient Hospitalization) under Section C.I.(i) below 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.

(d) Day Care Treatment:

What is covered

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

Conditions

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

What is not covered

OPD treatment is not covered under this Benefit.

(e) Domiciliary Hospitalization (Home Care):

What is covered

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

Conditions

(i) The Domiciliary Hospitalization continues for at least 3 consecutive days in which case We shall make payment under this Benefit in respect of Medical Expenses incurred from the first day of 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 C.I.(b) and Section C.I.(c) respectively for the same Illness/Injury.

What is not covered

We shall not be liable to pay for any claim in connection with:
(1) Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
(2) Arthritis, gout and rheumatism;
(3) Chronic nephritis and nephritic syndrome;
(4) Diarrhea and all type of dysenteries, including gastroenteritis;
(5) Diabetes mellitus and insipidus;
(6) Epilepsy;
(7) Hypertension;
(8) Psychiatric or psychosomatic disorders of all kinds;
(9) Pyrexia of unknown origin.

(f) Road Ambulance Cover:

What is covered

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

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

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

Conditions

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

What is not covered

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

(g) Organ Donor Expenses:

What is covered

We shall cover the Medical Expenses, up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy, incurred by or in respect of the organ donor, for organ transplant Surgery towards the harvesting of the organ donated.

Conditions

(i) The 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

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

(h) Reload of Sum Insured:

What is covered

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

Conditions

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

(i) Ayush (In-patient Hospitalization)

What is covered

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

Conditions

(i) Treatment taken is within India; and
(ii) Exclusion mentioned in Section D.II.(24) does not apply to this Benefit

(j) Daily Allowance

We shall pay a fixed amount as specified in the Policy Schedule / Product Benefit Table of this Policy, for each continuous and completed period of 24 hours of Hospitalization of the Insured Person.

Conditions

(i) We shall not be liable to make a payment under this Benefit for more than 5 consecutive days of Hospitalization for every period of Hospitalization.
(ii) We have accepted a claim for In-patient Hospitalization under Section C.I.(a) above for the same Illness/ Injury.

(k) Vaccination Cover:

What is covered

We shall cover the Insured Person up to the limit as specified in the Policy Schedule / Product Benefit Table of this Policy, towards vaccination expenses for the Insured Person up to 18 years of Age, for protection against Diphtheria, pertussis, Tetanus, Polio, Measles, Hepatitis B and Tuberculosis, which fall under category of vaccine preventable diseases as per the grid provided below

S.No	Vaccination & its presentation	Protection Against
1	BCG (Bacillus Calmette Guerin)-Lyophilized vaccine	Tuberculosis
2	OPV (Oral Polio Vaccine)-Liquid Vaccine	Poliomyelitis
3	Hepatitis B - Liquid Vaccine	Hepatitis B
4	DPT (Diphtheria, Pertussis and Tetanus Toxoid)-Liquid Vaccine	Diphtheria, Pertussis and Tetanus
5	Measles-Lyophilized vaccine	Measles
6	TT (Tetanus Toxoid) - Liquid Vaccine	Tetanus
7	JE Vaccination - Lyophilized vaccine	Japanese Encephalitis (Brain Fever)
8	Hib (Given as pentavalent containing Hib+DPT+Hep B)-Liquid Vaccine	Hib, Pneumonia and Hib meningitis

Section II: Additional Benefits

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

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

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

(I).a.No Claim Bonus:

What is covered

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

Conditions

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

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

(iii) If the Policy Period is two or three years, No Claim Bonus that has accrued for the first/second Policy Year will be credited at the end of the first/sec ond Policy Year as the case may be and will be available for claims made in the subsequent Policy Year.

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

(v) The accumulated No Claim Bonus can be utilised only when Sum Insured, Accidental Hospitalization Booster (if opted and as specified in the Policy Schedule)/ Cancer Hospitalization Booster (if opted and as specified in the Policy Schedule) have been completely exhausted.

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

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

(viii) If the Insured Persons in the expiring Policy are covered on a Family Floater Policy basis and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two 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.

(ix) 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.

(x) 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.

(xi) 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.

(xii) In case of Family Floater Policies, 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.

(l).b. No Claim Discount

We shall apply a No claim discount at such percentage as mentioned in the Policy Schedule on the premium of the Insured Persons expiring policy year, provided that the Insured Person(s) has not made any claim under Section C.I in a policy year, and has successfully renewed the policy with us continuously and without any break on or before the Grace Period.

