ADITYA BIRLA CAPITAL
HEALTH INSURANCE

Activ One
Policy Wording

This detailed document outlines the full terms and conditions of the coverage offered under your health insurance policy, including available coverage, benefits, claim and grievance redressal procedures, exclusions, and other related terms and conditions. It serves as a legal contract between You (Policyholder) and Us (the insurer) which mentions rights, responsibilities, coverage details, and exclusions in clear terms.

Section A. Preamble

This Policy is a contract of insurance issued by ADITYA BIRLA HEALTH INSURANCE CO. LIMITED. (hereinafter called the 'We / Our / Us / Insurer / Company') to the proposer mentioned in the Policy Schedule (hereinafter called the 'You / Your / Policyholder') to cover the person(s) named in the Policy Schedule (hereinafter called the 'Insured Person/s). The Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided by You in respect of the Insured Persons in the Proposal Form and on the statements and declaration provided by the Policyholder in the Proposal Form as well as in any welcome or other tele-verification calls with the Company's authorized person and is subject to receipt of the requisite premium in respect of the Insured Persons in full and its acceptance by Us, and the terms, conditions and exclusions as specified in this Policy, the Policy Schedule, and the Product Benefit Table of this Policy.

Key Notes:
The terms listed in Section B (Definitions) and which have been used elsewhere in the Policy shall have the meaning set out against them in Section B (Definitions), wherever they appear in the Policy. If a word is not specifically defined in the following section, it's common meaning will apply.
All claims under the Policy must be made in accordance with the process defined under Section E.2.7 - Claims.

Annexures Summary:

No.	Description
Annexure I	List of Non-Medical Expenses: List I, List II, List III and List IV: The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment normally may be covered under this Product if Claim Protect (Non-Medical Expense Waiver) is applicable to You and mentioned in the Policy Schedule. For details of Claim Protect please refer Appendix A.
Annexure II	Contact details of Insurance Ombudsman Offices
Annexure III	Product Benefit Table - All the benefits (including optional benefits) which are available under the Policy along with the respective limits / amounts applicable based on the Sum Insured have been summarized in the Product Benefit Table To check the applicability of these benefits to You please refer the Policy Schedule. (The Policy Schedule shall specify which of the specified variant's base covers and optional covers are in force and available for the Insured Persons under the Policy during the Policy Period)
Annexure IV	Applicability Matrix of Chronic Management Program for listed 7 Chronic conditions

Section B. Definitions

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

B.1 – Standard Definitions

1. **Accident:** Sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **AYUSH Hospital:** Is a healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a. Central or State Government AYUSH Hospital; or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or
   c. AYUSH Hospital, standalone or co-located with In-Patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
   i. Having at least 5 In-patient beds;
   ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
   iii. Having dedicated AYUSH therapy sections as required and / or has equipped operation theatre where surgical procedures are to be carried out;
   viii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3. **AYUSH Day Care Centre:** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical / para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without In-Patient services and must comply with all the following criterion:

a. Having qualified registered AYUSH Medical Practitioner(s) in charge;
b. Having dedicated AYUSH therapy sections as required and / or has equipped operation theatre where surgical procedures are to be carried out;
c. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

4. **AYUSH Treatment:** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

5. **Break in Policy:** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

6. **Cashless Facility:** A facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization is approved.

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

8. **Condition Precedent:** A policy term or condition upon which the Insurer's liability under the policy is conditional upon.

9. **Congenital Anomaly:** A condition which is present since birth, and which is abnormal with reference to form, structure or position.
   a. Internal Congenital Anomaly
      Congenital anomaly which is not in the visible and accessible parts of the body.
   b. External Congenital Anomaly
      Congenital anomaly which is in the visible and accessible parts of the body.

10. **Co-Payment:** means a cost sharing requirement under a health insurance policy that provides that the Policyholder / Insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

11. **Coma of Specified Severity:**
    a. 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.
    b. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

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

13. **Day Care Treatment:** means medical treatment, and / or surgical procedure which is
    a. Undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
    b. Which would have otherwise required hospitalization of more than 24 hours.

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

14. **Deductible:** means a cost-sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days / hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured. The deductible is separate from any Aggregate Deductible that may be in-force and applicable under the Policy, as specified in the Policy Schedule.

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

16. **Deafness:**
    Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing" in both ears.

17. **Disclosure of information norm:** means the policy shall be void and all premium paid hereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

18. **Domiciliary Hospitalization:** means medical treatment for an illness / disease / injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

a. The condition of the patient is such that he / she is not in a condition to be removed to a hospital, or
b. The patient takes treatment at home on account of non-availability of room in a hospital.

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

20. **Emergency Assistance Service Provider:** means the licensed entity which will provide identified emergency medical assistance and personal services to people travelling more than 150 (one hundred and fifty) kilometres from their declared place of residence in India.

21. **End Stage Lung Failure:** means End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
    a. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
    b. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
    c. Arterial blood gas analysis with partial oxygen pressures of 55mmHg or less (PaO2 <55 mm Hg); and
    d. Dyspnea at rest.

22. **End Stage Liver Failure:**
    a. Permanent and irreversible failure of liver function that has resulted in all three of the following:
        i. Permanent jaundice; and
        ii. Ascites; and
        iii. Hepatic encephalopathy.
    b. Liver failure secondary to drug or alcohol abuse is excluded.

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

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

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

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

    a. **Acute condition** – Acute condition means is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease / illness / injury which leads to full recovery.
    b. **Chronic condition** – A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        i. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests;
        ii. It needs ongoing or long-term control or relief of symptoms;
        iii. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it;
        iv. It continues indefinitely;
        v. It recurs or is likely to recur.

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

28. **In-Patient Care:** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

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

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

31. **Kidney Failure Requiring Regular Dialysis:**
    End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

32. **Loss of Speech:**
    Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by and Ear, Nose, Throat (ENT) specialist.

33. **Major Organ / Bone Marrow Transplant:**
    a. 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.

    b. The following are excluded:
        i. Other stem-cell transplants
        ii. Where only islets of langerhans are transplanted

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

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

36. **Medical Practitioner:** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. Medical Practitioner who is sharing the same residence as the Insured Person and is a Family Member of the Insured Person are not considered as Medical Practitioner under the scope of this Policy.

    Medical Practitioner (Definition applicable for the treatment taken outside India) means a licensed medical practitioner acting within the scope of his license and who holds a degree of a recognized institution and is registered by the Authorized Medical Council of the respective country.

37. **Medically Necessary Treatment:** means any treatment, test, medication, or stay in hospital or part of stay in hospital which:
    a. Is required for the medical management of the illness or injury suffered by the insured;
    b. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
    c. Must have been prescribed by a medical practitioner;
    d. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

38. **Migration:** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

39. **Myocardial Infarction (First Heart Attack of specific severity):**
    a. 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.
    b. 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.

40. **Maternity Expense shall include:**
    a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);
    b. Expenses towards lawful medical termination of pregnancy during the Policy Period.

41. **Motor Neuron Disease with Permanent Symptoms:**
    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.

42. **Multiple Sclerosis with Persisting Symptoms:**
    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.

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

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

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

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

47. **Open Heart Replacement Or Repair Of Heart Valves:**
    The actual undergoing of open-heart valve Surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy / valvuloplasty are excluded.

48. **Open Chest CABG:**
    a. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive key hole coronary artery bypass procedures.
    The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
    b. The following are excluded:
        i. Angioplasty and / or any other intra-arterial procedures

49. **Portability:** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

50. **Permanent Paralysis of Limbs:**
    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.

51. **Pre-existing disease (PED):** means any condition, ailment, injury or disease:
    a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
    b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

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

53. **Post-Hospitalization Medical Expenses:** means Medical Expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:
    a. Such Medical Expenses are for the same condition for which the Insured person's hospitalization was required, and
    b. The In-patient hospitalization claim for such hospitalization is admissible by the Insurance company.

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

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

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

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

58. **Surgical Treatment for benign Brain Tumour:**
    a. We will be covering surgical treatment of Benign solid brain tumour limited to;
        i. Surgical Removal of solid brain tumour through Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy
        ii. Embolization of Intra cranial blood vessels, needed for the treatment of solid brain Tumour
    b. Benign solid brain tumour is defined as a life threatening, non-cancerous tumour in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI.
    c. This brain tumour must result in at least one of the following and must be confirmed by the relevant medical specialist.
        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 tumour.

    The following conditions are excluded:
    Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, tumors of skull bones and tumors of the spinal cord.

59. **Stroke Resulting in Permanent Symptoms:**
    a. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit

        lasting for at least 3 months has to be produced.
    b. 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.

60. **Specific Waiting Period:** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases /treatments shall be covered provided the policy has been continuously without any break.

61. **Third Degree Burns:**
    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.

62. **Unproven / Experimental Treatment:** means the treatment including drug experimental therapy which is based on established medical practice in India, is a treatment experimental or unproven.

B.2 – Specific Definitions

1. Adventure / Hazardous Sports: means any sport or activity involving physical exertion and skill 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, in which an Insured Person participates or competes for entertainment or as part of his profession whether he / she is trained or not.

2. Age / Aged: means completed years on last birthday as on Commencement Date.

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

4. Annexure: A document attached and marked as Annexure to this Policy.

5. Annual Health Check-up: means a package of medical test(s) undertaken for general assessment of health status, excluding any diagnostic or investigative medical tests for evaluation of any Illness.

6. Associated Medical Expenses: means consultation fees, charges on operation theatre, surgical appliances and nursing, and expenses on anaesthesia, blood, oxygen incurred during Hospitalization of the Insured Person. Associated Medical Expenses does not include cost of pharmacy and consumables, cost of implants and medical devices, and cost of diagnostics.

7. Alzheimer's Disease: We will be covering the Unequivocal diagnosis of Alzheimer's disease (presenile dementia) before age 60 that has to be confirmed by a consultant physician of bacterial meningitis that must be proven on analysis of the cerebrospinal fluid.

    There must also be permanent objective neurological deficit that is present on physical examination at least 3 months after the diagnosis of the meningitis infection.

8. **Aorta Graft Surgery:**
   a. We will be covering the actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.
   b. The following are excluded:
      i. Surgery performed using only minimally invasive or intra-arterial techniques.
      ii. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.

9. **Aplastic Anemia:** Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:
   a. Blood product transfusion;
   b. Marrow stimulating agents;
   c. Immunosuppressive agents; or
   d. Bone marrow transplantation

   The diagnosis must be confirmed by a haematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following:
   a. Absolute neutrophil count of 500/mm^3 or less
   b. Platelets count less than 20,000/mm^3 or less
   c. Absolute Reticulocyte count of 20,000/mm^3 or less

   Temporary or reversible Aplastic Anaemia is excluded. In this condition, the bone marrow fails to produce sufficient blood cells or clotting agents

10. **Bank Rate:** means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year, which shall be applied depending on the year in which a claim is due.

11. **Base Sum Insured:** means the pre-defined Policy limit applicable for claims made during each Policy Year, as specified against an Insured Person or all Insured Persons in the Policy Schedule and Annexure III - Product Benefit Table.

12. **Bacterial Meningitis:** Bacterial meningitis is a bacterial infection of the meninges of the brain causing brain dysfunction. There must be an unequivocal diagnosis by a consultant physician of bacterial meningitis that must be proven on analysis of the cerebrospinal fluid. There must also be permanent objective neurological deficit that is present on physical examination at least 3 months after the diagnosis of the meningitis infection.

13. **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.

14. **Bone Marrow Transplant:** We will be covering Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured originating from:
   a. The Insured (Autologous bone marrow transplant); or
   b. From a living compatible donor (allogeneic bone marrow transplant).

15. **Cancer Treatment:**
   a. We will be covering Primary Treatment of a malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy.
      The term cancer including but not limited to leukaemia, lymphoma and sarcoma (except cutaneous lymphoma)
   b. Any In-situ Cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues.
   c. Any pre-cancerous change in the cells that are cytological or histologically classified as high grade dysplasia or severe dysplasia

16. **Cardiac Arrest (excluding angioplasty):** Cardiac arrest is defined as confirmation by a cardiology medical specialist of a definite diagnosis of sudden cardiac arrest that results in unconsciousness, loss of effective circulation and the undergoing of cardio-pulmonary resuscitation to sustain life. Diagnosis must be evident by electrographic changes. For the above definition, following is not covered:
   a. Cessation of cardiac function induced to perform a surgical or medical procedure.

17. **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.

18. **Commencement Date:** means the date of commencement of insurance coverage under the Policy as specified in the Policy Schedule.

19. **Coronary Artery By-Pass Surgery:**
   a. We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
   b. The following are excluded: Angioplasty and / or any other intra-arterial procedures.

20. **Cerebral Aneurysm** - with Surgery or Radiotherapy: we will be covering Cerebral aneurysm and Surgical treatment diagnosed by appropriate medical consultant supported with evidence of cerebral angiogram and / or magnetic resonance angiography and / or CT scan.
   Treatment for a cerebral aneurysm using any one of the following:
   i. Craniotomy
   ii. Stereotatic radiotherapy
   iii. Endovascular treatment by using coils to cause thrombosis (embolisation)

   For the above definition the following are not covered:
   i. Cerebral arteriovenous malformation

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

22. **Empanelled Service Providers:** means service provider (Doctor's clinic, Diagnostic centre, Medicine, Drug vendor, medical service provider and Home care treatment provider) enlisted by Us, TPA or jointly by Us and TPA to provide OPD medical services to an Insured Person by a Cashless Facility.

23. **Evidence Based Clinical Practice** means process of making clinical decisions for Inpatient Care using current best evidence in conjugation with clinical expertise.

24. **E-Consultation** means opinion from a Medical Practitioner who holds a valid registration from the medical council of any state or medical council of India or council for Indian medicine or for homeopathy set up by the Government of India or a state government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

25. **Fulminant Viral Hepatitis:** a sub-massive to massive necrosis of the liver by any virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:
    a. Rapid decreasing of liver size; and
    b. Necrosis involving entire lobules, leaving only a collapsed reticular framework; and
    c. Rapid deterioration of liver function tests; and
    d. Deepening jaundice; and
    e. Hepatic encephalopathy.
    Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

26. **Fulminant Hepatitis:** a sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:
    a. Rapid decreasing of liver size;
    b. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
    c. Rapid deterioration of liver function tests;
    d. Deepening jaundice; and
    e. Hepatic encephalopathy.
    Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

27. **Hospital (outside India)** means an institution (including nursing homes) established outside India for Inpatient medical care and treatment of sickness and injuries which has been registered and licensed as such with the appropriate local or other authorities in the relevant area, wherever applicable, and is under the constant supervision of a Medical Practitioner. The term Hospital shall not include a clinic, rest home, or convalescent home for the addicted, detoxification centre, sanatorium, old age home.

28. **Home:** means the Insured Person's place of permanent residence as specified in the Policy Schedule.

29. **Heart Transplant:** we will be covering the actual undergoing of a transplant of human heart due to irreversible end-stage failure of the heart. The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

30. **Heart Valve Replacement:**
    a. 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.
    b. The following are excluded: Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

31. **Insured Person:** means persons named in the Policy Schedule who are insured under the Policy and in respect of whom the applicable premium has been received in full.

32. **IRDAI:** The Insurance Regulatory and Development Authority of India.

33. **Kidney Transplant Surgery in case of End Stage Renal Failure:** we will be covering Kidney Transplant Surgery due to following cases:
    End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner.

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

35. **Live-in Partner** shall, for the purpose herein, means either half of the two unmarried adult persons of any gender and irrespective of the sexual orientation, who have consensually chosen to reside jointly with the other adult person, in a long term relationship and in the same residence. For the purpose of clarity, it is, hereby, mentioned that this definition shall be construed to include persons belonging to the LGBT community, wherein the scope of LGBT shall be in accordance with the standings laws of India, as may be in force from time to time.

36. **LGBT** will mean and include a sexual orientation or a gender expression as defined below
    a. Lesbian: means a woman who has the capacity to form enduring physical, romantic, and / or emotional attractions or sexual attraction towards other woman.
    b. Gay: means a man who has the capacity to form enduring physical, romantic, and / or emotional attractions or sexual attraction towards other man.
    c. Bisexual: A person who has the capacity to form enduring physical, romantic, and / or emotional attractions to those of the same gender or to those of another gender or more than one gender.
    d. Transgender: means a person whose gender does not match with the gender assigned to that person at birth and includes trans-man or trans-wom an (whether or not such person has undergone Sex Reassignment Surgery or hormone therapy or laser therapy or such other therapy), person with intersex variations, genderqueer and person having such socio-cultural identities as kinner, hijra, aravani and jogta.

