

Arogya Sanjeevani Policy, Aditya Birla Health Insurance Co. Limited Prospectus



1. Key Highlights

An Indemnity Health Insurance Product covering Hospitalization expenses, Ambulance Charges, Day Care Procedures, AYUSH Coverage, Cataract Treatment, Pre-Hospitalisation, Post-Hospitalisation, Modern Treatment methods and Cumulative bonus.



2. Eligibility and Terms

1. Eligibility Criteria

1. This Policy covers persons in the age group 3 months to 65 years.
2. The maximum entry age is restricted to 65 years. Proposer with higher age can obtain policy for family, without covering self.
3. Dependent Children from Age – 3 months to 25 years will be covered only if one adult member is covered under the Policy.
4. Children between the age 3 months to 25 years can be covered as dependents. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.
5. Age is calculated as number of years completed as on last birthday.
6. Policy is subject to lifelong renewability.
7. This policy is issued on Individual basis/ floater basis.
8. In case of an Individual policy, each individual family member under the policy will have a separate Sum Insured.
9. In case of a floater Policy, single opted Sum Insured shall apply to the entire family.
10. Relationships covered in Individual Policy: Self, spouse, dependent children, mother, father, mother in-law, father in-law.
11. Relationships covered in Floater policy: Self, spouse, dependent children, mother, father, mother in-law, father in-law. Maximum number of adults covered in case of floater policy is 6.

2. Policy Period

The Policy will be issued for a period of 1 year.

3. Sum Insured

The policy offers following sum insured options on Individual and/or Floater basis

INR 0.5 Lac, 1 Lac, 1.5 Lacs, 2 Lacs, 2.5 Lacs, 3 Lacs, 3.5 Lacs, 4 Lacs, 4.5 Lacs, 5 Lacs, 5.5 Lacs, 6 Lacs, 6.5 Lacs, 7 Lacs, 7.5 Lacs, 8 Lacs, 8.5 Lacs, 9 Lacs, 9.5 Lacs, 10 Lacs

4. Pre Policy Check up

Pre-Policy medical check- up may be required based on Sum Insured, Age and/or any health declaration. Medical tests will be facilitated by Us and conducted at Our network of diagnostic centres. At least 50% of pre policy medical check-up will be borne by the Us for all accepted proposals. In case of rejected proposals or where a counter offer is not accepted by the customer, We will bear at least 0% of the cost for pre policy medical check-up. We may revise this from time to time basis the current experience, within the range as may be prescribed by under then prevailing IRDAI Regulations.

5. Underwriting and Loading

- 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.

6. Discount Under the Policy

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

A 10% discount is applicable for employees of intermediaries of Aditya Birla Health Insurance Company Limited upon purchase of this product.



3. Benefits Covered under the Policy

I. Coverage

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

1. Hospitalization

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

- i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.
- ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs. 10,000/- per day.
- iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor/ surgeon or to the hospital
- iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

1.1. Other expenses

- i. Expenses incurred on treatment of cataract subject to the sub limits as mentioned in Section 4.3 below
- ii. Dental treatment, necessitated due to disease or injury
- iii. Plastic surgery necessitated due to disease or injury
- iv. All the day care treatments
- v. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment
2. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent / ICU / ICCU charges.

2. AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

3. Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs.40,000/-, whichever is lower, per each eye in one policy year.

4. Pre Hospitalization

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

5. Post Hospitalisation

The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

6. The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:
 - 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 prostate (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.
7. The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure - A respectively.

II.a. Cumulative Bonus (CB)

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

Notes:

- i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
- ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.
- iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.

- iv. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons
- v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum insured in to 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 CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy
- vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
- vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
- viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn

(II).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. 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.
- v. 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.
- vi. 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.
- vii. 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.
- viii. 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.
- ix. 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
- x. 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.
- xi. 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.
- xii. 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



4. Exclusions

I. Standard Exclusions

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below in 4.I.1, 4.I.2 and 4.I.3:

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 36 months of continuous coverage after the date of inception of the first policy with Us.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If the Insured Person is continuously covered without any break as defined under the 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 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

2. 30 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.

3. Specific Waiting Period: (Code- Excl02)

- a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. 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.

i. 24 Months waiting period

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. Internal Congenital Anomalies

ii. 36 Months waiting period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

4. Investigation & Evaluation (Code- Excl04)

- a) Expenses related to any admission primarily for diagnostics and evaluation purposes.
- b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

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 comorbidities 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 and disclosed in our 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 health spas, 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 sterilization
- ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- iii. Gestational Surrogacy
- iv. Reversal of sterilization

18. Maternity Expenses (Code - Excl18):

- i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- ii. expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

II. Specific Exclusions

19. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
20. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
 - a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.
 - b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any illness, incapacitating disablement or death.
 - c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.
21. Any expenses incurred on Domiciliary Hospitalization and OPD treatment
22. Treatment taken outside the geographical limits of India
23. 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.