Conditions:

i. Insured Person can either opt for (No Claim Bonus) or (No Claim Discount) at the time of renewal.

ii. No Claim Discount can be availed maximum upto the threshold of No Claim Bonus limit as specified in the Policy Schedule / Product Benefit Table.

iii. No Claim Discount is applicable on every claim free year, provided the policy is renewed with Us without a break, up to the maximum threshold of No Claim Bonus limit as specified in the Policy Schedule / Product Benefit Table.

iv. Applicability of HR + Renewal discount
The maximum discount shall be 100% of the premium, in case Insured Person has earned HR and is eligible for No Claim Discount

v. Application of No Claim Discount (NCD) in case of Individual Policy:
In case where the policy is on individual basis, the NCD shall be applied on Previous year policy premium as discount individually to the Insured person who was there in expiring policy and if no claim has been reported. NCD shall not be applicable only in case of claim from the same Insured Person.

vi. Application of No Claim Discount (NCD) in case of Floater Policy:
In case where the policy is on floater basis, the NCD shall be applied on Previous year policy premium as discount to the family on floater basis (Policy level), provided no claim has been reported from any member of the family. NCD shall not be applicable in case of claim from any of the Insured Persons.

vii. Application of No Claim Discount – Grace Period
NCD shall be available only if the Policy is renewed/ premium paid on or within the Grace Period.

viii. Application of No Claim Discount in case of Reduction in Sum Insured:
If the Sum Insured has been reduced at the time of Renewal, the NCD shall be calculated basis on the policy premium proportionate to the renewed Sum Insured.

ix. Application of No Claim Discount in case of Increase in Sum Insured:
If the Sum Insured under the Policy has been increased at the time of Renewal the NCD shall be calculated basis on the Previous Year policy premium.

x. Application of No Claim Discount in case of claim post payment of renewal premium:
If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any NCD offered shall be reduced from claim payable for the claimed policy year

xi. Application of No Claim Discount in case of Individual to Floater during renewal:
If the Insured Persons in the expiring policy are covered on an individual basis and such expiring policy has been Renewed on a floater policy basis, then the NCD to be applied on Previous Year Policy Premium provided no claim has been reported from any member of the family in previous policy.

xii. Application of No Claim Discount in case of Family Floater basis to Individual Basis during renewal:
If the Insured Persons in the expiring policy are covered on Family floater basis and such expiring policy has been Renewed on an individual policy basis, then the NCD to be applied on Previous Year Policy Premium provided no claim has been reported from any member of the family in previous policy.

xiii. Application of No Claim Discount in case of splitting the Sum insured into two or more floater policies /individual policies:
In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum insured into two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the NCD of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy

xiv. Application of No Claim Discount in case of Multi Year policies:
In case of Multi-year Policy, the NCD shall be applied on the Previous year policy premium on expiry of policy period as opted, provided there are no claims made in the last policy year. Only at the time of renewal, policyholder will be given the choice of NCB and NCD in case of last policy year being claim free.

(m)Health Check-up Program

What is covered

All Insured Persons in the Policy may avail a comprehensive health check-up once in a Policy Year in accordance with the table below.
Medical tests covered in the Health Check-up Program, applicable for Sum Insured up to 75 Lakh rupees for Insured Persons who are Aged 18 years and above on the Start Date are as follows:

List of Tests - During Annual Health Check up	Sum Insured
MER, CBC with ESR, Urine routine, Blood Group, Fasting Blood Sugar, Serum Cholesterol, SGPT, Serum Creatinine, ECG	Up to 4 Lacs
MER, CBC with ESR, Urine routine, Blood Group, Fasting Blood Sugar, Lipid Profile, Kidney Function Test, ECG	5 Lacs -10 Lacs
MER, CBC with ESR, Urine routine, Blood Group, Fasting Blood Sugar, Lipid Profile, TMT, Kidney Function Test	15 Lacs -75 Lacs

Medical tests covered in the Health Check-up Program, applicable for Sum Insured above 75 Lakh rupees for Insured Persons who are Aged 18 years and above on the Start date are as follows:

List of Tests - During Annual Health Check up	Sum Insured
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

Medical tests covered in the Health Check-up Program, for Insured Persons who are Aged less than 18 years on the Start date are as follows.

List of Tests - During Annual Health Check up	Sum Insured
Physical examination (Height, weight and BMI). Eye examination, Dental Examination and scoring, Growth Charting, Dr Consultation, Urine Examination (Routine and microscopic)	All Sum Insured

Reference:
MER - Medical Examiner's Report stamped and signed by a Medical Practitioner who is an MD physician,
BMI - Body Mass Index,
HWR – Hip waist ratio
CBC - Complete Blood Count,
ESR – Erythrocyte sedimentation rate
ECG – Electrocardiogram,
S.Creat - Serum Creatinine,
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 haemoglobin 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 (such as Diagnostic centres);
(ii) The Network Provider /Empanelled Service Provider shall be assigned by us post receiving customer's request to avail this Benefit;
(iii) The Insured Person shall be eligible to avail a health check-up every Policy Year.
(iv) Section D.II.(22) is not applicable in respect of coverage under this Benefit.
(v) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider / Empanelled Service Providers in relation to the health check-up.