37. **Lung Transplant Surgery in case of End Stage Lung Disease:**
    We will be covering Lung Transplant Surgery due to following cases:
    a. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
        i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
        ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
        iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
        iv. Dyspnea at rest

38. **Liver Transplant Surgery in case of End Stage Liver Disease:** we will be covering The actual undergoing of a Liver Transplant due to Permanent and irreversible failure of liver function that has resulted in all three of the following:
    a. Permanent jaundice; and
    b. Ascites; and
    c. Hepatic Encephalopathy.

    The diagnosis and the undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.
    Liver failure secondary to drug or alcohol abuse is excluded.

39. **Material Facts:** means all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

40. **Major Illness:** means any of the Illnesses, medical events or Surgical Procedures as specifically listed under applicable section of Appendix A.

41. **Muscular Dystrophy:** a group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist acceptable to Us, with confirmation of at least 3 of the following 4 conditions:
    a. Family history of muscular dystrophy;
    b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
    c. Characteristic electromygrom; or
    d. Clinical suspicion confirmed by muscle biopsy.

    The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months.

42. **Motor Neuron Disease with Permanent Symptoms:** we will be covering surgical treatment for Motor Neuron disease diagnosed by a specialist consultant 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.

43. **Neurosurgery:** we will be covering any
    a. Surgical intervention of the brain or any other intracranial structures;
    b. Surgical Treatment of benign solid tumours located in the spinal cord.

44. **Parkinson's disease** - resulting in permanent symptoms: A definite diagnosis of Parkinson's disease by a Consultant Neurologist. There must be permanent clinical impairment of motor function with either associated tremor or muscle rigidity. For the above definition the following are not covered:
    a. Parkinsonian syndromes/Parkinsonism

45. **Policy:** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof, as amended from time to time, and which shall be read together. The Policy sets out details of the extent of cover available to the Insured Person, applicable exclusions and the terms & conditions applicable under the Policy.

46. **Policy Period:** means the period between the Commencement Date and either the Expiry Date specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.

47. **Policyholder:** means person who has proposed the Policy and in whose name the Policy is issued.

48. **Policy Schedule:** means the Policy Schedule attached to and forming part of this Policy specifying the details of the Insured Persons, the Sum Insured, the Policy Period and the Sub-limits to which benefits under the Policy are subject to, including any annexures and /or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

49. **Policy Year:** means a period of twelve months beginning from the Commencement Date and ending on the last day of such twelve-month period. For the purpose of subsequent years, Policy Year shall mean a period of twelve months commencing from the end of the previous Policy Year and lapsing on the last day of such twelve-month period.

50. **Pulmonary Artery Graft Surgery:** we will be covering the undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

51. **Permanent Paralysis of Limbs:** we will be covering surgical treatment for total and irreversible loss of use of one 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

52. **Pneumonectomy** - Removal of an entire lung: The undergoing of surgery to remove an entire lung for disease or trauma.

    The following is not covered:
    a. Partial removal of a lung (lobectomy) or lung resection or incision.
    The diagnosis and undergoing of the surgery has to be confirmed by a specialist Medical Practitioner.

53. **Surgical removal of an eyeball:** surgical removal of a complete eyeball as a result of injury or disease. For the above definition the following is not covered:
    a. Self- inflicted injuries

    The diagnosis and undergoing of the surgery has to be confirmed by a specialist Medical Practitioner

54. **Shared Room:** a basic (cheapest) category of Shared Room in a Hospital with / without air-conditioning with two or three patient beds.

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

56. **Second Medical Opinion for Major Illness:** means a procedure where by upon request of the Insured Person, an independent Medical Practitioner reviews and opines on the treating Medical Practitioner's recommendation as to care and treatment of the Insured Person by reviewing Insured Person's medical status and history. Such an opinion shall not be deemed to substitute the Insured Person's physical visit or consultation to an independent Medical Practitioner.

57. **Sum Insured:** means the aggregate limit of indemnity consisting of the Base Sum Insured, Super Reload, Super Credit (if applicable), Cancer Booster (if applicable) and any other benefit or section (if applicable) whose Sum Insured is over and above Base Sum Insured for the Insured Person. It represents the maximum, total and cumulative liability of the Company for any and all claims made under the Policy (under any and all Benefits), in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year, as specified against an Insured Person or all Insured Persons in the Policy Schedule.

    Sum Insured will be utilized as per the following sequence in event of any claim:
    a. Base Sum Insured followed by;
    b. Super Credit (if inbuilt / opted and applicable) followed by;
    c. Super Reload followed by;
    d. Cancer Booster (if opted and applicable)

58. **Surgical Treatment of Coma:**
    a. We will be covering surgical treatment of Coma limited to;
        i. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy
    b. 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.
        iv. The condition has to be confirmed by a specialist Medical Practitioner.

    c. The following are excluded:
    Coma resulting directly from alcohol or drug abuse is excluded.

59. **Skin Grafting Surgery for Major Burns:**
    a. We will be covering the undergoing of skin transplantation due to accidental major burns where major burns as defined below:
        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.
    b. Skin grafting surgery for Major Burns should be medically required and not aesthetic / cosmetic in nature

60. **Surgery for Pheochromocytoma:**
    a. We will be covering the actual undergoing of surgery to remove the tumour
    b. Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines and the Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who is an endocrinologist.

61. **Surgical Treatment for Stroke:**
    a. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extra cranial 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.
    b. We will be covering surgical treatment of Stroke limited to;
        i. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy;
        ii. Stenting of Intra cranial blood vessels, needed for the treatment of Stroke.
    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.

62. **We / Our / Us / Company / Insurer:** Aditya Birla Health Insurance Co. Limited.

63. **Waiting Period:** means a period from the inception of this Policy during which specified diseases / treatments are not covered. On completion of the Waiting Period, diseases / treatments shall be covered provided the Policy has been continuously renewed without any break

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

Section C. Benefits Covered Under the Policy

For the details of the benefits that are applicable to You as specified in the Policy Schedule, please refer Appendix A. All the Benefits under the Appendix A might not be applicable to the Insured Person(s), please refer to the Policy Schedule for the list of Benefits applicable to You.

Section D. Waiting Period and Permanent Exclusions

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

D.1 Standard Exclusions	Word Explanations
D.1.1 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.	**Pre Existing Disease:** A medical condition that a person already have before getting insurance or a healthcare plan. **Portability:** A person can switch to a new insurance company without losing the benefits and coverage already earned under the current Policy.
D.1.2 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:	**Waiting Period:** A specified period of time during which certain coverage or benefits are not provided after purchasing a Policy.

	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	Medical & Surgical Treatment
		Meniscus Tear	Medical & Surgical Treatment
		Joint Replacement Surgery	Medical & Surgical Treatment
		Non Specific Arthritis	Medical & Surgical Treatment
5	Gastroenterology (Alimentary Canal and related Organs)	Stone in Gall Bladder, Bile duct & other parts of Biliary System	Medical & Surgical Treatment
		Cholecystitis	Surgical Treatment
		Pancreatitis	Surgical Treatment
		Fissure, Fistula in Ano, Hemorrhoids (Piles), Pilonidal Sinus, Ano-rectal & Perianal Abscess	Medical & Surgical Treatment
		Rectal Prolapse	Medical & Surgical Treatment
		Gastric or Duodenal Erosions or Ulcers + Gastritis & Duodenitis & Colitis	Medical & Surgical Treatment
		Gastro Esophageal Reflux Disease (GERD)	Medical & Surgical Treatment
		Cirrhosis	Medical & Surgical Treatment
		Chronic Appendicitis	Surgical Treatment
		Appendicular Lump, Appendicular Abscess	Medical & Surgical Treatment
6	Urogenital (Urinary and Reproductive System)	Stones in Urinary System (Stone in the Kidney, Ureter, Urinary Bladder)	Medical & Surgical Treatment
		Benign Hypertrophy / Enlargement of Prostate (BHP / BEP)	Medical & Surgical Treatment
		Hernia, Hydrocele,	Medical & Surgical Treatment
		Varicocoele / Spermatocoele	Medical & Surgical Treatment
7	Skin	Skin Tumour (unless malignant)	Medical & Surgical Treatment
		All Skin Diseases	Medical & Surgical Treatment
8	General Surgery	Any Swelling, Tumour, Cyst, Nodule, Ulcer, Polyp Mass, Swelling, Lump, Granulomas, Benign Tumour anywhere in the body (Unless Malignant)	Medical & Surgical Treatment
		Varicose Veins, Varicose Ulcers	Medical & Surgical Treatment

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.1.1.

D.1.3 30-day Waiting Period (Code-Excl03) a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered. b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months. c) The within referred Waiting Period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.	**Commencement date:** Date when this Policy becomes active and provides coverage to the Insured Person.
D.1.4 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.	**Diagnostic expenses:** Costs associated with medical tests and procedures used to diagnose a health condition.
D.1.5 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.	**Custodial Care:** Non-medical assistance with daily tasks for individuals who need help due to physical or mental limitations.
D.1.6 Obesity / Weight Control (Code- Excl06) Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions: a) Surgery to be conducted is upon the advice of the Doctor. b) The surgery / Procedure conducted should be supported by clinical protocols. c) The member has to be 18 years of age or older and	**BMI:** Measurement that helps determine if a person has a healthy weight based on their height and weight. **Co-Morbidities:** Additional medical conditions or diseases that occur alongside a primary health condition or illness.

d) Body Mass Index (BMI); 1) greater than or equal to 40 or 2) 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	**Obesity-related cardiomyopathy:** Heart condition caused by excessive weight, which weakens the heart muscle. **Coronary Heart Disease:** Condition where the heart's blood vessels become narrowed or blocked, leading to reduced blood flow to the heart muscle. **Sleep Apnea:** Sleep disorder where breathing stops or becomes very light during sleep, causing sleep interruptions and daytime tiredness.
D.1.7 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.	**Change of Gender Treatments:** Medical procedures and support services that help individuals transform from one gender to another
D.1.8. 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.	**Reconstruction:** Process of repairing or rebuilding damaged or lost body parts through surgical procedures to improve function and appearance.
D.1.9. 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	**Hazardous or Adventure Sports:** Activities that are considered high-risk and may require specific coverage or have exclusions due to the potential for injuries or accidents.
D.1.10. 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.	**Breach of Law:** When someone breaks a law or fails to meet legal requirements, which is considered a wrongdoing or illegal action.
D.1.11. 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 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.	**Excluded Providers:** Healthcare professionals, hospitals, or medical facilities that are specifically listed by the insurer as not covered under this Policy.
D.1.12. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code-Excl12)**	**Addictive Condition:** When someone becomes dependent on substances or behaviours, leading to uncontrollable and harmful use.
D.1.13. 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)	**Domestic Reasons:** Situations where a person is admitted to a healthcare facility primarily for non-medical or non-health-related purposes.
D.1.14. 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)	**Dietary Supplements:** Products intended to supplement or enhance the diet and provide essential nutrients like vitamins, minerals, amino acids, or herbs.
D.1.15. Refractive Error:(Code-Excl15) - Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.	**Refractive Error:** A vision problem that causes blurred vision due to the eye's inability to focus light properly at the back of the eye.
D.1.16. 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.	**Unproven Treatments:** Medical approaches that have not been proven to work or shown to be safe.
D.1.17. Sterility and Infertility: (Code-Excl17) Expenses related to sterility and infertility. This includes: a) Any type of contraception, sterilization b) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI c) Gestational Surrogacy d) Reversal of sterilization	**Sterility:** Condition or state of being unable to conceive a child or reproduce. **Infertility:** Inability to get pregnant or conceive a child despite trying for a certain period of time. **Assisted Reproduction Services:** Medical procedures or techniques that assist individuals or couples in achieving pregnancy when they are facing difficulties conceiving naturally. **IVF (In Vitro Fertilization):** Process where doctors help couples have a baby by combining an egg and sperm in a lab and then placing the fertilized egg into the woman's womb to grow into a baby.

	ZIFT (Zygote Intrafallopian Transfer): A fertility procedure where a fertilized egg is placed in the fallopian tube to increase the chances of pregnancy. GIFT (Gamete Intrafallopian Transfer): A fertility treatment where eggs and sperm are placed directly into the fallopian tube to increase the chances of pregnancy ICSI (Intracytoplasmic Sperm Injection): A fertility procedure where a sperm is directly injected into an egg to aid fertilization. Gestational Surrogacy: Type of surrogacy arrangement where a woman, known as the gestational surrogate or gestational carrier, carries and gives birth to a child on behalf of another individual or couple
D.1.18. Maternity Expenses (Code-Excl18): a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy; b) Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period	**Ectopic Pregnancy:** When a fertilized egg grows outside the uterus, often in the fallopian tube .It is a dangerous condition that cannot develop into a healthy baby and requires medical attention
D.2 Specific Exclusions	**Word Explanations**
D.2.1 Circumstantial Exclusion a) Treatment resulting from war, invasion, civil war, revolt, or military involvement: Medical treatment that arises from or is related to acts of war, military operations, or involvement in armed forces activities b) Exclusion of certain acts and substances: Treatment or consequences related to unlawful acts, nuclear weapons / materials, chemical and biological weapons, radiation exposure, or contamination by radioactive materials or substances. c) The Insured Person's direct participation in terrorist acts;	**Circumstantial Exclusion:** Exclusion of coverage for certain situations or conditions based on specific circumstances specified in the Policy
D.2.2 Behavioural Exclusions a) Suicide or attempted suicide, intentionally hurting oneself on purpose; b) Illegal act of the Insured Persons c) Any treatment for Injury resulting from the consumption of alcohol or any intoxicating substance, its intake or abuse thereof d) the use of drugs (other than drugs taken under treatment prescribed and directed by a Medical Practitioner but not for the treatment of drug addiction);	**Behavioural Exclusions:** Situations the Policy does not cover certain health conditions or treatments that are caused by a person's actions or behaviour, such as self-harm or drug abuse
D.2.3 Medical Exclusions a) All routine examinations and Health Check-ups except as per terms and conditions mentioned under Annual Health Check-up in Appendix A b) Circumcisions (unless required for medical reasons or as part of a treatment plan for an illness or injury); c) Conditions for which treatment could have been done on an outpatient basis without any Hospitalization d) Preventive care, vaccinations and immunizations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing e) Admission for nutritional and electrolyte supplements unless certified by the attending medical practitioner that they are necessary as a direct result of a covered claim f) Any conditions or abnormalities that are present at birth and are visible on the outside of the body, as well as any related diseases or defects, g) Stem cell therapy except Hematopoietic stem cells for bone marrow transplant for haematological conditions) or Surgery, or growth hormone therapy or Hormone Replacement Therapy. h) Dental / Oral Treatment: Treatment, procedures and preventive, diagnostic, restor ative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident i) AYUSH Treatment Any form of AYUSH Treatments, except as mentioned under Section AYUSH Treatment in Appendix A	**Circumcision:** A surgical procedure that involves removing the foreskin covering the tip of the male genitalia **Stem Cell Therapy:** A medical treatment that uses cells to repair or replace damaged tissues in the body. **Growth Hormone Therapy:** Involves administer-ing synthetic growth hormone to treat deficiencies and promote growth in children and adolescents **Hormone Replacement Therapy (HRT):** Medical treatment that involves taking hormones to reduce or relieve symptoms related to hormonal changes in the body.
D.2.4 Prosthesis and Devices a) Hearing aids, spectacles or contact lenses including optometric therapy, multifocal lens b) Wigs, or toupees, and related expenses. c) Expenses for prosthesis (artificial body parts), corrective devices, external durable medical equipment, wheelchairs, crutches, or instruments used in the diagnosis / treatment of sleep apnea syndrome and other sleep disorders 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.	**Optometric Therapy:** A specialized treatment by optometrists that uses exercises to improve visual skills and abilities **Multifocal Lenses:** Special glasses or contact lenses that allow people with difficulty seeing up close and far away to see clearly at different distances without needing separate pairs of glasses

	COPD: Chronic lung disease that makes it hard to breathe, usually caused by smoking or exposure to harmful substances. **Cochlear Implant:** A special device that can help people who have severe hearing loss or are completely deaf.
D.2.5 Non-Medical Expenses As mentioned under Annexure (I), items in List I, II, III & IV will be excluded unless forms a part of In-patient hospitalization.	**Non-Medical Expenses:** Costs or expenditures that are not directly related to medical treatments or healthcare services,
D.2.6 Specific treatment Exclusion Treatment involving Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy, KTP Laser Surgeries, Cyber Knife Treatment, Femto Laser Surgeries, Bioabsorbable Stents, Bioabsorbable Valves, Bioabsorbable Implants. Use of Radio Frequency (RF) probe for ablation.	**RFQMR:** New device developed for Tissue Regeneration, Degeneration and Repair for the purposes of treating several chronic or degenerative diseases such as Cancer & Arthritis. **ECP:** Non-Surgical Therapy that uses cuffs to apply rhythmic pressure to improve blood flow to the heart **EECP:** Non-Surgical Therapy that improves blood flow to the heart using cuffs placed on the legs, buttocks, and lower abdomen. **Hyperbaric Oxygen Therapy:** Treatment where a person breathes pure oxygen in a pressurized chamber to promote healing and improve certain medical conditions. **KTP Laser Surgery:** Medical procedure that uses a specialized laser to treat blood vessel abnormality, skin pigmentation, and certain tumors **Femto Laser Surgeries:** Advanced medical procedures that use a special laser to perform precise and gentle treatments, often used for eye surgeries like LASIK or cataract removal. **Radiofrequency (RF) probe for ablation:** Medical device used in minimally surgical procedures to treat certain conditions, such as abnormal heart rhythms or tumors.
D.2.7 Activities and Profession Exclusions a) Treatment received from a person who is not recognized as a registered Medical Practitioner by any state medical council or the medical council of India. b) Medical or treatment fees charged by unlicensed and unauthorized practitioners are not covered c) Treatments provided by a Medical Practitioner who is a family member of the Insured Person or resides in the same household, unless pre-approval is obtained from Us.	**Activities and Profession Exclusions:** Specific occupations, hobbies, or activities that are not covered under the policy due to the increased risks associated with them.
D.2.8 Geographical Exclusion Treatment taken outside India, unless specified to be covered in the Policy Schedule.	**Geographical exclusion:** Certain locations or regions are not covered by Policy, so any medical expenses incurred in those areas will not be payable.