5. General Terms and Clauses

I. Standard General Terms and 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-disclosure of any material fact.

2 Condition Precedent to Admission of Liability

The due observance and fulfilment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

3 Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim

4. Multiple Policies

- i. 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.
- ii. 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.
- iii. 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.
- iv. 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 shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a 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 policy 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 mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

6. Cancellation

- a) The Policyholder may cancel his / her policy at any time during the term, by giving 7 days notice in writing. The Company shall 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. 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. No refund is applicable for Half Yearly, Quarterly & Monthly premium frequencies.
- b) The Company may cancel the Policy at any time on grounds of mis-representation, 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 mis-representation, non-disclosure of material facts or fraud.

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, Cumulative 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. Premium Payment in Installments

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.

11. 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.

12. 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 is not 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.

13. 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.

14. 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.

15. Redressal Of Grievance

Grievance-In case of any grievance relating to servicing the Policy, the insured person may submit in writing to the Policy issuing office or regional office for redressal.

For details of grievance officer, kindly refer the link :gro.healthinsurance@adityabirlacapital.com

IRDAL Integrated Grievance Management System – <https://bimabharosa.irdai.gov.in/>

Insurance Ombudsman -The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-B.

No loading shall apply on renewals based on individual claims experience. Insurance is the subject matter of solicitation.

16. 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 1st day of the financial year in which the claim has fallen due)

II. Specific Terms & Clauses

17. Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and/ or premium, if necessary, accordingly.

18. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

19. Notice & Communication

- i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
- ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
- iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

20. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

21. Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate:

1. In the case of his/ her (Insured Person) demise. However the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

22. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

23. Arbitration

- i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
- ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.
- iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

24 Endorsements (Changes in Policy)

- i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
- ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

25. Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in Sum Insured, the waiting period shall start afresh only for the enhanced portion of the sum insured.

26. Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.



6. Other Terms and conditions

6.1. CLAIM PROCEDURE

1. Procedure for Cashless claims:

- (i) Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA.
- (ii) We offer Cashless Everywhere, even in hospitals which are not part of our network. For More details and process please visit our website: <https://www.adityabirlacapital.com/healthinsurance/faqs>
- (iii) Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.
- (iv) The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.
- (v) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
- (vi) The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
- (vii) In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company/TPA for reimbursement.

2. Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to TPA (if applicable)/Company within the prescribed time limit as specified hereunder.

Sl No	Type of Claim	Prescribed Time limit
1	Reimbursement of hospitalization, day care and prehospitalization expenses	Within thirty days of date of discharge from hospital
2	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

6.2 Notification of Claim

Notice with full particulars shall be sent to the Company /TPA (if applicable) as under:

- i. Within 24hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
- ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

6.3 Documents to be submitted:

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

1) Hospitalization / In- patient Claims:

- a. Duly signed, stamped and Completed claim form
- b. Photo ID & age proof
- c. Original discharge card / day care summary / transfer summary
- d. Original final bill of the Provider with all original deposit & final payment receipt.
- e. Original invoice with payment receipt & implant stickers for all implants used during surgeries i.e. lens sticker & invoice in cataract surgery,

- f. Treating doctor's letter stating:
 - i. Presenting complaints with duration & past history.
 - ii. Medical history of co-morbidities e.g. hypertension, heart ailment, etc.
 - iii. Treatment detail with name of drugs & route of administration.
- g. All previous consultation papers indicating history & treatment details for current ailment.
- h. All original diagnostic reports (including imaging and laboratory) along with the doctor's prescription & invoice / bill with receipt from diagnostic center.
- i. All original medicine / pharmacy bills along with the doctor's prescription.
- j. MLC / FIR Copy – in accidental cases only
- k. Copy of Death Summary & Death Certificate (in death claims only)
- l. Treating doctor's letter stating – in Accidental Cases Only:
 - i. Details of accident/trauma.
 - ii. Whether the patient was under the influence of alcohol or any intoxicating substance during incident / accident.
 - iii. Pre & Post- Operative Imaging reports – in Accidental Cases Only.
- m. Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, & patient's progress.
- n. KYC documents & CKyc form (where applicable)
- o. Photocopy of entire claim document duly attested by previous insurer or TPA.
- p. Original payment receipts for expenses not claimed/settled by the previous insurer.
- q. Discharge voucher/settlement letter by previous insurer.