(n) Second E-Opinion on Critical Illnesses

What is covered

If an Insured Person is diagnosed with any of the following listed Critical Illness during the Policy Period, the Insured Person may at his/her sole discretion choose to avail an E-opinion from Our panel of Medical Practitioners.
For the purpose of this Benefit, Critical Illness shall mean the following:

1. **CANCER OF SPECIFIED SEVERITY**
   - I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
   - II. The following are excluded –
     - i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
     - ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
     - iii. Malignant melanoma that has not caused invasion beyond the epidermis;
     - iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
     - v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
     - vi. Chronic lymphocytic leukaemia less than RAI stage 3
     - vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
     - viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. **MYOCARDIAL INFARCTION (First Heart Attack of specified severity)**
   - I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
     - i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
     - ii. New characteristic electrocardiogram changes
     - iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
   - II. The following are excluded:
     - i. Other acute Coronary Syndromes
     - ii. Any type of angina pectoris
   - iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

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 keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
   - II. The following are excluded:
     - i. Angioplasty and/or any other intra-arterial procedures

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/valvu loplasty are excluded.

5. **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.

6. **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 (haemo dialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

7. **STROKE RESULTING IN PERMANENT SYMPTOMS**
   - I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.
   - II. The following are excluded:
     - i. Transient ischemic attacks (TIA)
     - ii. Traumatic injury of the brain
     - iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. **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

9. **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.

10. MOTOR NEURONE 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.

11. 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. Neurological damage such as SLE is excluded.

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. BLINDNESS

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.
II. The Blindness is evidenced by
   i. corrected visual acuity being 3/60 or less in both eyes or;
   ii. the field of vision being less than 10 degrees in both eyes.
   III. The diagnosis of blindness must be confirmed and must not be correctable by aides or surgical procedure.

14. BENIGN BRAIN TUMOR

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.
II. This brain tumor must result in at least one of the following and must be confirmed by the relevant specialist Medical Practitioner.
   i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
   ii. Undergone surgical resection or radiation therapy to treat the brain tumor.
III. The following conditions are excluded:
   Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

15. 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 mmHg); and
   iv. Dyspnea at rest.

Conditions:

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

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

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

What is covered

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

(1) Emergency Medical Evacuation: When an adequate medical facility is not available in the proximity of the Insured Person, as determined by Our Empanelled Service Provider for providing such Emergency Services, the consulting Medical Practitioner and the Medical Practitioner attending to the Insured Person, transportation under appropriate medical supervision will be arranged, through an appropriate mode of transport to the nearest medical facility which is able to provide the required care.
(2) Medical Repatriation (Transportation): When medically necessary, as determined by Us and the consulting Medical Practitioner, transportation under medical supervision shall be provided in respect of the Insured Person to the residential address as 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.
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:

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

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

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

What is covered

We will provide the Emergency medical assistance outside India as described below when an Insured Person is travelling 150 (one hundred and fifty) kilometres or more away from his/her residential address as mentioned in the Policy Schedule for a period of less than 90(ninety) days.
(1) Emergency Medical Evacuation: When an adequate medical facility is not available in the proximity of the Insured Person, as determined by Our Empanelled Service Provider for providing such Emergency Services, the consulting Medical Practitioner and the Medical Practitioner attending to the Insured Person, transportation under appropriate medical supervision will be arranged, through an appropriate mode of transport to the nearest medical facility which is able to provide the required care.
(2) Medical Repatriation (Transportation): When medically necessary, as determined by Us and the consulting Medical Practitioner, transportation under medical supervision shall be provided in respect of the Insured Person to the residential address as 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.
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:
(1) Travel undertaken specifically for securing medical treatment.
(2) Injuries resulting from participation in acts of war or insurrection.
(3) Commission of an unlawful act(s).
(4) Attempt at suicide.
(5) Incidents involving the use of drugs unless prescribed by a Medical Practitioner.
(6) Transfer of the Insured Person from one medical facility to another medical facility of similar capabilities which provides a similar level of care.
(7) Trips exceeding 90 days from residential address without prior notification to Us.

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

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 C.III are subject to the terms, conditions and exclusions of this Policy.

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

(q) HealthReturns™

(q.1) Health Assessment™

What is covered

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

Conditions

If the Insured Person who has undergone tests under Health Check-up Program/Comprehensive health check-up with Dental investigation, then those specific tests shall not be permitted to be repeated under the Health Assessment in the same Policy Year.

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.

(q.2) HealthReturns™

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

How to Earn HealthReturns™

Earned by way of a percentage of Premium through Healthy Heart Score™ and Active Dayz™

Step 1 – Complete Health questionnaire & Health Assessment™ (applicable for each individual Insured Person)- This is not applicable for individuals who have undergone pre-Policy medical examination before issuance of the Policy, for the first Policy Year.
(i) Complete the online health questionnaire through Our website or mobile application. If requested, We would assist the Insured Person in completing the questionnaire over a call. The result of this questionnaire would help the Insured Person understand his/her current health status. This is not mandatory to earn HealthReturns™.