Section E. General Terms and Conditions

E.1. Standard General Terms and Clauses **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: a) 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 b) 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 c) 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.	**Simpler version*** If the insured does not make any claim during the Free Look Period, they can get a refund of the premium they paid, except for any expenses incurred by the Company for medical examination and stamp duty. If the risk has already started and the insured decides to return the policy, the Company will deduct a portion of the premium for the coverage period, expenses incurred by the Company on medical examination and stamp duty charges. If only a part of the insurance coverage has started, the Company will deduct a partial premium refund based on the coverage during that period, expenses incurred by the Company on medical examination and stamp duty charges. A request 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.
E.1.2. Cancellation a) The Policyholder may cancel this policy by giving 7 days' written notice and in such an event, 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 b) 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 E.1.2 a).a or E.1.2 a).b above shall be applicable for 'Yearly / Annual / One Time' premium payment frequency No refund is applicable for Half Yearly, Quarterly & Monthly premium frequencies. iii. In case of death of an Insured Person, proportionate Refund of the Premium for the deceased Insured Person will be refunded, provided there is no history of claim. iv. 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 v. 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	**Simpler version*** You are free to cancel your Policy at any time by giving 7 days written notice Note: We will NOT refund any premium if we have paid a claim. If you don't make a claim, we'll give you a proportionate refund of your premium for unexpired policy period. If an Insured Person dies and there is no history of a claim, the premium paid for that person will be refunded on a proportional basis Policy cancellation with no premium refund is possible if you're dishonest or fraudulent in providing information. The company will notify you in writing 15 days prior to cancellation If you cancel your Policy, all the coverage, benefits, and earnings on HealthReturns™ will end automatically. However, if you have any HealthReturns™ that you haven't claimed from the previous Policy Year or Policy Month, you can still claim them within three months from the date of cancellation or termination

E.1.3. 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 fifteen days where premium payment mode is monthly and 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 of sum insured.

Simpler version*

To keep your benefits uninterrupted, pay your renewal premium before your policy ends. If you miss the deadline, a grace period is available after the policy expires to pay the premium and maintain continuity of benefits.

Note: You are NOT insured during the grace period.

E.1.4. 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.

Simpler version*

The Company can change the Policy's terms and premium rates if Product Management Committee, of the Company approves it. The Insured Person will be informed three months before the changes take place

E.1.5. Nomination

The Policyholder 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 (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

Simpler version*

- Choose a person to get money if you die when buying or renewing the policy.
- Tell the company in writing if you want to change the person and get it approved.
- If you die, the person you named gets the money or your family gets it.
- If your family gets the money, it's the last payment the company has to make.

E.1.6. 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 Company.

Simpler version*

- If you lie or use dishonest ways to get money from the policy, you lose the benefits and the money you paid for it.
- If the company finds out later that you made a fraudulent claim, you have to pay back the money you received.
- Everyone who made the fraudulent claim has to pay the money back, and they are all responsible for it

Simpler version*

If you can prove that you did not lie on purpose and the insurance company already knew about the truth, they cannot reject your claim or cancel your policy due to fraud

E.1.7. Withdrawal of Policy a) 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. b) 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, Specific waiting periods, waiting period for Pre-existing disease, moratorium period, Super Credit, waiver of Waiting Period, provided the Policy has been maintained without a break.	**Simpler version*** a) If the Company plans to discontinue this product, they will notify the Insured Person 90 days before the policy expires. b) The Insured Person can choose to switch to a similar health insurance product available with the Company at the time of renewal, keeping all the continuity benefits, like Specific waiting periods, waiting period for Pre-existing disease, moratorium period, Super Credit, waiver of Waiting Period as long as the Policy is maintained without a break.
E.1.8. Redressal of Grievance: In case of any grievance the Insured Person / Policyholder may contact the Website: https://www.adityabirlacapital.com/healthinsurance/faqs Toll - Free: 1800 270 7000 E-Mail: care.healthinsurance@adityabirlacapital.com (Senior citizens may write to us at: seniorcitizen.healthinsurance@adityabirlacapital.com) In case you are not satisfied with the resolution you may write to Head – Customer Care : carehead.healthinsurance@adityabirlacapital.com **Courier:** Write to our HO at below address Unit no 1101 & 1104 11th floor, Unit no 1501& 1502 15th floor, G Corp Tech Park, Kasarwadavali, Ghodbunder Road, Thane West-400601 Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance. If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at:gro.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 (at the addresses given in Annexure II) Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://bimabharosa.irdai.gov.in/	**Simpler version*** If the Insured Person has a complaint, they can reach out to the company through their different modes to resolve their problems The Insurance Ombudsman is a government body that helps resolve disputes between policyholders and insurance companies. Insured individuals can approach the Ombudsman for assistance if they are not satisfied with the resolution of their complaint
E.1.9. Claim Settlement (Provision for Penal Interest) a) Settlement of claims (other than cashless) shall be settled within 15 days from submission of claim. b) 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	**Simpler version*** a) The company must settle or reject a claim within 15 days from submission of claim. b) If the company takes more than 15 days to settle or reject a claim, it must pay the Policyholder interest at a rate of 2% above the bank rate
E.1.10. 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	**Simpler version*** After completion of 5 years of the policy (including portability and migration), no health insurance claim can be rejected except in cases of proven fraud or permanent exclusions listed in the policy contract. However, the policy still has limits, sub-limits, co-payments, and deductibles that apply

E.1.11. Multiple Policies a) 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. b) 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. C. 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. d) 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 are entitled to claim from all the insurers under all policies.	a.If you have multiple health insurance policies, you can choose which one to use for settling a claim. The insurer of the chosen policy shall be treated as primary insurer and will settle the claim if it's within the policy's limits and terms b.You can use one insurance policy to claim for costs that another policy does not cover, even if the coverage limit has not been reached. The insurance company will process the claim separately based on the terms and conditions of the policy c. If the claim amount is more than the Sum Insured under one 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 d. If you have multiple insurance policies from different insurers that cover the same risk, you will only receive treatment costs according to the terms and conditions of the policy you choose
E.1.12. 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	**Simpler version*** You can switch to other health insurance plans offered by the same company by applying 30 days before renewal. If you've been continuously covered under any health insurance plan by the same company, you'll get benefits of the Waiting Periods, morotorium etc as per IRDAI norms on migration
E.1.13. 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 migration, kindly refer the link https://www.adityabirlacapital.com/healthinsurance/downloads	**Simpler version*** You can switch your health insurance policy to another insurer along with your family members, by applying at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines. If you have been continuously covered under any health insurance policy with an Indian insurer, you will get the Waiting Periods, morotorium etc benefits as per IRDAI norms on portability.
E.1.14. Disclosure of Information The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policyholder. (Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)	**Simpler version*** If you don't tell the truth or hide important information when you buy the policy, and the insurance company finds out, they can cancel the policy and keep all the money you paid.
E.1.15. 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	**Simpler version*** The Insured Person must follow the rules of the policy so that the Company can pay for any claim(s) that come up under the policy
E.1.16. 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.	**Simpler version*** If the Company pays any amount for a claim to the policyholder, Insured Person, their representatives, or the hospital, it will be considered as a valid payment for that specific claim
E.1.17. 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) a) 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. b) 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.	**Simpler version*** If the Insured Person has chosen to pay premiums in instalments (such as half-yearly, quarterly, or monthly), certain conditions will apply as mentioned in the policy schedule/ certificate of insurance The policy allows a grace period of 15 days for monthly premium policies and 30 days for other policies for payment of premium. During the grace period, coverage will be available.

c) 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. d) No interest will be charged If the instalment premium is not paid on due date e) In case of instalment premium due not received within the grace period, the policy will get cancelled. f) In the event of a claim, all subsequent premium instalments shall immediately become due and payable g) The Company has the right to recover and deduct all the pending instalments from the claim amount due under the Policy.	The Insured Person can still receive continuity benefits for Waiting Periods if they pay the premium within the grace period. No interest will be charged if the instalment premium is not paid on the due date, but if it's not paid within the grace period, the policy will be cancelled. If a claim is made, all upcoming premium payments must be made immediately
E.2. Specific Terms and Clauses **E.2.1. Automatic Cancellation:** Cover under the Policy shall automatically terminate in the event of death of the all Insured Person(s). A refund in accordance with Section E.1.2 (Cancellation) shall be payable provided that no claim has been admitted or lodged or not benefit has been availed by the Insured Person under the Policy However, the cover shall continue for the remaining Insured Persons, if any, 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 guardians 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, proportionate refund of premium of the of the deceased Insured Person for the balance period of the Policy will be effective. Automatic change in coverage under the Policy : Upon exhaustion of Sum Insured and Super Credit , for the Policy Year. However, the Policy is subject to Renewal on the due date as per the applicable terms and conditions.	**Simpler version*** If all Insured Persons die, the Policy will end and a refund, as per Section E.1.2 (Cancellation) will be given if no claims have been made or benefits availed under the Policy.
E.2.2. 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.	**Simpler version*** Any information that customer know or should reasonably know, which is related to the questions in the Proposal Form and is important for us to decide whether to provide insurance coverage should be disclosed. The customer has the responsibility to disclose this information to us before renewing, extending, changing, or adding anything to the insurance contract. The terms and conditions of the Policy will not be changed.
E.2.3. No Constructive Notice Any knowledge or information of any circumstance or condition in relation to the Policyholder/ Insured Person which is in Our possession and not specifically informed by the Policyholder / Insured Person shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium	
E.2.4. Additional premium (Risk Loading) a) The Company may apply loading on the premium, specific Waiting Period or any permanent exclusions, based on the declarations made in the Proposal Form and the health status, habits and lifestyle, past medical records, and the results of the Pre-Policy medical examination of the persons proposed to be insured under the Policy b) Loadings shall be applied from Commencement Date including subsequent Renewal(s), and on increased Sum Insured c) Proposer shall be informed about the proposed loading with premium, specific Waiting Period or permanent exclusion (if any) through a counter offer letter and Policy will be issued only on specific acceptance within 15 days of the receipt of such counter offer letter. In case the Company does not receive any response to the counter offer letter from the proposer within 15 days, the application shall be cancelled and any premium received shall be refunded within 7 days.	**Simpler version*** The Company may charge extra on the premium, apply Waiting Period, or exclude certain conditions based on the health status, medical records, and pre-policy medical examination of the proposed Insured Person. The proposer will be informed about the extra charge through a letter, and the Policy will only be issued if the proposer accepts within 15 days. If there is no response within 15 days, the application will be cancelled, and any premium received will be refunded within 7 days.
E.2.5. Other Renewal Conditions: a) Renewal Premium: Renewal premium will alter based on Age. For Floater plan, the age of eldest Insured Person will be considered for calculating the premium. b) Addition of Insured Persons on Renewal: If a new member is added in the Policy, either by way of endorsement or at the time of Renewal, the Pre-existing Disease clause, exclusions, loading (if any) and Waiting Periods will be applicable afresh for that member. Option of Mid-term inclusion of a Person in the Policy as an Insured will be only upon marriage or childbirth (inclusion of child only after completed 90 days and less than 1 year of age), Additional differential premium will be calculated on a pro rata basis. Otherwise child addition can happen only in next Renewal or at the start of next Policy Year in multi-year policies.	**Simpler version*** a) The cost of renewing the Policy will depend on the age of the oldest person insured for the family plan. b) If a new person is added to the Policy during renewal or by endorsement, the pre-existing disease clause, exclusions, loading, and Waiting Periods will apply to the new person as if they were starting a new Policy. c) At the time of renewal, you can request to increase the sum insured, but it will be subject to underwriting.

c) Changes to Sum Insured on Renewal: You may opt for enhancement of Sum Insured at the time of Renewal, subject to underwriting. All Waiting Periods as defined in the Policy shall apply afresh for this enhanced limit from the effective date of such enhancement d) 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. e) Any unutilised funds under HealthReturns™ (from the previous Policy year/ month) will be available for claims during the Grace Period. f) You shall not be able to earn HealthReturns™ during the Grace Period. g) 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. h) 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. i) 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. j) You shall disclose to Us in writing of any chronic condition acquired by any Insured Person at the time of seeking Renewal of this Policy or during the Policy tenure, irrespective of any claim arising or made. k) 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. l) Where an Insured Person is added to this Policy, either by way of endorsement, all Waiting Periods under Section D.1.1 (Pre-Existing Diseases (Code- Excl01)), D.1.2 (Specified disease / procedure Waiting Period: (Code- Excl02)) and D.1.3 (30-day Waiting Period (Code- Excl03)) will be applicable considering such Policy Year as the first year of Policy with Us with respect to the Insured Person. m) Applicable Super Credit shall be accrued on each Renewal as per eligibility under the plan in force. n) 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.	The Waiting Periods defined in the Policy will apply again for the enhanced limit from the effective date of such enhancement d) We will not be responsible for any claims related to an ailment, hospitalization, or illness that occurs between the end date of your previous Policy and the start date of your new Policy. Such conditions will be considered as pre-existing diseases and will not be covered e) You can use any remaining funds in your HealthReturns™ account from the previous Policy Year or month during the grace period to make claims f) During the grace period, which is a specific period of time after the due date for payment, insured won't be able to accumulate or earn any HealthReturns™
E.2.6. 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.	**Simpler version*** You or the Insured Person should maintain accurate medical records and allow us or our representatives to review them. You or the Insured Person should also provide any information required by us under the Policy during the Policy Period and up to three years after the Policy expires or until all claims are settled
E.2.7 Claims The fulfilment of the terms and conditions of this Policy (including the requirements in this Section) in so far 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: **a) Notification of a Claim** Notice with full particulars shall be sent to the Company as under: i. Within 24 hours 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 or decision to avail treatment under Section Home Health Care as specified in Appendix A. iii. If the claim is not notified to Us within the timelines indicated in this Section, 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.	**Simpler version*** a) To inform the insurance company about hospitalization, the Insured Person or their representative must give notice with full details: Within specified timelines to experience a smooth claims process.
Type of claim	**Prescribed Time Limit**
Reimbursement of Hospitalization, Day Care Treatment or Pre Hospitalization Expenses	Within 30 days of date of discharge from Hospital.
Reimbursement of Post Hospitalization Expenses	Within 15 days from completion of post Hospitalization treatment.

b) List of documents required for a Claim

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

i. Duly Completed claim form,
ii. Photo ID and Age Proof,
iii. Copy of the Hospital's Registration Certificate/ Hospital Registration number in case of Hospitalization in any non-Network Provider of the Company or certificate from Hospital authorities providing facilities available including number of beds,
iv. Discharge Card / Day Care Summary / Transfer Summary,
v. Final Hospital bill with all original deposit and final payment receipt and refund receipt(s), if advance amount refunded,
vi. Invoice with payment receipt and implant stickers for all implants used during Surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery,
vii. All previous consultation papers indicating history and treatment details for current Illness and advice for current Hospitalization,
viii. All diagnostic reports (including imaging and laboratory) along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre,
ix. All medicine / pharmacy bills along with prescription by Medical Practitioner,
x. MLC / FIR Copy – in Accident cases only,
xi. History of alcohol consumption or any intoxication certified by first treating doctor in case of Accident cases,
xii. Copy of Death Summary and copy of Death Certificate (in death claims only),
xiii. Copy of indoor case papers with nursing sheet detailing medical history of the Insured Person, treatment details, and patient's progress (to be submitted wherever required by the Company).
xiv. Invoice for vaccination and payment receipt,
xv. Original invoices for the expenses incurred towards ambulance facility along with details of loss in the Company's prescribed format,
xvi. KYC documents of the Policyholder as per AML guidelines,
xvii. Duly filled NEFT form with cancelled blank cheque (with IFSC code, A/C number, and name mentioned on cheque leaf),
xviii. Legal heir/succession certificate, wherever applicable,
xix. Additional documents for claims outside India of Insured Person and Accompanying Person (as applicable) –
   - Passport copy with entry and exit stamps
   - Flight Tickets and Boarding Pass, if applicable
   - Accommodation Invoices, if applicable
   - Written advice from the overseas treating Medical Practitioner for requirement of an accompanying person during treatment.
   - Additional documents as specified under each benefit
xx. Any other relevant document required by Company for assessment of the claim.