2) Pre- & Post- hospitalization Medical Expenses Claims:

- a. Duly filled claim form (Insured / patient & hospitalization details).
- b. Photo ID & age proof
- c. Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents).
- d. Copy of the Provider's Registration Certificate / Copy of Form C in case of hospitalization.
- e. Original discharge card / day care summary / transfer summary in case of hospitalization.
- f. Doctor's consultation or follow- up prescription with bill & receipt.
- g. Copy of final bill of the Provider with all original deposit & payment receipt.
- h. Original invoice with payment receipt & implant stickers.
- i. All original investigation report with original bill & payment receipt of investigation reports
- j. All original medicine / pharmacy bills & receipts along with the doctor's prescription.
- k. Cashless authorization letter / Reference number.

3) Contribution Claims:

- a. Photocopy of entire claim document duly attested by previous insurer or TPA.
- b. Original payment receipts for expenses not claimed/settled by the previous insurer.
- c. Discharge voucher/settlement letter by previous insurer.

4) Road Ambulance Cover:

- a. Photocopy of discharge card
- b. Original ambulance invoice & paid receipt

[Note: Insurer may specify the documents required in original and waive off any of above required as per their claim procedure!]

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

6.4 Co-payment

Each and every claim under the Policy shall be subject to a Co-payment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

6.5 Services Offered by TPA (To be stated where TPA is involved)

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of preauthorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

- i. Claim settlement and claim rejection;
- ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

6.6 Payment of Claim

All claims under the policy shall be payable in Indian currency only

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.

Product Benefit Table.

Name	Arogya Sanjeevani Policy, Aditya Birla Health Insurance Co. Limited
Product Type	Individual/ Floater
Category of Cover	Indemnity
Sum insured	INR 0.5 Lac, 1 Lac, 1.5 Lacs, 2 Lacs, 2.5 Lacs, 3 Lacs, 3.5 Lacs, 4 Lacs, 4.5 Lacs, 5 Lacs, 5.5 Lacs, 6 Lacs, 6.5. Lacs, 7 Lacs, 7.5 Lacs, 8 Lacs, 8.5 Lacs, 9 Lacs, 9.5 Lacs, 10 Lacs
	• On Individual basis - Sum Insured shall apply to each individual family member.
	• On Floater basis - Sum Insured shall apply to the entire family
Policy Period	1 year
Eligibility	Policy can be availed by persons between the age of 18 years and 65 years, as Proposer. Proposer with higher age can obtain policy for family, without covering self.
	Policy can be availed for Self and the following family members
	i. legally wedded spouse.
	ii. Parents and Parents-in-law
	iii. Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals
Grace Period	The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
Hospitalisation Expenses	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible
	Time limit of 24 hrs shall not apply when the treatment is undergone in a Day Care Centre.
Pre- Hospitalisation Expenses	For 30 days prior to the date of hospitalization
Post- Hospitalisation Expenses	For 60 days from the date of discharge from the hospital
Sublimit for room / doctors fee	1. Room Rent, Boarding, Nursing Expenses all inclusive as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/- per day.
	2. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all inclusive as provided by the Hospital / Nursing Home up to 5% of the sum insured subject to maximum of Rs. 10,000/-, per day
Cataract Treatment	Up to 25% of Sum insured or INR.40,000/-, whichever is lower, Per eye, under one policy year.
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered upto sum insured, during each Policy year as specified in the policy schedule.
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered after a waiting period of 3 years
Cumulative bonus or No Claim Discount	Increase in the sum insured by 5% in respect of each claim free year subject to a maximum of 50% of SI. In the event of claim the cumulative bonus shall be reduced at the same rate. or No claim discount, Applicable on the premium of the expiring policy year provided no claim under the policy.
Co Pay	5% co pay on all claims

Aditya Birla Health Insurance Co. Limited

Product Name: Arogya Sanjeevani Policy, Aditya Birla Health Insurance Co. Limited, Product UIN: ADIHLIP20170V011920.
 1800 270 7000 | care.healthinsurance@adityabirlacapital.com | www.adityabirlahealthinsurance.com
 Trademark/Logo Aditya Birla Capital is owned by Aditya Birla Management Corporation Private Limited and
 Trademark/Logo HealthReturns, Healthy Heart Score and Active Day are owned by Momentum Metropolitan Life Limited
 (Formerly known as MMI Group Limited). These trademark/Logos are being used by Aditya Birla Health Insurance Co. Limited
 under licensed user agreement(s).

Registered Office:

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 841, Senapati Bapat Marg, Elphinstone Road, Mumbai 400013.
 CIN:U66000MH2015PLC263677
 IRDA Registration No. 153