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

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

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

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

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

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

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

(ii) One Active Dayz™ can be earned by:
  (1) completing a Fitness centre or yoga centre activity for a minimum of 30 minutes at Our repanel of Fitness or yoga centers, OR;
  (2) Recording 10,000 or more steps in a day (tracked through Our mobile application or a wearable device linked to the Policy number) OR;
  (3) burning 300 calories or more in one exercise session per day OR;
  (4) participation in a recognized marathon/ walkathon/ cyclothon or a similar activity which offers a completion certificate with timing

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

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

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

			Healthy Heart Score™		
No of Active Dayz™ in a calendar month	OR	Fitness Assessment Result*	**Red**	**Amber**	**Green**
13 or more		Level 5	6.0%	12.0%	30.0%
10 – 12		Level 4	3.6%	7.2%	18.0%
07—09		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%

*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.

The grid above is calculated on the Monthly Premium (excluding GST). The Insured Person can earn up to 30% of their Monthly Premium as HealthReturns™ based on the grid above.

How it works for an Individual Policy
In case of an Individual Policy, each Insured Person would be tracked separately and shall earn HealthReturns™ based on individual performance as per grid of Healthy Heart Score™ and Active dayz™. The following relations upto Age of 25 years shall not be eligible for earning HealthReturns™ namely son, daughter, brother, sister, grandson, granddaughter, brother in-law, sister in-law, nephew, niece.

How it works for a Family Floater Policy
In case of a Family Floater Policy, each Insured Person would be tracked separately and shall earn HealthReturns™ based on individual performance as per grid of Healthy Heart Score™ and Active dayz™. For the purpose of calculating HealthReturns™, We will allocate the overall premium to the adults in the Policy. Weightages for allowed family combinations are as described in the table below.
(Dependent Children upto 25 years of Age shall not eligible for HealthReturns™).

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

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

How can one spend HealthReturns™:

Funds under HealthReturnsTM may be utilized towards the following expenses:

(i) In-patient Medical Expenses and Day Care Treatment, provided that the Sum Insured, No Claim Bonus(if any), Super NCB(if any), Accidental Hospitalization Booster(if opted as specified in the Policy Schedule)/ Cancer Hospitalization Booster (if opted as specified in the Policy Schedule), Reloaded Sum Insured (if any) and Unlimited Reload of Sum Insured (if opted and available) are exhausted during the Policy Year as specified in section E.(II).(30)
(ii) Payment of Co-payment (wherever applicable).
(iii) For non-payable claims, in case of an In-patient Hospitalization or Day Care Treatment.
(iv) Non-Medical Expenses listed in Annexure I 'Non-Medical Expenses' that would not otherwise be payable under the Policy.
(v) Out-patient expenses up to the value of accrued funds.
(vi) Ayush Treatments in excess of the limits as specified in Policy Schedule / Product Benefit Table of this Policy.
(vii)Payment of Premium for any other Retail Policy with Aditya Birla Health Insurance Co Ltd

Alternatively, funds can also be utilized to pay Renewal Premium. Funds earned as HealthReturns™, once earned can be carried forward each month/ each Policy Year (as applicable) and as long as the Policy is Renewed with Us in accordance with the Renewal Terms under the Policy.
If HealthReturns™ earned is not utilized during the Policy Year, by default it will be automatically adjusted to pay Renewal premium prior to the due date for payment for Renewal premium.

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

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

(q.3) Health Coach

All Insured persons Aged 18 Years or above, suffering from any one or more of the listed chronic conditions namely Asthma, Hypertension, Hyperlipidemia or Diabetes Mellitus is/are eligible for a health coaching session with Our expert Health Coach. Our Health Coach shall be coaching the Insured Person on better lifestyle management to take care of such chronic condition.

Conditions

a) These coaches shall be available over a telephonic discussion as a call back service. The request for call back may be placed through our toll free number or via E-Mail.
b) A maximum of 2 coaching sessions may be availed by the Insured Person during a Policy Year.
c) It is agreed and understood that Our Health Coaches are not providing and shall not be deemed to be providing any Medical Advice. They shall only provide a suggestion for the Insured Person's consideration and it is the Insured Person's sole and absolute choice to follow the suggestion for any health related advice.
d) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this Benefit.

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

Benefits under this Section C.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 C.IV must be made in accordance with the procedure set out in Section F.1 Wherever a claim qualifies under more than one Benefit in Section C.IV, We shall pay for all such eligible covers opted and in force.

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

(r) Unlimited Reload of Sum Insured

What is covered

We shall reload the Sum Insured, up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy, unlimited times during the Policy Year.