Note:

- The Company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
- 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.
- If requested by the Company, at the Company's cost, the Insured Person must submit to medical examination by Medical Practitioner appointed by the Company as often as it is considered reasonable and necessary and Company's 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.

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

E.2.7.1 Claims Procedure for Benefits other than Personal Accident and Critical Illness

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. The complete list of Network 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 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. It is advisable that 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 Policy Number;
   2. Nature of the Illness/Injury and the treatment/Surgery required;
   3. Name and address of the attending Medical Practitioner;
   4. Hospital where treatment/Surgery is proposed to be taken;
   5. Proposed date of admission.
   6. Preauthorisation form dully filed sign and stamp by hospital and insured / relative
   7. Insured ID card
   8. Policy copy
   9. All Past consultation papers
   10. CKYC form with CKYC number mandatory for all claims. (PAN & Aadhar card of Proposer both are Mandatory as per IRDA Guideline).
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, applicable Deductibles 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 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 Policy Number;
   2. Nature of the Illness / Injury and the treatment / Surgery required;
   3. Name and address of the attending Medical Practitioner;
   4. Hospital where treatment / Surgery is proposed to be taken;
   5. Proposed date of admission.
   6. Preauthorisation form dully filed sign and stamp by hospital and insured / relative.
   7. CKYC form with CKYC number mandatory for all claims. (PAN & Aadhar card of Proposer both are Mandatory as per IRDA Guideline).
   8. Discharge summary/Day care Summary/ Death summary

9. Final hospital bills with detailed item and cost wise break up
10. Investigation reports supporting to initial and final diagnosis
11. Complete set of Indoor case paper with TPR / BP / Nursing and Medicine chart
12. Implant invoice / sticker / Post operative x ray in surgical Management cases
13. FIR/Medico Legal Certificate in accidental claim
14. Operation Theatre notes in surgical Management cases
15. Consultation papers
16. Past history and duration of chronic ailments , co morbid condition and diseases if any , supported with first consultation papers.

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, applicable Deductibles 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 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.

e) Claims Documentation:

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

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

ii. For those claims for which the use of Cashless Facility has been authorised, We will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:
   1. Duly filled and signed Claim Form Part A
   2. Duly filled and signed Claim Form Part B for hospitalization claim
   3. Proposer's ID Proof : PAN Card & Adhaar card (If CKYC not registered). If CKYC registered: CKYC form and CKYC number
   4. Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents)
   5. Copy of the Network Provider's Registration Certificate / Copy of Form C in case of Hospitalization.
   6. Original Discharge Card / Day Care Summary / Transfer Summary
   7. Original Hospital Final Bill with detailed break up and all original Deposit & Final Payment Receipts.
   8. Original Invoice with Payment receipt & implant Stickers for all Implants used during Surgeries i.e. Lens Sticker & Invoice in Cataract Surgery, Stent Invoice & Sticker in Angioplasty Surgery.
   9. All previous consultation papers indicating history & treatment details for current ailment
   10. All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription & invoice / bill with receipt from diagnostic centre
   11. All Original Medicine / Pharmacy Bills along with Medical Practitioner's prescription
   12. MLC / FIR Copy – in Accidental Cases Only
   13. Copy of Death Summary & Copy Death Certificate (in Death Claims Only)
   14. Pre & Post-Operative Imaging reports – for Accident Cases Only
   15. Copy of Indoor case papers with nursing sheet detailing medical history of the patient, treatment details, & patient's progress (if available)
   16. Treating Medical Practitioner letter stating:
   - Presenting complaints with duration & past history
   - Medical history of Co-morbidities e.g. Hypertension, Heart ailment etc.
   - Treatment detail with name of drugs & route of administration
   17. Treating Medical Practitioner letter stating – for Accident Cases Only
   - Details of Accident/trauma
   - Whether patient was under the influence of alcohol or any intoxicating substance during incident / Accident
   18. KYC documents in accordance with the provisions of the regulations, circulars and guidelines issued by the IRDAI with respect to KYC from time to time.
   19. Legal Heir / Succession Certificate in case of Proposer's Death
   20. Affidavit-NOC from other Legal Heirs in Stamp Paper certified by Notary Public (In case of settlement to one Legal Heir)
   21. Investigation / Diagnostic Reports Including CT / MRI / USG / HPE / ECG / X-Ray / MRI / CT Films and reports
   22. Doctor Consultation Bills and consultation papers
   23. All previous consultation papers
   24. Medico Legal Case (MLC) / Accident Report (AR) / (In case of Accident)
   25. First Information Report (FIR) in case of Accident
   26. Proposer's Bank Account Details- Cancelled Cheque Leaf with Proposer name pre-printed OR Bank Passbook 1st page
   27. Nominee / Legal Heir Bank Account Details-Cancelled Cheque Leaf / Passbook / Bank Statement (in case of Proposer's Death)

Additional documents in case of below covers

In case of Multiple Policy claims:

1. Photocopy of entire claim document duly attested by previous Insurer or TPA
2. Original payment receipts for expenses not claimed/settled by previous insurer
3. Discharge voucher/settlement letter by previous insurer

Road Ambulance Cover:

1. Photocopy of discharge card
2. Original Ambulance invoice & paid receipt

E.2.7.2 Claim Procedure for Personal Accident, Critical Illness Benefit

a) Intimation of Claim

You or anyone on behalf of the Insured Person(s) shall intimate a claim to Us within 7 days from the date of the Accident or diagnosis of the Critical Illness or admission in the Hospital (as the case may be) by any of the following means

- Call centre
- Email
- Fax
- Writing to Our office address

The following minimum details are required to be provided at the time of intimation of claim:

i. The Policy number;
ii. Name of the Policyholder;
iii. Name and address of the Insured Person in respect of whom the request is being made

b) Claim Documents:

The claims documents as specified in below sections for various covers must be provided to Us within 30 days of occurrence of the event giving rise to a claim under the Policy at Your own / Insured Person's expenses.

Where there is a delay in intimation of claim and/or submission of claim documents is proved to be genuine and for reasons beyond the control of the claimant, We may condone such delay and process the claim. We reserve the right to decline such requests for claim process where there is no merit behind such delay.

b.1. Personal Accident Cover

Documents required for all Benefits under Personal Accident Cover

1. Photo ID and Age proof of Insured Person / Nominee (if Insured Person is not alive);
2. Claim intimation or claim reference number (if any);
3. Attested copy of medico legal certificate copy / first information report copy / Panchnama (spot / inquest);
4. Copies of consultation letters detailing the treatment taken immediately after Accident;
5. Radiological investigation reports like X ray, CT scan, MRI etc with films supporting the diagnosis of Injury;
6. Cancelled cheque for NEFT.
7. Duly completed personal accident policy claim form signed by Insured Person.
8. CKYC form with CKYC number mandatory for all claims. (PAN & Aadhar card of Proposer both are Mandatory as per IRDA Guideline).
9. Discharge Summary
10. Original Final Hospital Bill with Breakup & Paid Receipts
11. Implant invoice/sticker in case of Surgery
12. Death summary - In case of Death
13. Operation Theatre notes – In case of Surgery
14. Pharmacy/Lab/Doctor Consultation bills with supporting paid receipt
15. Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details and patient's progress where applicable.
16. Personalized Cancelled Cheque with Insured name on the Cheque / Passbook / NEFT form sign by Bank. In case of Death Cancelled cheque of Nominee

Additional documents required for Specific Benefits

If these details are not provided in full or are insufficient for Us to consider the request, We shall request additional information or documentation in respect of that request.

b.1.1 Accidental Death Cover (AD)

1. Attested copy of the death certificate issued by government / municipal authorities
2. Attested copy of cause of death certificate issued by treating Medical Practitioner/ Hospital
3. Copy of burial certificate (wherever applicable)
4. Attested copy of post-mortem report, if applicable
5. Attested copy of viscera report and chemical analysis report (6) Attested copy of witness statement (if available)
6. Attested copy of witness statement (if available)
7. Copy of death summary if the Insured Person was Hospitalised
8. Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details and patient's progress (where the death summary is not detailed) (if available)
9. Translation of all vernacular documents in English duly notarized.
10. Salary slips for last 3 months with seal and signature of authorized signatory of the organization (if employed)
11. Last 3 years' financial years' income tax return for self-employed persons
12. Legal heir certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized (If Nominee name is not mentioned on Policy Schedule or Nominee is a minor, then legal guardian.)
13. Duly completed personal accident policy claim form signed by Insured Person.
14. CKYC form with CKYC number mandatory for all claims. (PAN & Aadhar card of Nominee and Insured both are Mandatory as per IRDA Guideline).
15. Cancelled cheque copy with pre-printed name of Nominee, bank name, branch name, MICR code, IFSC code, account number and account type ; if name is not pre-printed then please provide copy of 1st page of pass book or bank account statement of the claimant
16. Attested copy of medicolegal certificate/ first information report / Panchnama (Spot/Inquest)
17. Kindly provide current loan outstanding details
18. Driving license
19. Copy of Final Police Report
20. Newspaper Cutting, if any
21. Motor vehicle settlement letter
22. Legal Heir Certificate (incase Nominee name is not declare in Policy copy/ death of contratual nominee)
23. Please confirm if Insured has taken any other Insurance Policy. If yes, please share Policy schedule and settlement letter

b.1.2 Permanent Total Disablement (PTD) & Partial Permanent Disability (PPD)

1. Attested copy of disability certificate issued by civil surgeon of district Hospital mentioning the type and percentage of disability.
2. Original photograph of the Insured Person reflecting the disablement or injured part for which the claim is made.
3. Leave records with seal and signature of authorized signatory of the organization (if employed).
4. Salary slips for last 3 months with seal and signature of authorized signatory of the organization (if employed).
5. Last 3 years financial years income tax return for self-employed persons.
6. Copies of medical documents towards treatment taken during disability period, including discharge summary of the Hospital.
7. Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details and patient's progress (where the discharge summary is not detailed) (if available)
8. Duly completed personal accident policy claim form signed by Insured Person.
9. CKYC form with CKYC number mandatory for all claims. (PAN & Aadhar card of Proposer both are Mandatory as per IRDA Guideline).
10. Personalized Cancelled Cheque with Insured name on the Cheque / Passbook / NEFT form sign by Bank. In case of Death Cancelled cheque of Nominee
11. Radiological investigation reports like X ray, CT scan, MRI etc. with films supporting the diagnosis of Injury
12. Discharge Summary
13. Legal Heir Certificate (incase Nominee name is not declare in Policy copy/ death of contratual nominee)
14. FIR / MLC

Additional documents required for Specific Benefits If these details are not provided in full or are insufficient for Us to consider the request, We shall request additional information or documentation in respect of that request.

c) Critical Illness Cover

1. Claim Form (in original) duly completed and signed as prescribed by Us.
2. Photo ID and Age proof of Insured Person / Nominee (if Insured Person is not alive).
3. Copy of the claim intimation, if any.
4. Final Hospital bill.
5. Hospital discharge summary / day care summary / transfer summary.
6. Operation theatre notes.
7. Investigation reports (Including CT scan / MRI / USG / Histopathology or Biopsy report).
8. Doctor's prescriptions.
9. Cancelled cheque for NEFT.
10. Others

Additional documents for submission of claims under Critical Illness Cover

The Insured Person at their own expenses shall submit the following documents within 30 (thirty) days of the earliest of the date of first diagnosis of the Critical Illness/ date of Surgical Procedure or date of occurrence of the medical event, as the case may be:

1. Medical certificate confirming the diagnosis of Critical Illness
2. Certificate from attending Medical Practitioner confirming that the claim does not relate to any Pre-Existing Disease or any Illness or Injury which was diagnosed within the first 90 days of the Inception Date
3. Photocopy of discharge certificate / card from the Hospital, if any
4. Photocopy of investigation test reports confirming the diagnosis
5. Photocopy of first consultation letter and subsequent prescriptions
6. Photocopy of indoor case papers if applicable (if available)
7. Specific documents (if any) listed under the respective Critical Illness
8. In the cases where Critical Illness arises due to an Accident, FIR copy or medico legal certificate shall be required wherever conducted.

We may call for any additional documents / information as required based on the circumstances of the claim
For details on the claims process or assistance during the process, You may contact Us at Our call centre on the toll free number specified in the Policy Schedule or through Our website.

E.2.7.3 Procedure for Cashless Claims in case of Home Health Care:

On receipt of duly filled pre-authorization form with other sufficient details to assess a cashless request, the Company will inform the Home Health Care service provider or Network Provider, who will share the care plan and treatment cost estimation with the Company. On receipt of the complete documents the Company may:

a. issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable, or
b. reject the request for pre-authorization specifying reasons for the rejection

E.2.7.4 Claims Procedure for Claims Outside India

Claims Procedure for claims outside India then as a Condition Precedent to Our liability under the Policy the following procedure shall be complied with:

a. For Availing Cashless Facility

i. Cashless Facility can be availed only at Our Network Providers / Empanelled Service Providers.
ii. We reserve the right to modify, add or restrict any Network Provider / Empanelled Service Provider for Cashless Facilities at Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers and Empanelled Service Providers on Our website.

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

i. We / Our Empanelled Service Provider must be contacted to pre-authorise Cashless Facility for planned treatment at the earliest possible prior to the proposed treatment. Each request for pre-authorisation must be accompanied with all the following details
   1. The health card issued by Us to the Insured Person, along with the Insured Person's KYC documents.
   2. The Policy Number;
   3. Name of the Policyholder;
   4. Name and address of Insured Person in respect of whom the request is being made;
   5. Nature of the Illness/Injury and the treatment / Surgery required;
   6. Name and address of the attending Medical Practitioner;
   7. The Insured Person on diagnosis of the Illness should share the following for e-opinion
      - First consultation paper from treating medical practitioner in India
      - Final Diagnosis paper
      - Treating doctor certification on final diagnosis
      - All investigation reports supporting documents
      - Consent Form to collect documents from various source
      - Any other relevant documents to ascertain eligibility of claim

8. On the basis of the Insured Person's medical condition, We / Our Empanelled Service Provider will identify 3 Hospitals from Our network.
    9. The Insured Person may choose one of the Hospitals / treatment centres out of the 3 choices given by Us / Our Empanelled Service Provider.
    10. Medical Reports and all other information is shared with the chosen Hospital / clinic.
    11. After the receipt of all medical information, a detailed Medical Opinion from the selected Hospital / treatment centre would be delivered to You at the earliest.
    12. Insured Person must notify Us of the willingness to take the treatment abroad and the country of choice.
    13. On receipt of the Insured Person's confirmation of his/her decision to receive treatment abroad at the selected country for treatment, We / Our Empanelled Service Provider will identify 3 Hospitals from our Network.
    14. You may choose one of the Hospitals / treatment centres out of the 3 Choices given by Us / Our Empanelled Service Provider or You may choose from a fourth option from Our/Empanelled Service Provider's network Hospitals.
    15. We will organize the necessary logistical, travel, accommodation and medical arrangements for the correct admission of the Insured Person and will issue a Preliminary Medical Certificate valid only for that Hospital.
    16. We will provide coverage only in the indicated Hospital in the Preliminary Medical Certificate. Any expense incurred in a different Hospital from the one specified in the Preliminary Medical Certificate will not be covered.
    17. Any expense incurred before the issuance of the Preliminary Medical Certificate will not be covered.
    18. The list of recommended Hospitals and the Preliminary Medical Certificate are issued on the basis of the medical condition of the Insured Person at the time of issue of Preliminary Medical Certificate. Since the health condition of the Insured Person may change over time, both documents will have a validity of three months.
    19. In the event that the Insured Person does not select a Hospital from the list of recommended Hospital or does not initiate treatment within 3 months of issuance of Preliminary Medical Certificate within 3 months of issue, We on the request of customer shall reinitiate the process of Pre-Authorisation for planned treatment based on the health condition of the Insured Person at that time.

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 within 24 hours of receiving the complete information.

c. For Reimbursement Claims:

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

ii. If the claim is not notified to Us within the earlier of 72 hours of the Insured Person's admission to the Hospital or within 72 hours of the Insured Person's discharge from the Hospital.

d. Claims Documentation:

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

i. Claims for Post-Hospitalization Medical Expenses to be submitted to us within 30 days of the completion of the post Hospitalization treatment.
ii. For those claims for which the use of Cashless Facility has been authorised, We / Our Empanelled Service Provider will be provided these documents by the Network Provider / You (as the case may be) immediately following the Insured Person's discharge from Hospital:
    1. Duly signed, stamped and completed Claim Form
    2. Photo ID & Age Proof
    3. Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents)
    4. Copy of the Network Provider's Registration Certificate / Copy of Form C in case of Hospitalization
    5. Original Discharge Card / Day Care Summary / Transfer Summary
    6. Original final Hospital Bill with all original deposit and final payment receipt
    7. Original invoice with payment receipt and implant stickers for all implants used during surgeries i.e. invoice in Surgery, stent invoice and sticker in Angioplasty Surgery.
    8. All previous consultation papers indicating history and treatment details for current ailment
    9. All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription and invoice / bill with receipt from diagnostic center
    10. All original medicine / pharmacy bills along with Medical Practitioner's prescription
    11. MLC / FIR Copy – in Accidental cases only
    12. Copy of Death Summary and copy of Death Certificate (in death claims only)
    13. Pre and Post-Operative Imaging reports – in Accidental cases only
    14. Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress (if available)
    15. KYC documents in accordance with the provisions of the regulations, circulars and guidelines issued by the IRDAI with respect to KYC from time to time.
    16. A valid ticket / proof of travel (such as Airline boarding pass) to the location the Insured Person is traveling as a bona fide passenger

    Note: For the following Claims, please notify the same at our call centre / website / E-Mail:
    - Health Assessment
    - HealthReturns™
    - Annual Health Check-up

Refer Appendix A for the applicability of the benefits mentioned above.

E.2.7.5 Claims Assessment & Repudiation

a. At Our discretion, We may investigate claims to determine the validity of a claim. This investigation will be conducted within 15 days
All costs of investigation will be borne by Us and all investigations will be carried out by those individuals / entities that are authorised by Us in writing. If there are any deficiencies in the necessary claim documents which are not met or are partially met, we will be sending communications to address the deficiency

b. 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.

E.2.8. Policy Disputes Any dispute concerning the interpretation of the terms, conditions, limitations and / or exclusions contained herein shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.	**E.2.8 Simpler version*** If there is a disagreement about what something in this document means, Indian law will be used to resolve it, and the matter will be decided in an Indian court
E.2.9. Premium through National Automated Clearing House (NACH) / Standing Instruction (SI) provided that You may pay the premium through National Automated Clearing House (NACH) / Standing Instruction (SI) provided that: NACH / Standing Instruction Mandate form is completely filled & signed by You. The Premium amount which would be auto debited & frequency of instalment is duly filled in the mandate form. New Mandate Form is required to be filled in case of any change in the Policy Terms and Conditions whether or not leading to change in Premium. You need to inform us at least 15 days prior to the due date of instalment premium if You wish to discontinue with the NACH / Standing Instruction facility. Non-payment of premium on due date as opted by You in the mandate form subject to an additional renewal / revival period will lead to termination of the Policy	
E.2.10. Alteration to the Policy This Policy constitutes the complete contract of insurance. Any change in the Policy will only be evidenced by a written endorsement signed and stamped by Us. No one except Us can change or vary this Policy.	**E.2.10 Simpler version*** This Policy is the entire agreement for insurance. Any changes to the Policy can only be made in writing and signed by us. Only we can change or modify this Policy.
E.2.11. Zonal pricing For the purpose of calculating premium, the country has been divided into the following 3	
Zone 1 - Delhi NCR (includes Delhi, Baghpat, Bulandshahr, Gautam Buddha Nagar, Ghaziabad, Hapur, Meerut, Muzaffarnagar, Shamli, Charkhi Dadri, Faridabad, Gurugram, Jhajjar, Jind, Karnal, Mahendragarh, Nuh, Palwal, Panipat, Rewari, Bhiwani, Alwar, Bharatpur, Rohtak, Sonipat, any other city defined by Govt.) Mumbai Metropolis Area (including Mumbai suburban, Thane, Palghar, Raigad, any other city defined by Govt.) Gujarat State, Aligarh, Mathura **Zone 2:** Kolkata, Pune, Hyderabad, Chennai, Chandigarh, Mohali, Panchkula, Lucknow, Patna **Zone 3:** Rest of India	
E.2.12. Assignment The Policy can be assigned subject to applicable laws	**E.2.12 Simpler version*** The Policy can be assigned under present regulations.
E.2.13. Arbitration clause If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independent of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties thereto, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of 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 who shall act as the presiding arbitrator and Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996 (as amended). It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator / arbitrators of the amount of the loss or damage shall be first obtained.	

E.2.14. Utilization of Sum Insured The sequence of utilization of Sum Insured in this Policy, subject to the Optional Covers in force under the Policy, will be as follows: a. Base Sum Insured followed by; b. Accumulated Super Credit (if inbuilt / opted and applicable) followed by; c. Super Reload followed by; d. Cancer Booster (if opted and applicable)	
E.2.15. Endorsements 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 or modification that the Company makes will be evidenced by a written endorsement signed and stamped by the Company.	**E.2.15 Simpler version*** This Policy is the whole agreement of insurance. No one, including an insurance agent or broker, can change it except the Company. If the Company makes any changes, it will be in writing and signed by the Company
E.2.16. Communication & Notice Policy and any communication related to the Policy shall be sent to through electronic modes or to the address of the following. a. The Policyholder's, at the address / E-Mail address specified in the Policy Schedule. b. To the Company, at the address specified in the Policy Schedule. c. Insurance agents, brokers, other person or entity is / are not authorised to receive any notice on the behalf of the Company, unless stated in writing by the Company.	**E.2.16 Simpler version*** The Policy and related communication will be sent via electronic means or to the addresses mentioned in the Policy Schedule. Only the Policyholder and the Company can receive notices, and no one else is authorized unless approved in writing by the Company
E.2.17. Instalment Premium payment through Auto Debit / ECS Facility a. If premium payment is opted for by instalments through auto debit / ECS facility, a separate authorization form shall be submitted by Insured Person specifying the frequency chosen for premium to be debited. b. Where there is a change either in the terms and conditions of the coverage or Policy or in the premium rate, the ECS authorization shall be obtained afresh. c. The Insured Person has the option to withdraw from the ECS mode at least fifteen days prior to the due date of instalment premium payable. d. No additional charges will be levied or recovered in any manner from the benefits payable towards cancellation of the ECS mode	
E.2.18. 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 transations 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.	**E.2.18. Simpler version*** Both You and Insured Person agree to follow our rules for electronic transactions. They undestand that transactions conducted online or through other electronic means will be legally valid if they comply with our terms and conditions. When purchasing insurance through electronic methods, all necessary information and disclosures will be provided to You. We will keep a record of consent, such as voice recordings, to ensure everything is properly documented and confirmed
E.2.19. Premium The premium payable under this Policy shall be paid in accordance with the schedule of payments in the Policy Schedule agreed between the Policyholder and Us in writing. No receipt for premium shall be valid except on Our official form signed by Our duly authorized official. The due payment of premium and realization thereof by Us and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to Our liability to make any payment under this Policy	**E.2.19. Simpler version*** Premium must be paid as per the agreed schedule in the Policy Schedule, using our official form signed by our authorized official for valid receipts. Payment and adherence to Policy terms by the insured are prerequisites for our liability to pay under this Policy

Annexure I- List of Non-Medical Expenses
Annexure II- Contact Details of Insurance Ombudsman offices
Annexure III - Product Benefit Table
Annexure IV – Applicability Matrix of Chronic Management Program for listed 7 Chronic conditions

This is not a comprehensive list of amendments of Insurance Regulatory And Development Authority Of India Health Insurance Regulations 2016 and only a simpler version prepared for general information to the policyholders for easy comprehension. Policy Holders are advised to refer to Original Regulations and subsequent amendments for complete and accurate details. In the event of any inconsistency or interpretation issues vis vis the original clause and its corresponding simpler version, the original clause shall prevail.

ADITYA BIRLA CAPITAL
HEALTH INSURANCE

Activ One VIP+
Appendix A

Section C. Benefits Covered Under the Policy

Benefits under this Section are subject to the terms, conditions and exclusions of this Policy. Payment of claims under these Benefits shall be subject to the availability of the Base Sum Insured and the overall Sum Insured as applicable to the Insured Person and as specified in the Policy Schedule.

The Benefits applicable, the Sum Insured limits, and Exclusions (including Waiting Periods) are as opted by You in the Proposal Form and as specified to be in-force for the person(s) in the Policy Schedule. All the Benefits under this Section might not be applicable to the Insured Person(s), please refer to the Policy Schedule for the list of Benefits applicable to You.

C.1 Hospitalization Treatment

C.1.1 In-Patient Treatment

The Company shall indemnify the Medical Expenses incurred for Hospitalization of the Insured Person during the Policy Period due to Illness or Injury, for one or more of the following:

a. Room Rent, boarding, nursing expenses as provided by the Hospital / Nursing Home.
b. Intensive Care Unit (ICU) Charges / Intensive Cardiac Care Unit (ICCU) expenses.
c. Surgeon, anaesthetist, Medical Practitioner, consultants, specialist's fees during Hospitalization and forming part of the Hospital bill.
d. Investigative treatments and diagnostic procedures directly related to Hospitalization.
e. Medicines and drugs prescribed in writing by Medical Practitioner.
f. Intravenous fluids, blood transfusion, surgical appliances, allowable consumables and / or enteral feedings.
g. Operation theatre charges.
h. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery.

C.1.1.1 Other Expenses Covered

a. Expenses incurred on **Road Ambulance** if the Insured Person is required to be transferred to the nearest Hospital for Emergency Care or from one Hospital to another Hospital or from Hospital to Home following Hospitalization.
b. Dental Treatment under Inpatient Care, medically necessitated due to Illness or Injury
c. Plastic Surgery, medically necessitated due to Injury
d. All **Day Care Treatments**
e. Expenses incurred by towards treatment taken by the Insured Person during In-patient Treatment under Section (C.1.1) or Day Care Treatment under Section (C.1.1.1.d) arising out of any of the below mentioned Indicative list of **Modern Procedures / Treatments** (Below mentioned list can be modified basis medical advancements and evolution).

Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Immunotherapy- Monoclonal Antibody to be given as injection	Vaporisation of the Prostrate (Green laser treatment or holmium laser treatment)	Stem Cell Therapy: Hematopoietic Stem Cells for Bone Marrow Transplant for Haematological Conditions
Balloon Sinuplasty	Oral Chemotherapy	Robotic Surgeries	Stereotactic Radio Surgeries
Deep Brain Stimulation	Intra Vitreal Injections	Bronchial Thermoplasty	IONM - (Intra Operative Neuro Monitoring)

f. **HIV / AIDS and STD Cover:** Medical Expenses incurred towards treatment taken by the Insured Person during Hospitalization Treatment under Section (C.1) of the Insured Person arising out of condition caused by or associated with HIV or HIV related illnesses, including AIDS or AIDS related Complex (ARC) and / or any mutant derivative or variations there of or sexually transmitted diseases (STD) during the Policy Period.

g. **Mental Illness Hospitalization:** Medical Expenses incurred towards treatment taken by the Insured Person during Hospitalization Treatment under Section (C.1) of the Insured Person during the Policy Period, arising out of a condition caused by or associated to medical illness, stress, anxiety, depression or a medical condition impacting mental health of the Insured.

h. **Obesity Treatment:** Medical Expenses incurred towards treatment taken by the Insured Person during Hospitalization Treatment under Section (C.1) of the Insured Person arising out of Hospitalization for a Bariatric Surgery during the Policy Period subject to the conditions that needs to be fulfilled as per Section D.1.6– Standard Exclusions - Obesity / Weight Control (Code- Excl06).

Note:

a. 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 Treatments.
b. The Hospitalization must be for Medically Necessary Treatment, and prescribed in writing by Medical Practitioner

C.2 Pre-Hospitalization Expenses

The Company shall indemnify the Pre-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization of the Insured Person under Section C.1 (Hospitalization Treatment) or Section C.5 (Domiciliary Hospitalization) or Section C.6 (Home Health Care) or Section C.7 (AYUSH Treatment) for up to 90 days immediately prior to the date of such Hospitalization.

C.3 Post-Hospitalization Expenses

The Company shall indemnify the Post-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization of the Insured Person under Section C.1 (Hospitalization Treatment) or Section C.5 (Domiciliary Hospitalization) or Section C.6 (Home Health Care) or Section C.7 (AYUSH Treatment) for up to 180 days from the date of discharge from the Hospital.

C.4 Claim Protect (Non-Medical Expense Waiver)

The Company shall indemnify the Non-Medical Expenses listed under Annexure I (all 4 lists) to this Policy incurred in relation to a claim admissible under Section C.1 (Hospitalization Treatment) or Section C.5 (Domiciliary Hospitalization) or Section C.6 (Home Health Care) or Section C.7 (AYUSH Treatment) or Section C.8 (Organ Donor Expenses) during the Policy Period.

Exclusion 11. Excluded Providers: (Code- Excl11) of Section D.1. shall not apply to this Cover.

C.5 Domiciliary Hospitalization

The Company shall indemnify the Medical Expenses incurred during the Policy Period on Domiciliary Hospitalization of the Insured Person due to Illness or Injury provided that:

a. Domiciliary Hospitalization continues for at least 3 consecutive days.
b. The condition of the Insured Person is such that he / she could not be removed / admitted to a Hospital.
   or,
   the Medically Necessary Treatment is taken at Home on account of non-availability of room in a Hospital of Home city.
C. The Domiciliary Hospitalization is prescribed in writing by treating Medical Practitioner

C.6 Home Health Care

The Company shall indemnify the Medical Expenses incurred towards the Insured Person availing Medically Necessary Treatment at Home during the Policy Period, if prescribed in writing by the treating Medical Practitioner, provided that:

a. The treatment in normal course would require In-patient Care at a Hospital and be admissible under Section C.1 (Hospitalization Treatment).
b. The treatment is pre-authorized by the Company as per procedure given under Claims Procedure - Section E.2.7.3.
c. Records of the treatment administered, duly signed by the treating Medical Practitioner, are maintained for each day of the Home treatment.
d. We do not assume any liability towards and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner and / or Network Provider / Empanelled Service Provider or in any service under this Benefit or for any consequences of actions taken or not taken in reliance thereon.
e. We do not assume any liability towards any additional or incidental charges / expenses, including but not limited to any charges towards breakage, damage, deposit for equipment, and equipment transportation. All such charges / expenses shall be borne by the Insured Person.
f. The foregoing home treatment services are provided through Network Provider / Empanelled Service Provider in select cities for select treatment procedures only. Please contact Us or refer to Our website for updated list of treatment procedures and cities where home treatment service is provided.
g. This Benefit requires pre-authorisation and is not available on Reimbursement basis.

C.7 AYUSH Treatment

The Company shall indemnify the Medical Expenses incurred for Inpatient Care of the Insured Person under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during the Policy Period in any AYUSH Hospital or AYUSH Day Care Centre.