Conditions

(i) "Unlimited Reload of Sum Insured" is an extension of the Benefit mentioned in Section C.I.(h) (Reload of Sum Insured) and therefore all the conditions and provisions stated under Section C.I.(h) shall also be valid and applicable in relation to this Section C.IV.(r), except that the reload of Sum Insured shall be available unlimited times during the Policy Period. It is, however clarified that in case of a single claim payout, Our maximum liability shall not exceed the limit as specified in the Policy Schedule/Product Benefit Table of this Policy.
(ii) No Claim Bonus (Section C.II.(l)) and Super NCB (Section C.IV.(s)) shall not be considered while calculating the Unlimited Reload of Sum Insured.

(s) 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 C.II.(l)) 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 C.I in the Policy Schedule on a cumulative basis, provided that the Insured Person(s) has not made any claim under Section C.I 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 C.II.(I) (No Claim Bonus) and therefore all the conditions and provisions stated under Section C.II.(I) shall also be valid and applicable in relation to for this Section C.IV.(s).
(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 reload amount (Reload of Sum Insured and Unlimited Reload of Sum Insured), Accidental Hospitalization Booster, Cancer Hospitalization Booster and accumulated NCB shall not be considered while calculating the Super NCB.

(t) Accidental Hospitalization Booster

What is covered

We shall provide an additional Sum Insured towards Medical Expenses incurred for In-patient Hospitalization, up to the limit specified in the Policy Schedule / Product Benefit Table of this Policy, following an Emergency caused solely and directly due to an Accident causing Injury, of the Insured Person who is Hospitalized for the treatment of such Injury.

We shall cover the following Medical Expenses:

- Reasonable and Customary Charges for Room Rent for accommodation in Hospital room up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy;
- ICU Charges;
- Operation theatre expenses;
- Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
- Qualified Nurses' charges;
- Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
- Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized and conducted within the same Hospital where the Insured Person is admitted;
- Anaesthesia, blood, oxygen and blood transfusion charges;
- Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Conditions

(i) This Benefit shall be utilized only after the Sum Insured has been completely exhausted.
(ii) The total amount payable under this optional cover shall not exceed the sum total of the Sum Insured, No Claim Bonus (if earned), Super NCB (if opted and as specified in the Policy Schedule) and Accidental Hospitalization Booster.
(iii) This Benefit shall be available only for such Insured Person for whom claim for Hospitalization following the Accident has been accepted under this Policy.
(iv) This Benefit shall be available only once during the Policy Year.
(v) The conditions stipulated under Section C.I.(a) shall be applicable.

(u) Cancer Hospitalization Booster

What is covered

If an Insured Person is diagnosed with "Cancer of Specified Severity" (as defined under this Benefit) during the Policy Period, We shall provide an additional Sum Insured towards Medical Expenses incurred for In-patient Hospitalization, up to the limit as specified in Policy Schedule / Product Benefit Table of this Policy, for the Insured Person who is Hospitalized for the treatment of "Cancer of Specified Severity", during the Policy Year.

We shall cover the following Medical Expenses:

- Reasonable and Customary Charges for Room Rent for accommodation in Hospital room up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy;
- ICU Charges;
- Operation theatre expenses;
- Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
- Qualified Nurses' charges;
- Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
- Investigative tests or diagnostic procedures directly related to Cancer of Specified Severity for which the Insured Person is Hospitalized and conducted within the same Hospital where the Insured Person is admitted;
- Anaesthesia, blood, oxygen and blood transfusion charges;
- Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Conditions

(i) This Benefit shall be utilized only after the Sum Insured has been completely exhausted.
(ii) The total amount payable under this optional cover shall not exceed the sum total of the Sum Insured, No Claim Bonus (if earned), Super NCB (if opted and as specified in the Policy Schedule) and Cancer Hospitalization Booster.
(iii) This Benefit shall be available only for such Insured Person for whom claim for Hospitalization following Cancer of Specified Severity has been accepted under the Policy.
(iv) This Benefit shall be available only once during the Policy Year.
(v) In addition to the foregoing, the conditions stipulated under Section C.I.(a) shall be applicable.

For the purpose of this Benefit, Cancer of Specified Severity is defined as follows:

CANCER OF SPECIFIED SEVERITY

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
II. The following are excluded –
   i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
   ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
   iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

(v) Any Room Upgrade

What is covered

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

(w) Preferred Provider Network (PPN)

What is covered

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

Conditions

i. If the Insured Person takes Inpatient hospitalization treatment as applicable under section C.I.(a) in a Hospital other than those listed as "Preferred Provider Network", then the Policyholder / Insured Person shall bear a Co-Payment of 10% on each and every claim arising in such regard, which will be in addition to any other Co-Payment applicable under the Policy.
ii. The updated list of Hospitals listed as "Preferred Provider Network" can be referred to on Our website.

Section D. 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 years / 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 applicable norms on portability stipulated by IRDAI, 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:

Sr.No	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	
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

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 D.II.1 .

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:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

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 III 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)**:
v. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
vi. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

II. Specific Exclusions

19. Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, uprising, revolution, insurrection, military or usurped acts, nuclear weapons / materials, chemical and biological weapons, ionizing radiation, contamination by radioactive material or radiation of any kind, nuclear fuel, nuclear waste.