C.8 Organ Donor Expenses

The Company shall indemnify the Medical Expenses listed under Section C.1 (Hospitalization Treatment) which are incurred during the Policy Period towards the organ donor's Hospitalization for harvesting of the donated organ where an Insured Person is the recipient, subject to the following conditions:

a. The Organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994, the Transplantation of Human Organ (amendment) Act, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable laws and / or regulations, as amended from time to time.
b. Recipient Insured Person's claim under Section C.1 (Hospitalization Treatment) is admissible under the Policy in relation to such organ transplant.
c. Expenses listed below are excluded from this Cover:
i. The organ donors Pre-Hospitalization Expenses and Post-Hospitalization Expenses.
ii. Expenses related to organ transportation or preservation.
iii. Any other Medical Expenses or Hospitalization of the organ donor consequent to the organ harvesting.

C.9 Annual Health Check-up

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

Medical tests covered under this Benefit are as follows:

Sum Insured	INR 50 lacs - 6 Crores
TEST	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.

Conditions:

a. The health check-ups shall be arranged by Us only on Cashless basis at Our Network Providers / Empanelled Service Providers (such as Diagnostic centres);
b. The Network Provider / Empanelled Service Provider shall be assigned by us post receiving customer's request to avail this Benefit;
c. The Insured Person will be eligible to avail a health check-up every Policy Year.
d. For calculation of Healthy Heart Score™, tests under Health Assessment™ namely - MER (including BP, BMI, HWR and smoking status), Blood Sugar, Total Cholesterol or any other additional test added / replaced will have to be carried out at one go (together) and at least once every Policy Year.
e. Apart from the tests under Health Assessment™ mentioned under point d) above, Insured Persons shall be entitled to avail the other tests under the Health Check-up Program in one instance or at separate times during the Policy Period provided that the same test cannot be repeated during the same Policy Year.
f. 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 Provider in relation to the health check-up.

C. 10 Super Reload

If the Base Sum Insured along with accumulated Super Credit (if applicable) for the Policy Year in respect of the Insured Person, is completely exhausted or is insufficient for covering a claim, then We shall provide for a reload amounting to the Base Sum Insured ("Super Reload"), unlimited times during the Policy Year, subject to the following conditions:

a. A claim shall be admissible under this Benefit only if the claim is admissible under Section C.1(Hospitalization Treatment) or Section C.5 (Domiciliary Hospitalization) or Section C.6 (Home Health Care) or Section C.7 (AYUSH Treatment) or Section C.8 (Organ Donor Expenses) arising in that Policy Year for any or all Insured Person(s).
b. The Super Reload of the Sum Insured is not payable in the first claim in the life of the policy (as maybe specified in the Policy Schedule / Product Benefit Table). However, it shall be payable for all subsequent claims always as per sequence of utilization of Sum Insured mentioned below.
c. Our total, maximum liability under a single claim under this Benefit shall not be more than the Base Sum Insured.
d. The Super Reload Sum Insured shall not be considered while calculating the accumulated amount of Super Credit.

The sequence of utilization of Sum Insured will be as below:

a. Base Sum Insured followed by;
b. Super Credit (if applicable) followed by;
c. Super Reload followed by;
d. Cancer Booster (if opted and applicable)

C.11 Super Credit

On availing this Benefit, an additional limit under the current Policy Year ("Super Credit") will be applied / increased by a fixed percentage of the Base Sum Insured of immediately preceding Policy Year irrespective of any claims in previous Policy Year, provided the Policy is renewed with the Company without a break, subject to maximum cap as specified in the Policy Schedule against this Benefit.

i. In case where the Policy is on individual basis as specified in the Policy Schedule, the Super Credit shall be added and available individually to the Insured Person.
ii. In case where the Policy is on floater basis, the Super Credit shall be added and will be available to the family on floater basis.
iii. Super Credit shall be available only if the Policy is renewed / premium paid within the Grace Period or before.
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 Super Credit for such Insured Persons under the expiring Policy, and such expiring Policy has been renewed on a floater Policy basis then the Super Credit to be carried forward for credit in such Policy and shall be the lowest one that is applicable among all the Insured Persons.
v. In case of floater policies where the Insured Persons renew their expiring Policy by splitting the Base 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 maximum permissible age, the Super Credit of the expiring Policy shall be apportioned to such renewed policies in the proportion of the Base Sum Insured of each renewed Policy.
vi. If the Base Sum Insured has been reduced at the time of Renewal, the applicable Super Credit shall be reduced in the same proportion to the Base Sum Insured in current Policy.
vii. If the Base Sum Insured under the Policy has been increased at the time of Renewal, the Super Credit shall be calculated on the Sum Insured of the last completed Policy Year.

C.12 Global Cover (Emergency Only)

The Company shall indemnify the Insured Person for Emergency Medical Expenses which are diagnosed and incurred outside India, related to the Benefits mentioned below:

Emergency Hospitalisation
Emergency Medical Evacuation
Global Compassionate Visit
Emergency Air Ambulance
Care and / or Transportation of Minor Children
Return of Mortal Remains
Medical Referral
Medical Repatriation
Loss of Passport
Loss of Checked-in Baggage
Trip Cancellation & Interruption
Trip Delay
Delay of Checked-in Baggage

Global Health Cover (Emergency Treatments Only) is applicable subject to following terms and conditions:

i. Our maximum liability in a Policy Year for claims under this cover shall not exceed the Base Sum Insured as specified in the Policy Schedule.
ii. There is no separate Sum Insured for this cover and any claim triggered under this Benefit shall reduce the Base Sum Insured.
iii. Claims shall normally be payable on Cashless and Reimbursement basis both unless specifically mentioned under the benefits below. Cashless facility may be arranged on case to case basis.
iv. The treatment should be taken in a registered Hospital, as per law, rules and / or regulations applicable to the country, where the treatment is taken.
v. The payment of any Claim under this Benefit will be based on the rate of exchange as on the date of discharge from to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of Claims. If on the Insured Person's date of discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.
vi. We would not be liable to pay any claim wherein the medical treatment taken has not commenced within the first 45 days (for Base Sum Insured INR 1 Crore and above) / 15 days (for Base Sum Insured INR 50 Lacs and INR 75 Lacs) of a trip.

Note: Each trip shall be deemed to start within the Policy Period and from the date Insured Person finally boards the flight (scheduled aircraft operated under a valid license for the transportation of fare paying passengers under a valid ticket) to leave from India.

vii. Clause D.2.8 under Specific Exclusions is superseded to the extent covered under this Benefit.

Specific Exclusions applicable to Global Health Cover (Emergency Treatments Only)

i. Any Planned treatments
ii. Treatment or part of treatment for any condition which is not Life threatening in nature and can be safely postponed till the Insured Person returns to India.
iii. Medical treatment taken outside India if that is the sole reason or one of the reasons for the journey.
iv. Any treatment of orthopaedic diseases or conditions except for fractures, dislocations and / or Injuries suffered during the Policy Period.
v. The Company may not be liable to make any payment under this Policy, wherein the Government of India has laid down territorial restriction

C.12. (a) Emergency Hospitalization

We will indemnify the Medical Expenses incurred for the Hospitalization of the Insured Person until they reach a Medically Stable Condition during the Policy Period, provided that:

I. The Hospitalization is Medically Necessary and follows the written advice of the treating Medical Practitioner.
II. The Insured Person is required to be admitted in a Hospital in an Emergency which is Life threatening in nature even if it is caused due to a Pre-Existing Disease.
III. The Medical Expenses incurred are for one or more of the following:
    I. Room Rent: Room boarding and nursing charges during Hospitalization as charged by the Hospital where the Insured Person availed medical treatment;
    II. Medical Practitioners' fees, excluding any charges or fees for Standby Services;
    III. Investigative tests or diagnostic procedures directly related to the Insured Event which led to the current Hospitalization;
    IV. Medicines, drugs as prescribed by the treating Medical Practitioner related to the Insured Event that led to the current Hospitalization;
    V. Intravenous fluids, blood transfusion, injection administration charges and / or allowable consumables;
    VI. Operation theatre charges;
    VII. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery;
    VIII. Intensive Care Unit Charges.

C.12. (b) Emergency Medical Evacuation

Our Service Provider will arrange and we shall indemnify the expenses, for ambulance services under appropriate medical supervision on Cashless Facility basis only, when an adequate medical facility is not available proximate to the Insured Person, as determined by the Insured Person's attending physician and agreed by Us / Our Service Provider. We will arrange an appropriate mode of transport as decided by Us / Our Service Provider's consulting physician and patient's attending physician to the nearest medical facility capable of providing the required care.

C.12. (c) Global Compassionate Visit

The Company shall indemnify expenses, for the travel of a family member to visit the Insured Person in the event that the Insured Person is hospitalized for more than seven (7) consecutive days without a companion or does not have a companion by their side. We will cover an appropriate means of transportation via economy carrier transportation. The family member is responsible to meet all travel document requirements, as may be applicable.

C.12. (d) Emergency Air Ambulance

The Company shall indemnify expenses incurred by the Insured Person during the Policy Year towards Ambulance transportation in an airplane or helicopter for Emergency Care which requires immediate and rapid Ambulance transportation that ground transportation cannot provide from the site of first occurrence of the Illness or Accident to the nearest Hospital. The claim is subject to a maximum of limit as specified in the Policy Schedule against this Cover, and subject to the following conditions:

i. The Air Ambulance transportation is advised in writing by a Medical Practitioner.
ii. Medically Necessary Treatment is not available at the location where the Insured Person is residing at the time of emergency.
iii. The Air Ambulance provider is a registered entity.
iv. No return transportation to the Insured Person's residing location or elsewhere by the Air Ambulance will be covered under this Cover.
v. A claim for the same Hospitalization is admissible under Section C.12.(a) (Emergency Hospitalization).
vi. The amount specified in the Policy schedule against this benefit denotes the Company's maximum liability in respect to the benefit and shall reduce the Base Sum Insured of the policy.

C.12. (e) Care and / or Transportation of Minor Children

The Company shall indemnify the expenses for one-way economy common carrier transportation, including attendants if necessary, to transport unattended minor child(ren) to their place of residence in the event of a medical emergency or the death of an Insured Person.

C.12. (f) Return of Mortal Remains

We will indemnify the cost for the return of the mortal remains of the Insured Person to an authorized funeral home near the Insured Person's legal residence in the event of their death.

C.12. (g) Medical Referral

Insured Person(s) will have tele-access to an operations center of Our Service Provider, who will provide reference of doctors in the vicinity where the Insured Person is located for medical consultations. This medical consultation is only facilitated by Us / Our Service Provider and is independent judgment of medical consultant. We do not assume any liability and shall not be deemed to 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 professional giving medical consultant.

C.12. (h) Medical Repatriation

Our Service Provider will arrange, and we shall indemnify expenses, for transportation under medical supervision to the Insured Person's residence or to a medical or rehabilitation facility near the Insured Person's residence (as mentioned in the Policy Schedule) when the Insured Person's attending physician determines that transportation is medically necessary and is agreed by Us / Our Service Provider, at such time as the Insured Person is medically cleared for travel by Us / Our Service Provider's consulting physician and Insured Person's attending physician.

C.12. (i) Loss of Passport

I. We shall indemnify, solely through a Reimbursement basis, the Insured Person for the expenses incurred in obtaining a duplicate or new passport, up to INR 20,000 in the event of the loss of the original passport
II. Documents to be submitted for any Claim under this Benefit:
It is a condition precedent to the Company's liability under this Benefit that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:
i. Copy of the police report
ii. Details of the attempts made to trace the passport;
iii. Original receipt for payment of charges to the authorities for obtaining a new or duplicate passport.

C.12. (j) Loss of Checked-In Baggage

We shall indemnify, solely through a Reimbursement basis, the Insured Person for the expenses incurred in replacing the entire checked-in baggage and its contents at market value, up to a maximum of INR 10,000 in the event of its loss while in the custody of the common carrier, subject to the conditions specified below:

I. Coverage under this Benefit shall commence only after the checked-in baggage is entrusted to the common carrier and a receipt obtained and coverage under this Benefit shall terminate automatically on the common carrier reaching the place of destination specified in the ticket of the Insured Person during the Policy Period;
II. If the lost / undelivered checked-in baggage is subsequently traced and offered for delivery to the Insured Person, the Insured Person shall refund the amount paid by the Company under this Benefit in full irrespective of whether delivery of the baggage is taken or not;
III. If a portion of the lost / undelivered checked-in baggage is subsequently traced and offered for delivery to the Insured Person, the Insured Person shall refund the amount paid by the Company under this Benefit attributable to the portion of checked-in baggage traced in full irrespective of whether delivery of the baggage is taken;
IV. Our liability shall be determined based on the market value of the contents of the checked-in baggage as on the scheduled / expected date of delivery at the destination port;
V. Documents to be submitted for any Claim under this Benefit:

It is a condition precedent to the Company's liability under this Benefit that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

i. Property irregularity report issued by the appropriate authority.
ii. Voucher of the common carrier for the compensation paid for the non-delivery / short delivery of the checked-in baggage.
iii. Copies of correspondence exchanged, if any, with the common carrier in connection with the non-delivery / short delivery of the checked-in baggage.

VI. Additional exclusions applicable to Benefit C.12. (j) - Loss of Checked-In Baggage:

Any Claim in respect of the Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible under this Benefit:

i. Any partial loss or damage of any items contained in the checked-in baggage.
ii. Any loss arising from any delay, detention, confiscation by customs officials or other public authorities.
iii. Any loss due to damage to the checked-in baggage.
iv. Any loss of the checked-in baggage sent in advance or shipped separately.
v. Valuables (Valuables shall mean and include photographic, audio, video, painting, computer and any other electronic equipment, telecommunications and electrical equipment, telescopes, binoculars, antiques, watches, jewellery and gems, furs and articles made of precious stones and metals).

C.12 (k) Trip Cancellation & Interruption

I. Trip Cancellation

i. If the Insured Person's outward journey as a fare paying passenger from the country of residence to an international place of destination on a common carrier is unavoidably cancelled before the commencement of the period of insurance as specified in the Policy Schedule due to any of the reasons specified herein below, then We shall indemnify, up to the amount specified against this Benefit in the Policy Schedule, through Reimbursement basis only, for those travel expenses that the Policyholder incurred and cannot recover and for which no value can be derived without knowledge of the likelihood of cancellation:

- The Insured Person's immediate family member (spouse, children or parents) dies or is Hospitalized in an Emergency due to an unforeseen Illness or Injury for at least 2 consecutive days; or
- The Insured Person is Hospitalized in an Emergency due to an unforeseen Illness or Injury and such Hospitalization continues for at least 2 consecutive days and the treating Medical Practitioner certifies in writing that the Insured Person is not fit to undertake travel;

- Earthquake, storm, flood, inundation, cyclone or tempest provided that the peril takes place prior to the commencement of the period of insurance at or in the vicinity of the place of origin of the journey, the ultimate scheduled place of destination or any intermediate place which is involved in or related to the proposed journey.
- Terrorism provided that the peril takes place prior to the commencement of the period of insurance at or in the vicinity of the place of origin of the journey, the ultimate scheduled place of destination or any intermediate place which is involved in or related to the proposed journey;

ii. Any amount refunded to the Insured Person by the common carrier in relation to the cancellation shall be deducted from the amount payable to the Insured Person under this Benefit.

II. Trip Interruption:

i. If the Insured Person's overseas stay is unavoidably curtailed after the commencement of the Period of Insurance due to any of the reasons as specified herein below, We shall indemnify the costs of economy airfare of the Insured Person, through Reimbursement basis only, to return to the country of residence:
   - The Insured Person's immediate family member (spouse, children or parents) dies or is Hospitalized in an Emergency due to an unforeseen Illness or Injury and such Hospitalization continues for at least 2 consecutive days;
   - Earthquake, storm, flood, inundation, cyclone or tempest provided that the peril takes place after the commencement of the period of insurance at or in the vicinity of the place of origin of the journey, the ultimate scheduled place of destination or any intermediate place which is involved in or related to the proposed journey.
   - Terrorism provided that the peril takes place after the commencement of the period of insurance at or in the vicinity of the place of origin of the journey, the ultimate scheduled place of destination or any intermediate place which is involved in or related to the proposed journey;

ii. Any amount refunded to the Insured Person by the common carrier in relation to the curtailment shall be deducted from the amount payable to the Insured Person under this Benefit.

III. Additional exclusions applicable to Benefit C.12. (k) - Trip Cancellation & Interruption:

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

i. Strikes or labour disputes or slowdown;
ii. Interruption or cancellation of the journey either wholly or in partly at the instance of the Common Carrier (apart from the reasons listed above) or by the travel agent;
iii. Interruption or cancellation of the journey either wholly or in partly at the instance of the authority governing the Common Carrier or the government;
iv. Any Claim under the Policy which arises out of an event which occurs prior to Policy Period Start Date.

IV. Documents to be submitted in support of the Claim under Benefit C.12. (k) - Trip Cancellation & Interruption

It is a condition precedent to the Company's liability under this Benefit that the following information and documents (as applicable) shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

i. Confirmation in writing of cancellation of the journey from the common carrier detailing the circumstances of cancellation;
ii. Ticket / boarding pass issued by the common carrier indicating the cost of ticket and receipt for the refund of the fare of the common carrier towards the cancelled portion of the journey indicating cancellation charges retained by the common carrier.
iii. Boarding pass in original for return journey from the place of cancellation to the country of residence which indicates the cost of the tickets together with the receipts for the refunds obtained towards the unfulfilled portion of the journey.
iv. A declaration from the Insured Person furnishing the circumstances that compelled him to cancel the journey;
v. Medical evidence as may be required in case of the cancellation of the journey arising out of personal contingencies of the Insured Person or his immediate family member;
vi. Receipt for the refund of the fare of the common carrier towards the cancelled portion of the journey indicating the cancellation charges retained;

C.12 (l) Trip Delay

I. The Company shall indemnify the expenses as specified in the Policy Schedule, through Reimbursement basis only, if the departure of a common carrier in which the Insured Person is scheduled to travel on a valid ticket during the Period of Insurance is delayed for more than 12 consecutive hours from the declared time of departure or expected time of departure whichever is later, due to any one of the following:
   i. Earthquake, flood, rains, storm, cyclone or tempest; or
   ii. Terrorism

II. Provided that the Company or the Assistance Service Company is
   i. Given written notice of the delay immediately and in any event within 30days of the commencement of the delay; and
   ii. Immediate alternative arrangements are made by the Insured Person for progressing the journey as scheduled

III. Additional exclusions applicable to Benefit C.12 (l) - Trip Delay:

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

i. Any contingencies other than those specifically named above;
ii. The Common Carrier is taken out of service on the instructions of the Civil Aviation Authority or any similar authority.

C.12 (m) Delay in Checked-in Baggage

I. The Company shall indemnify the expenses as specified in the Policy Schedule, through Reimbursement basis only, if the delivery of the Insured Person's checked-In baggage which has been entrusted to the common carrier is delayed by more than 12 hours from the Insured Person's arrival at the place of destination specified on his valid ticket during the period of insurance as specified in the Policy Schedule.
II. Additional exclusions applicable to Benefit C.12. (m) - Delay in Checked-in Baggage:
   Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible under this Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:
   i. Any delay which does not exceed the time period specified in this Benefit.
   ii. Any loss for which a Claim has already been made under Benefit C.12. (j) -Loss of checked-in Baggage
   iii. Any delay in delivery of the checked-in baggage arising out of or resulting from detention or confiscation of the baggage by the common carrier or customs or any government or other agencies.
   iv. Any delay attributable to damage to the checked-in baggage warranting an examined delivery by the Common Carrier.
   v. Self-carried or cabin baggage

III. Documents to be submitted for any Claim under this Benefit
It is a condition precedent to the Company's liability under this Benefit that the following information and documents shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

i. Property irregularity report issued by the appropriate authority stating the scheduled time of delivery and actual time of delivery of the checked-in baggage.
ii. Voucher of the common carrier for the compensation paid for the delay in delivery of the checked-in baggage.
iii. Copies of correspondence exchanged, if any, with the common carrier in connection with the delay in delivery of the checked-in baggage.

C.13 Maternity Cover

We shall indemnify Maternity Expenses incurred during the Policy Period, conditions, subject to fulfilment of following conditions:

a. This Benefit is available only under Family Floater policy subject to below:
   i. The female Insured Person of Age 18 years or above is covered under the Policy; and
   ii. Both the Insured Person and his / her legally married spouse or Live-in partner are covered under a Family Floater Policy.
b. The female Insured Person in respect of whom a claim for Maternity Benefits is made must have been covered as an Insured Person for a period of 24 months of continuous coverage since the inception of the First Policy, with maternity as a Benefit, with Us.
c. Fresh waiting period as mentioned above under (b) would apply for all the policies which are issued with continuity under portability or migration guidelines either from our existing Health Product or any other Non-Health or Standalone Health Insurance Company's Product.
d. The Maternity Benefit may be claimed under the Policy in respect of eligible Insured Person(s) only twice during the lifetime of the Policy including any Renewal thereafter for the delivery of a child or Medically Necessary and lawful termination of pregnancy up to maximum 2 pregnancies or terminations.
e. Any treatment related to the complication of pregnancy or termination will be treated within the maternity sub limits.
f. On Renewal, if an enhanced sub-limit is applicable under this Benefit, 24 months of continuous coverage (as per Section C.13.b) would apply afresh to the extent of the increased Benefit amount.
g. For Base Sum Insured of 1 Crore and above, this benefit is also available outside India.
h. Clause D.1.17(Sterility and Infertility (Code-Excl17)) & Clause D.1.18 (Maternity (Code-Excl18)) under Permanent Exclusions is superseded to the extent covered under this Benefit.

Expenses listed below are excluded from this Cover:

i. Expenses incurred in respect of the harvesting and storage of stem cells for any purposes whatsoever;
ii. Medical Expenses for ectopic pregnancy will be covered under the Section C.1 (Hospitalization Treatment) and shall not fall under the Maternity Benefit.
iii. Sections C.2 (Pre-hospitalization Expenses) and Section C.3 (Post- hospitalization Expenses) are not payable under this Benefit.
iv. Any expenses to manage complications arising from or relating to pregnancy or termination of pregnancy within 24 months from the inception of the First Policy with Us.
v. Pre-natal and post-natal Medical Expenses.

C.14 Global Enhanced (Any Illness / Injury - Planned treatment abroad)

The Company shall indemnify the Medical Expenses incurred towards medical treatment taken by the Insured Person during the Policy Period for any Illness or Injury. This Policy covers only treatment which is planned and scheduled in advance and taken outside India and does not cover any Emergencies occurring or Emergency Care required while the Insured Person is overseas, related to the Benefits mentioned below:

Hospitalization Expenses	Refer Section C.1
AYUSH Treatment	Refer Section C.7
Pre-Hospitalization Cover	Refer Section C.2
Post-Hospitalization Cover	Refer Section C.3
Organ Donor Expenses	Refer Section C.8
Emergency Air Ambulance	Refer Section C.12.(d)
Claim Protect	Refer Section C.4
Super Credit	Refer Section C.11

Global Health Cover (Planned Treatments) is applicable subject to following terms and conditions

I. The Medical Expenses are incurred outside India.
II. Our maximum liability in a Policy Year for claims under this cover shall not exceed the Base Sum Insured and Super Credit (if available).
III. Claims shall normally be payable on Cashless and Reimbursement basis both. Cashless facility may be arranged on case to case basis.
IV. The treatment should be taken in a registered Hospital, as per law, rules and / or regulations applicable to the country, where the treatment is taken.
V. Clause D.2.8 under Specific Exclusions is superseded to the extent covered under this Benefit
VI. The payment of any Claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of Claims. If on the Insured Person's Date of Discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.
VII. The Company may not be liable to make any payment under this Policy, wherein the Government of India has laid down territorial restriction.
VIII. There is no separate Sum Insured for this cover and any claim triggered under this Benefit shall reduce the Base Sum Insured and then Super Credit basis sequence of utilization defined under Section C.11 (Super Credit).

IX. In Section C.12.(d) (Emergency Air Ambulance) clause v stands modified as below:
"A claim for the same Hospitalization is admissible under Section C.1 (Hospitalization Expenses)".
X. Only those Pre-Hospitalization Medical Expenses and / or Post-Hospitalization Medical Expenses shall be admissible under this Benefit that have been incurred and paid overseas. Such expenses should be related to an admissible overseas Hospitalization claim only (as per details in invoice / supporting documents).

C.15 Health Management Program

C.15.1 Health Assessment™

Under this Benefit, We will provide a Health Assessment of the Insured Person, which can be undertaken in two ways: Digital Health Assessment at home (Section C.15.1.a) or Physical Health Assessment at Our Network Providers /Empanelled Service Providers on a Cashless Facility basis (Section C.15.1.b) After the results of the Health Assessment are received, a Healthy Heart Score (HHS) will be generated. The results will determine the general risk levels categorised below:

a. Green & Amber – Your body vitals are in a healthy / acceptable state, and You can begin doing your Activ Days to earn your HealthReturns™.
b. Red – Your body vitals are not within the normally acceptable range and You are advised to undergo a regular Health Assessment at your nearest facility for a second round of screening and better health insight.

Note – Based on the Insured Person's age and clinical condition, We may advise You or the Insured Person for either availing the Digital Health Assessment Section C.15.1.a or Physical Health Assessment (HA) (Section C.15.1.b) option, whichever is best suitable for You and the Insured Persons covered in Your Policy. The applicability and availability of the Digital Health Assessment will be on sole discretion of the Company. The Company can decide to introduce any new technology in addition or in replacement to the Digital Health Assessment or the Physical Health Assessment or both that can better evaluate the health condition of the Insured Persons(s) and generate a Healthy Heart Score™.

C.15.1.a Digital Health Assessment (DHA):

a. Digital Health Assessment generates a Healthy Heart Score™ which indicates your current heart health along with giving You vital health parameters like Blood Pressure, Heart Rate, BMI, Oxygen Saturation, and respiration rate, from the comfort of your home.

b. Concept:
Our system uses signal processing and AI technologies to predict body vitals through a face scan. We analyse pixel intensity changes on the skin using the noncontact rPPG (Remote Photo plethysmography) technique. No physical contact is needed, and You can conveniently check your body vitals at home with just a smartphone, laptop, or tablet and an internet connection.

c. Steps to undergo Digital Health Assessment:
i. Download and register on the Activ Health Mobile App or register on the ABHI Website.
ii. Once logged in, Insured Persons eligible for Digital Health Assessment, will be able to see "Digital Health Assessment" on the Mobile App and Website under the "Book Digital Health Assessment" tab.
iii. Answer simple questions related to your health.
iv. Submit the response and proceed with a Face Scan.
v. Provide a permission for your device camera access.
vi. Start the Face Scan and maintain a steady posture.
vii. During the "Calibration is in progress", make sure that your face is placed inside the circle shown on the screen.
viii. Once calibration is completed, hold the position for at least 30-40 seconds to determine your body vitals. For better results, the surrounding light should be bright and consistent.
ix. You can visit the reports section of the Mobile App / ABHI website, , to view your assessment reports immediately.
x. Your Healthy Heart Score (HHS) will be generated within an hour from the time of scan and will be valid for a year

d. Each Insured Person can avail a Digital Health Assessment once in an active Policy Year. If your scan is unsuccessful due to a technical error, You will be asked to take a re-scan by a message alert on the screen.

e. Healthy Heart Score (HHS) will be generated after the assessment.

Note -Digital Health Assessment is for screening purposes only and is not a substitute for the clinical judgment of a health care professional. It is intended to improve your awareness of general wellness. Digital Health Assessment does not diagnose, treat, mitigate or prevent any disease, symptom, disorder or abnormal physical state. Consult with a healthcare professional or contact emergency services if You believe You may have a medical issue.

f. Eligibility for DHA: Digital Health Assessment is made eligible based on certain demographic and clinical criteria.

C.15.1.b Physical Health Assessment (HA):
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. An appointment for the medical examination can be scheduled at a time convenient to the Insured Person by calling Our call centre. All tests mentioned as a part of Health AssessmentTM shall be conducted together subject to below conditions:

If the Insured Person who has undergone tests under Annual Health Check-up (Section C.9), then those specific tests shall not be permitted to be repeated under the Health Assessment in the same Policy Year.

C.15.2 HealthReturns™

An Insured Person can earn a percentage of the premium as HealthReturns™ during the Policy Period by looking after his / her health and being physically active on a regular basis in the manner specified below.

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 AssessmentTM (applicable for each individual Insured Person)

This is not applicable for individuals that have undergone Pre-Policy Medical Examination before issuance of the Policy, for the first Policy Year.

(i) The Insured Person must answer the online health questionnaire on our website or mobile application. If desired, We can assist the Insured Person in filling out the form over the phone. The answers to this questionnaire will help the Insured Person understand their current health status.

(ii) Undergo a Health Assessment™ (Section C.15.1):

Based on the test results of completed Health Assessment™, We will determine the Insured Person's Healthy Heart Score™. This score will be utilized to categorize the Insured Person's heart health in comparison with the peers in same Age and gender for the purpose of this Benefit Section C.15.2 (HealthReturns™)

- Green: low risk of heart disease.
- Amber: moderate risk of heart disease – intervention will be beneficial.
- Red: high risk of heart disease – 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.

If the Insured Person who has undergone tests under Section C.9 (Annual Health Check-up), then those specific tests shall not be permitted to be repeated under the Health Assessment in the same Policy Year.

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 at the Network Providers / Empanelled Service Providers.

Conditions

For Healthy Heart Score™ to be calculated the Section C.15.1(Health Assessment™) needs to be carried out at least once each 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:

a. Completing a fitness centre or yoga centre activity for a minimum of 30 minutes at Our panel of fitness or yoga centers, OR;

b. Recording 10,000 steps or more in a day for all Insured Persons Aged less than 60 years and 7,500 steps or more for all Insured Persons Aged 60 years above (tracked through Our mobile application or a wearable device linked to the Policy number) OR;

c. Burning 300 calories or more in one exercise session per day OR;

d. Participation in a recognized marathon / walkathon / cyclothon or a similar activity which offers a completion certificate with timing.

(iii) To make it easier for the Insured Person to earn HealthReturns™, We also provide two fitness assessments per Policy Year at Our Network Providers / Empanelled Service Providers on a Cashless Facility basis. 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 each 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).

Step 3 Calculation Methodology of HealthReturns™

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 monthly according to the following grid.

No of Active Dayz™ in a calender month	OR	Fitness Assessment Result*	Healthy Heart Score™		
			Red	Amber	Green
13 or more		Level 5	6.0%	12%	30%
10-12		Level 4	3.6%	7.2%	18%
7-9		Level 3	2.4%	4.8%	12%
4-6		Level 2	1.2%	2.4%	6%
0-3		Level 1	0%	0%	0%

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

In addition to the monthly earning slabs, the Insured Person will earn extra HealthReturns™ based on their Healthy Heart Score™ and the number of Active Dayz™ recorded. These additional earnings will be determined by below given grid that considers the number of Active Dayz™ achieved on a yearly basis. It's important to note that the Fitness Assessment Results will not be considered for earning the annual slabs mentioned below.

The mentioned slabs below are separate from the monthly slabs and are independent. For example, if an Insured Person has a Healthy Heart Score™ and accomplishes 13 days or more every month in a Policy Year, along with achieving at least 325 Active Dayz™ in the same Policy Year, they will be rewarded with 100% HealthReturns™. This includes 30% accumulated every month, 20% for achieving 275 Active Dayz, and 50% for achieving 325 Active Dayz.

No of Active Dayz™ in a year	Healthy Heart Score™		
	Red	Amber	Green
275	4.0%	8.0%	20.0%
325	10.0%	20.0%	50.0%

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.

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™:

Reward amounts under HealthReturns™ may be utilized by an Insured Person towards the following expenses, up to the value of the rewards accrued under this Benefit:

i. In-patient Medical Expenses provided that the Base Sum Insured, accumulated Super Credit (if any), Super Reload of Base Sum Insured and Cancer Booster (if opted and applicable) are exhausted during the Policy Year.
ii. Payment of Deductible (if opted), wherever applicable.
iii. For Non-Payable Claims, In case of an In-Patient Hospitalization.
iv. Expenses for OPD Treatment up to the value of rewards accrued.
v. AYUSH Treatments in excess of the limits as specified in Policy Schedule / Product Benefit Table of this Policy.
vi. For expenses towards buying any health wearable device which can be used to track steps and Active Dayz™.

Reimbursement claims for (v) and (vi) can be submitted quarterly in a Policy Year.

Alternatively, reward amounts can also be utilized towards the payment of Renewal Premium or payment of premium for any retail policy / rider with Us (new or renewal). Reward amounts earned as HealthReturns™, cannot be carry forwarded if not utilized in available options to next months.

If HealthReturns™ earned is not utilized during the Policy Year, by default it will be automatically adjusted to pay Renewal premium of this Policy[&] prior to the due date for payment for Renewal premium in accordance with the table below

[&]100% HealthReturns™ = 100% Base cover premium + Optional cover premium (if opted and also applicable^ under HealthReturns™ of immediately preceding Policy Year).