20. Willful or deliberate exposure to danger, intentional self-Injury, participation or involvement in naval, military or air force operation.

21. Any Illness/injury/accident due to abuse of intoxicants, smoking cessation programs and the treatment of nicotine addiction, unless prescribed by a Medical Practitioner.

22. All routine examinations and preventive health check-ups

23. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment);

24. Non allopathic treatment.

25. Conditions for which treatment could have been done on an outpatient basis without any Hospitalization

26. Investigational treatments, Experimental treatment, or drugs yet under trial, devices and pharmacological regimens.

27. Convalescence, cure, sanatorium treatment, private duty nursing, treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification centre, home for the aged, mentally disturbed remodeling clinic or any treatment taken in an establishment which is not a Hospital.

28. Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing

29. 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.

30. Hearing aids, spectacles or contact lenses including optometric therapy, multifocal lens

31. Treatment for alopecia, baldness, wigs, or toupees, and all treatment related to the same.

32. Medical supplies including elastic stockings, diabetic test strips, and similar products.

33. Any expenses incurred on prosthesis, corrective devices external durable medical equipment of any kind, like wheelchairs crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.), devices used for ambulatory monitoring of blood pressure, blood sugar, glucometers, nebulizers and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Cost of artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment. Sleep-apnea and other sleep disorders.

34. Parkinson and Alzheimer's disease, general debility or exhaustion ("rundown condition").

35. External Congenital Anomalies or diseases or defects.

36. Stem cell therapy (except Hematopoietic stem cells for bone marrow transplant for haematological conditions) or Surgery, or growth hormone therapy or Hormone Replacement Therapy.

37. Venereal disease, all sexually transmitted disease other than HIV/AIDS or Illness including but not limited to HPV, Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.

38. Expenses for organ donor screening, and to the extent provided for the treatment of the donor (including Surgery to remove organs from a donor in the case of transplant Surgery).

39. Admission for Organ Transplant but not compliant under the Transplantation of Human Organs Act, 1994 (amended)

40. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.

41. Dentures, implants and artificial teeth, Dental Treatment and Surgery of any kind, unless requiring Hospitalization due to an Accident.

42. Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose

43. 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.

44. Expenses which are medically not necessary such as items of personal comfort and convenience including but not limited to television (if specifically charged), charges for access to telephone and telephone calls (if specifically charged), food stuffs (save for patient's diet), cosmetics, hygiene articles, body care products and bath additives, barber expenses, beauty service, guest service as well as similar incidental services and supplies, vitamins and tonics unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

45. 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.

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

47. 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.

48. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.

49. Administrative charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, bio-medical, linen, documentation and filing, including MRD charges (medical records department charges).

50. Non-Medical Expenses including but not limited to RMO, CMO, DMO charges, surcharges, night charges, service charges levied by the Hospital under any head and as specified in the Annexure I - Non- Medical Expenses and on Our website www.adityabirlahealth.com/healthinsurance.

51. Treatment taken outside India

52. Use of Radio Frequency (RF) probe for ablation or other procedure unless specifically approved by Us in writing in advance.

53. In respect of the existing diseases, disclosed by the insured and mentioned in the Policy Schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes

Section E. General Terms and Clauses

I. Standard General Terms & Clauses

1. Disclosure of Information

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

2. Condition Precedent to Admission of Liability

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

3. Complete Discharge

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

4. Multiple Policies

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

Benefit based covers:

On occurrence of the insured event, the policyholders can claim from all Insurers under all policies.

5. Fraud

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

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

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

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

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

6. Cancellation

1. Cancellation by You

i. The Policyholder may cancel his / her policy at any time during the term, by giving 7 days notice in writing. The Company shall
   a. refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period.
   b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

Note: For Policies where premium is paid by instalment: In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.

ii. 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.

A refund in accordance with 6.1.i. (a) or6.1. i. (b) above shall be applicable for 'Yearly / Annual / One Time' premium payment frequency.

No refund is applicable for Half Yearly, Quarterly & Monthly premium frequencies

Provided that in case there is a request for refund where claim has been made only under Section C.III.(q.1) Health Assessment and/ or Section C.II.(m) Health Check-up Program, we shall process the refund in accordance with i. (a) or i. (b) above and after deduction of the charges for the claims made under the Sections referred herein above.

2. Automatic Cancellation:

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

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

c. Refund:
A refund in accordance with i. (a) or i. (b) 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 3 month period from the date of cancellation/ termination.

7. 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. 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 to the extent of the Sum Insured, No Claim Bonus if any, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period, provided the policy was renewed continuously without break.

For detailed guidelines on migration, kindly refer the link
https://www.adityabirlacapital.com/healthinsurance/downloads

8. 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 30 days before, but not earlier than 60 days from the policy renewal date. 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 to the extent of the Sum Insured, Cumulative Bonus, if any, specific waiting periods, waiting period for pre-existing disease, Moratorium period, provided the policy was renewed continuously without break.

For detailed guidelines on portability, kindly refer the link
https://www.adityabirlacapital.com/healthinsurance/downloads

9. Renewal of Policy

The Policy shall ordinarily be renewable provided the product is not withdrawn, except on grounds of established fraud or non-disclosure or 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 (15) fifteen days where premium payment mode is monthly and (30) thirty days in all other cases to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. The insurer shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.
vi. No loading shall apply on renewals based on individual claims experience
vii. An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.

10. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits to the extent of Sum Insured, Cumulative Bonus, if any, waiver of waiting period, Specific waiting periods, waiting period for Pre-existing disease, moratorium period, as per IRDAI guidelines, provided the policy has been maintained without a break.

11. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first Policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period..

12. 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) fifteen days in case of monthly premium policies, and a period of 30 days in case of other than monthly premium policies would be given to pay the instalment premium due for the policy.
ii. The Policy will be in force during such grace period and any claims arising during the Grace Period will be payable subject to policy terms and conditions
iii. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
vii. The Company has the right to recover and deduct all the pending instalments from the claim amount due under the Policy.

13. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, may revise or modify the terms of the Policy including the premium rates with prior approval of the Product Management Committee, of the Company. The Insured Person shall be notified three months before the changes are effected.

14. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies, except for those policies with tenure of less than a year. Free-Look shall not be applicable on renewals or at the time of porting / migrating the policy.

The Insured Person shall be allowed Free Look Period of thirty days from date of receipt of the policy document, whether received electronically or otherwise, 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 stamp duty charges, where the risk has not commenced 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, expenses, if any incurred by the Company on medical examination of the Insured Person and stamp duty charges or
III. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period, expenses, if any incurred by the Company on medical examination of the Insured Person and stamp duty charges.

A request received by insurer for cancellation of the policy during free look period shall be processed and premium shall be refunded within 7 days of receipt of such request.

15. Redressal of Grievance

In case of a grievance, the Insured Person/ Policyholder can contact Us with the details through:
Our website: https://www.adityabirlacapital.com/healthinsurance/faqs
Toll Free : 1800 270 7000
Email: care.healthinsurance@adityabirlacapital.com
Courier: Aditya Birla Health Insurance Co. Limited Unit no 1101 & 1104 11th floor, Unit no 1501 & 1502 15th floor, G Corp Tech Park, Kasarwadavali, Ghodbunder Road, Thane West - 400601

In case you are not satisfied with the resolution you may write to Head Customer Care : carehead.healthinsurance@adityabirlacapital.comInsured 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 gro.healthinsurance@adityabirlacapital.com
For senior citizens, please contact Our respective branch office or call at 1800 270 7000 or write an e- mail at seniorcitizen.healthinsurance@adityabirlacapital.com

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of the Ombudsman offices are provided on Our website and in this Policy at Annexure II
Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://bimabharosa.irdai.gov.in

16. Nomination:

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

17. Claim Settlement (provision for Penal interest)

i. Settlement of claims (other than cashless) shall be settled within 15 days from submission of claim.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of claim intimation till the date of payment of claim at a rate of 2% above the bank rate.
(Explanation: "Bank rate" shall mean rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1 st day of the financial year in which the claim has fallen due)

II. Specific Terms & Clauses

18. Material Change

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

19. Alterations in the Policy

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

20. No Constructive Notice

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

21. 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/Mar riage 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 D.I.1, D.I.2, D.I.3 will be applicable considering such Policy Year as the first year of Policy with Us with respect to the Insured Person.

(xi) Applicable No Claim Bonus shall be accrued on each Renewal as per eligibility under the plan in force.

(xii) In case of Family Floater Policies, children attaining 25 years at the time of Renewal will be moved out of the floater into an individual cover. 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 Persons(s) covered under the original Policy.

22. Records to be maintained

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

23. Endorsements

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

(i) Non-Financial Endorsements – which do not affect the premium.

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

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

(ii) Financial Endorsements – which result in alteration in premium.

(1) Addition of Insured Person^ (newly wedded spouse)
(2) Deletion of Insured Person on death or separation or Policyholder/Insured Person leaving India
(3) Change in Age/date of birth*
(4) Change in Height, weight*
(5) Others

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

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

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

24. Grace Period

The Policy may be Renewed by mutual consent for life subject to application of renewal and realization of renewal premium and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days (for Quarterly, Half yearly and annual instalments) & 15 days for Monthly policies from the date of expiry of the Policy. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.

25. Communications & Notices

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

(i) The Policyholder's, at the address/ E-mail ID as specified in the Policy Schedule/Proposal form or provided to Us by the Policyholder / Insured Person

(ii) To Us, at the address specified in the Schedule.

(iii) No insurance agents, brokers, other person or entity is authorised to receive any notice on the behalf of Us unless explicitly stated in writing by Us.

26. Electronic Transactions

The Policyholder and the Insured agree to adhere and comply with all such terms and conditions of electronic transactions as We may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of Us, for and in respect of the Policy or its terms, or Our other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with Our terms and conditions for such facilities, as may be prescribed from time to time.

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Policyholder. A voice recording in case of tele-sales or other evidence for sales through the Internet shall be maintained and such consent shall be subsequently validated / confirmed by the Policyholder.

27. Policy Dispute

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

28. Assignment

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

29. Territorial Jurisdiction

All benefits are available in India onlyexcept Section C.II.(P), and all claims shall be payable in India in Indian Rupees only.

30. Sequence of Sum Insured Utilisation

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

1. Sum Insured
2. Accidental Hospitalization Booster/ Cancer Hospitalization Booster (if opted and as specified in the Policy Schedule)
3. Accumulated No Claim Bonus
4. Accumulated Super NCB
5. Reload of Sum Insured
6. Unlimited Reload of Sum Insured (if opted and as specified in the Policy Schedule)

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

31. Co-payment

At the time of inception of initial policy (first policy) with Us, if the Age (Age at entry) of the Insured Person or eldest Insured Person (in case of a Family Floater Policy) is 61 years or above, such Insured Person or all Insured Persons (in case of Family Floater Policy) shall bear a Co-payment per claim (over and above any other Co-payment, if any) as specified in Product Benefit Table/Policy Schedule.

F. Other Terms and Conditions:

1. Claims Administration & Process

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

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

(2) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.

(3) We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

I. Claims Procedure

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

a. For Availing Cashless Facility

   i. Cashless Facilities can be availed only at Our Network Providers/ Empanelled Service Providers. The complete list of Network Providers and Empaneled Service Providers is available on Our website and at Our branches and can also be obtained by contacting Us over the telephone.

   ii. We reserve the right to modify, add or restrict any Network Provider/ Empaneled Service Provider for Cashless Facilities at Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers.

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

(i) We must be contacted to pre-authorise Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Each request for pre-authorisation must be accompanied with all the following details:
   (1) The health card issued by Us to the Insured Person, along with the Insured Person's KYC documents.
   (2) The Policy Number;
   (3) Name of the Policyholder;
   (4) Name and address of Insured Person in respect of whom the request is being made;
   (5) Nature of the Illness/Injury and the treatment/Surgery required;
   (6) Name and address of the attending Medical Practitioner;
   (7) 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 initial authorization letter shall be issued to the Network Provider immediately but not more than one hour of receipt of request 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 initial authorization letter shall be issued to the Network Provider immediately but not more than one hour of receipt of request 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) Part A & Part B for a hospitalization claim
   (2) Proposer's id proof: PAN Card & Adhaar card (If CKYC not registered). If CKYC registered: CKYC form and CKYC number
   (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 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) Proposer's Bank Account Details-Cancelled Cheque Leaf with Proposer name pre-printed OR Bank Passbook 1st page
(16) Legal Heir / Succession Certificate in case of Proposer's Death
(17) Affidavit - NOC from other Legal Heirs on a Stamp Paper certified by a Public Notary (In case of settlement to one Legal Heir)
(18) Nominee / Legal Heir Bank Account Details-Cancelled Cheque Leaf / Passbook / Bank Statement (in case of Proposer's Death)
(19) Pharmacy / Investigation / Diagnostic Bills with Prescriptions / Diagnostic
(20) Reason for delayed submission of claim (if submission is beyond 30 days from date of discharge/event/last treatment date)
(21) Invoice / Sticker for the implants used in the treatment
(22) ID Card issued by Employer (in case of Group Policy)
(23) In case of Accident:
Medico Legal Case (MLC) / Accident Report (AR)
First Information Report (FIR)
Police Final Report
(24) Original invoice for Vaccination and payment receipt
(25) KYC documents

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

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

(iii) For acceptance of claims in electronic mode, the documents shall be submitted in such form and manner as may be specified by Us.
(iv) For the following Claims, please notify the same at our call centre/website/e-mail

- Health Assessment™
- HealthReturns™
- Health Check-up Program
- Health Coach
- Domestic Emergency Assistance Services (including Air Ambulance)
- International Emergency Assistance Services (including Air Ambulance)
- Second E-Opinion on Critical Illnesses

III. Claims Assessment & Repudiation:
(a) At Our discretion, We may investigate claims to determine the validity of a claim. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals/entities that are authorised by Us in writing. We will be sending communications to address the deficiency.
(b) We may decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if We observe that such a claim is otherwise valid under the Policy.
(c) Payment for reimbursement claims will be made to You. In the unfortunate event of Your death, We will pay the Nominee named in the Policy Schedule or Your legal heirs or legal representatives holding a valid succession certificate.

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

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.