Optional Covers	HealthReturns™ Applicability
Reduction in Specific Disease waiting period: 2 year to 1 year	Yes
Reduction in Pre-Existing Disease waiting period	Yes
Critical Illness cover [Initial Waiting Period - 60 Days and Survival Period - 15 Days]	No
Personal Accident Cover -AD+PTD+PPD	No
Cancer Booster	Yes
Durable equipment cover	Yes
Compassionate Visit	No
Second Medical Opinion for listed Major Illness	No
Annual Screening Package for Cancer Diagnosed Patients	No

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.

C.16 Optional Covers (Please refer the Policy Schedule for applicability of Optional Covers)

The Benefits listed below are Optional Covers and shall be available to Insured Person only if the additional premium has been received or reduction in the Premium as applicable and the specific Benefit is specified to be in force for the Insured Person in the Policy Schedule of this Policy. Claims made under these Benefits will impact the Sum Insured and the overall Sum Insured, as applicable to the Insured Person and as specified in the Policy Schedule.

C.16.1 Reduction in Specific Disease waiting period

On availing this optional Cover, at the inception of the first policy with Us We shall reduce the applicable Specific Disease waiting period under Section D for claims related to such specified Illness / procedure to 1 Year.

This Benefit can only be opted at the time of inception of the first policy with Us and only for the Sum Insured originally opted at such inception.

The provisions of Section D continue to be valid in relation to this Section C.16.1(Reduction in Specific Disease waiting period) except that the claims will be admissible for any Medical Expenses incurred for Hospitalization in respect of diagnosis / treatment of any such specified Illness / procedure after one year, as applicable and specified in the Policy Schedule, if covered with Us since the inception of the first Policy with Us without any Break in Policy.

C.16.2 Reduction in Pre-Existing Disease waiting period

On availing this Optional Cover, at the inception of the first policy with Us, then We shall reduce the applicable Pre-Existing Disease waiting period under Section D for claims related to any Pre-Existing Disease specified in the Policy Schedule, to a specified number of years as mentioned in the Policy Schedule.

This Optional Cover can only be opted at the time of inception of the first policy with Us and only for the Sum Insured originally opted at such inception.

The provisions of Section D and definitions Including Section B.1.49 (Pre-Existing Disease (PED)), continue to be valid in relation to this Optional Cover except that the claims will be admissible for any Medical Expenses incurred for Hospitalization in respect of diagnosis / treatment of any Pre-Existing Disease after specified number of years, as applicable and mentioned in the Policy Schedule. This Optional Cover would apply afresh if covered with Us since the inception of the first Policy with Us without any Break in Policy.

C.16.3 Critical Illness cover

On availing this Optional Cover, if the Insured Person suffers from a Critical Illness of the nature as specified in this Section during the Policy Period and while the Policy is in force, then We shall pay the Sum Insured as mentioned in the Policy Schedule / Product Benefit Table for that Critical Illness after completion of 60 days from the Commencement Date and provided that the Critical Illness is first diagnosed or first manifests itself during the Policy Period as a first incidence.

List of Critical Illnesses as Applicable:

Sr No	Illnesses
1	CANCER OF SPECIFIED SEVERITY
2	MYOCARDIAL INFARCTION (FIRST HEART ATTACK OF SPECIFIC SEVERITY)
3	OPEN CHEST CABG
4	OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES
5	KIDNEY FAILURE REQUIRING REGULAR DIALYSIS
6	STROKE RESULTING IN PERMANENT SYMPTOMS
7	MAJOR ORGAN / BONE MARROW TRANSPLANT
8	PERMANENT PARALYSIS OF LIMBS
9	MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS
10	COMA OF SPECIFIED SEVERITY
11	MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS
12	THIRD DEGREE BURNS
13	DEAFNESS
14	LOSS OF SPEECH
15	APLASTIC ANAEMIA
16	END STAGE LIVER FAILURE
17	END STAGE LUNG FAILURE
18	BACTERIAL MENINGITIS
19	FULMINANT HEPATITIS
20	MUSCULAR DYSTROPHY

Conditions

i. Our total, cumulative, maximum liability during the lifetime of the Insured Person is upto the limit specified in the Policy Schedule.
ii. Once a claim for a listed condition is admissible in respect of an Insured Person, no further Renewals shall be allowed for that Insured Person under this Benefit.

Survival Period: The payment of a Benefit under Section shall be subject to survival of the Insured Person for 15 days following the first diagnosis of the Critical Illness / undergoing the Surgical Procedure for the first time.

Initial Waiting Period – 60 Days

C.16.4 Personal Accident Cover

On availing this Optional Cover, We will pay the amount specified in the Policy Schedule as a lumpsum pay out in case of Section 16.4.a (Accidental Death), Section 16.4.b (Permanent Total Disablement) and Section 16.4.c (Permanent Partial Disablement) up to the limit specified in the Policy Schedule.

C.16.4.a Accidental Death (AD)

On availing this Optional Cover, in the event of unfortunate demise of the Insured Person solely and directly due to an Accident which occurs during the Policy Period, We will pay the Sum Insured within 365 days from the date of the Accident.

The Personal Accident Cover will terminate after the Accidental Death Benefit is paid for.

C.16.4.b Permanent Total Disability (PTD)

On availing this Optional Cover, if the Insured Person suffers Permanent Total Disability of the nature as specified in the table below, solely and directly due to an Accident, which occurs during the Policy Period We will pay the Sum Insured within 365 days from the date of the Accident:

Sr No	Type of Permanent Total Disablement
1	Total and irrecoverable loss of sight of both eyes.
2	Loss by physical separation or total and permanent loss of use of both hands or both feet.
3	Loss by physical separation or total and permanent loss of use of one hand and one foot.
4	Total and irrecoverable loss of sight of one eye and loss of a Limb.
5	Total and irrecoverable loss of hearing of both ears and loss of one Limb / loss of sight of one eye.
6	Total and irrecoverable loss of hearing of both ears and loss of speech.
7	Total and irrecoverable loss of speech and loss of one Limb / loss of sight of one eye.
8	Permanent total and absolute disablement (not falling under the above) disabling the Insured Person from engaging in any employment or occupation or business for remuneration or profit, of any description whatsoever which results in Loss of Independent Living.

Total and irrecoverable loss of limb means physical separation or complete loss of functionality of the limb, within 365 days from the date of the Accident. This will include Paralysis including Paraplegia, Quadriplegia with loss of functional use of limb.

For the purpose of this Benefit:
- Limb means a hand at or above the wrist or a foot above the ankle;
- Physical separation of one hand or foot means separation at or above wrist and / or at or above ankle, respectively.

The Personal Accident Cover will terminate after the Permanent Total Disability Benefit is paid for.

C.16.4.c Permanent Partial Disability (PPD)

On availing this Optional Cover, if the Insured Person suffers a Permanent Partial Disability of the nature as specified in the table below, solely and directly due to an Accident, which occurs within the Policy Period, We will pay a percentage of the Sum Insured as per the below table:

Sr No	Loss Covered	Percentage of Sum Insured
1	Loss of Use / Physical Separation:	
	One entire hand	50%
	One entire foot	50%
	Loss of Sight of one eye	50%
	Loss of toes – all	20%
	Great both phalanges	5%
	Great – one phalanx	2%
	Other than great if more than one toe lost	1%
2	Loss of Use of both ears	50%
3	Loss of Use of one ear	20%

4	Loss of four fingers and thumb of one hand	40%
5	Loss of four fingers	35%
6	Loss of thumb - both phalanges - one phalanx	 25% 10%
7	Loss of Index finger - three phalanges two phalanges one phalanx	 10% 8% 4%
8	Loss of middle finger – three phalanges two phalanges one phalanx	 6% 4% 2%
9	Loss of ring finger – three phalanges two phalanges one phalanx	 5% 4% 2%
10	Loss of little finger – three phalanges two phalanges one phalanx	 4% 3% 2%
11	Loss of metacarpus – first or second (additional) third, fourth or fifth (additional)	 3% 2%
12	Any other permanent partial disablement	Percentage as assessed by the independent Medical Practitioner

If any loss in the nature of a Permanent Partial Disability is not specifically mentioned in the table above, then We will internally assess the degree of disablement and determine the amount of payment to be made as per Our sole and absolute discretion.

If there is more than one Permanent Partial Disability, then the total claim amount put together for all losses will not exceed the total Sum Insured specified in the Policy Schedule under this Optional Cover Section C.16.4 (Personal Accident Cover). and once such amount is paid for an Insured Person, no further Renewals shall be allowed for that Insured Person under this Optional Cover Section C.16.4.c (Permanent Partial Disablement).

C.16.5 Cancer Booster

On availing this Optional Cover, an additional amount as specified in the Policy Schedule / Product Benefit table will be available to the Insured Person as Sum Insured for Medical Expenses incurred in relation to an admissible Hospitalization of the Insured Person or "Cancer of Specified Severity" as defined in Section B (Definitions), provided such claim is admissible under Section C during the Policy Period.

Conditions:

i. Multiple claims during the Policy Year are payable under this Optional Cover, but upto the Base Sum insured. Such Base Sum Insured is available only once during the Policy Year.
ii. In addition to the foregoing, the conditions stipulated under the Hospitalization Treatment Benefit (Section C.1) shall be applicable.
iii. This Benefit shall be renewed life long and the Company shall not deny Renewal based on claims experience in the previous Policy Year.
iv. Expenses can be claimed under this Optional Cover on a Reimbursement basis only.

For avoidance of doubt, the sequence of utilization of Sum Insured will be as below:

a. Base Sum Insured followed by;
b. Super Credit (if applicable) followed by;
c. Super Reload followed by;
d. Cancer Booster (if opted and applicable)

For the purpose of this Benefit, Cancer of Specified Severity is defined in Section B (Definitions).

C.16.6 Durable Medical Equipment Cover

On availing this Optional Cover, We shall reimburse the expenses towards the cost of buying or renting any of "Durable Medical Equipment" as listed below, up to the overall limit specified in the Policy Schedule / Product Benefit Table, provided the same is prescribed to the Insured Person by the treating Medical Practitioner, during or after an admissible Hospitalization for a Medically Necessary treatment.

Conditions:

1. The expenses incurred must be related to an admissible Hospitalization of the Insured Person under Section C.1 (Hospitalization Treatment) or Section C.5 (Domiciliary Hospitalization) or Section C.6 (Home Health Care)
2. The need for Durable Medical Equipment is prescribed by an authorised Medical Practitioner during Hospitalization or within 30 days post discharge of the Insured Person from the Hospital.
3. Any purchase / renting of the Durable Medical Equipment should be done within 30 days of such recommendation.
4. Any Exclusion under the Policy with respect to any of the above listed Durable Medical Equipment shall not be applicable for this Optional Cover.
5. Any claim made under this cover will reduce the Sum Insured of the Underlying Policy.
6. List of Durable equipment covered:
   i. Ventilator
   ii. Wheelchair
   iii. Prosthetic device
   iv. Suction Machine
   v. Commode Chairs
   vi. Infusion pump
   vii. Continuous Passive motion devices in case of Knee Replacement
   viii. Oxygen concentrator

For the purpose of this cover, a Prosthetic device means an externally applied device used to replace wholly or partly an absent or deficient body part (limited to arm or leg or auditory system).

C.16.7 Compassionate Visit

On availing this Optional Cover , in the event of Hospitalization of the Insured Person exceeding 10 days in relation to a claim admissible under Section C.1 (Hospitalization Treatment) during the Policy Period Year, the cost of two way economy class air ticket or travel fare up to maximum of INR 50,000/- as specified in Policy Schedule, incurred by the Insured Persons "immediate family member" while travelling to place of Hospitalization from the place of origin / Home and back will be reimbursed.

"Immediate family member" would mean spouse / live-in partner, children, and dependent parent / parent-in-law.

Conditions:

i. This Benefit is applicable in the event of the Insured Person Being Hospitalized at a place away from his usual place of Home as mentioned in Policy Schedule.
ii. This Benefit is available for only one Immediate Family Member
iii. The Benefit will be available per hospitalization basis only once, the Benefit amount will reduce the Sum Insured and will be available only on Reimbursement basis
iv. The Benefit under this Optional Cover can be availed by an Insured Person only once in a Policy Year, and shall be available for each Insured Person in case the Policy is issued on a floater basis.

C.16.8 Second Medical Opinion for listed Major Illness

On availing this Optional Cover, We shall indemnify the expenses incurred towards Second Medical Opinion for the Insured Person for any Major Illness as specifically listed below and defined under Section B (Definitions), if availed from a Medical Practitioner through the Network Provider, subject to the following conditions:

i. Benefit under this Optional Cover shall be subject to the eligible geography of the Network Provider. The Insured Person may contact the Company or refer to its website for details on eligible Network Provider(s).
ii. The Benefit under this Optional Cover can be availed by an Insured Person only once in a Policy Year, and shall be available for each Insured Person in case the Policy is issued on a floater basis.
iii. The Insured Person is free to choose whether or not to obtain the Second Medical Opinion, and if obtained, it is the Insured Person's sole and absolute discretion to follow the suggestion for any advice related to his / her health. It is understood and agreed that any information and documentation provided to the Company for the purpose of seeking the Second Medical Opinion shall be shared with the Network Providers.
iv. Availing this Optional Cover shall not have any impact on the Sum Insured.

Note - Second Medical Opinion Services are being offered by Network Providers through its portal / mail / mobile application or any other electronic form to the Policyholders / Insured Person. In no event shall the Company be liable for any direct, indirect, punitive, incidental, special, or consequential damages or any other damages whatsoever caused to the Policyholders / Insured Person while receiving the services from Network Providers or arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Network Provider or treating Medical Practitioner.

List of Major Illnesses as Applicable:

Sr No	Major Illness
1	Cancer Treatment
2	Coronary Artery By-Pass Surgery
3	Heart Valve Replacement
4	Lung Transplant Surgery in case of End Stage Lung Disease
5	Kidney Transplant Surgery in case of End Stage Renal Failure
6	Liver Transplant Surgery in case of End Stage Liver Disease
7	Heart Transplant
8	Cardiac arrest (excluding angioplasty)
9	Bone Marrow Transplant
10	Neurosurgery
11	Surgical Treatment for benign Brain Tumour
12	Pulmonary Artery Graft Surgery
13	Aorta Graft Surgery
14	Surgical Treatment for Stroke
15	Surgical Treatment of Coma
16	Skin Grafting Surgery for Major Burns
17	Surgery for Pheochromocytoma
18	Permanent Paralysis of Limbs
19	Motor Neuron Disease with Permanent Symptoms
20	Multiple Sclerosis with Persisting Symptoms
21	Fulminant Viral Hepatitis
22	Bacterial meningitis
23	Alzheimer's Disease
24	Cerebral aneurysm - with surgery or radiotherapy
25	Parkinson's disease - resulting in permanent symptoms
26	Pneumonectomy - Removal of an entire lung
27	Surgical removal of an eyeball

C.16.9 Annual Screening Package for Cancer Diagnosed Patients

On availing this Optional Cover, We shall reimburse the Medical Expenses incurred up to the limit specified in the Policy Schedule / Product Benefit Table for an Annual Screening Package for the Insured Person(s) subject to below mentioned conditions:

i. Insured must be a diagnosed with "Cancer of Specified Severity" as defined in Section B (Definitions). This diagnosis must be evidenced by histological evidence of malignancy and confirmed by a pathologist. The date of diagnosis should be post inception of first policy with Us.
ii. The Optional Cover will only cover medically prescribed diagnostics used to monitor vitals or to evaluate the risk of recurrence of the patients.
iii. Expenses can be claimed under this Optional Cover on a Reimbursement basis only.
iv. This Optional Cover can only be bought at inception of first policy with Us under this product.

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Activ One VIP+
Annexure I - List of Non-Medical Expenses

Did you know that your hospital bills also contain out-of-pocket expenses from small items like a syringe to large items like ambulance equipment. This handy document gives you the list of such expenses which is now covered in your Activ One policy.

LIST I

1	BABY FOOD	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
2	BABY UTILITIES CHARGES	36	SPACER
3	BEAUTY SERVICES	37	SPIROMETRE
4	BELTS / BRACES	38	NEBULIZER KIT
5	BUDS	39	STEAM INHALER
6	COLD PACK / HOT PACK	40	ARMSLING
7	CARRY BAGS	41	THERMOMETER
8	E-MAIL / INTERNET CHARGES	42	CERVICAL COLLAR
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	43	SPLINT
		44	DIABETIC FOOTWEAR
10	LEGGINGS	45	KNEE BRACES (LONG / SHORT / HINGED)
11	LAUNDRY CHARGES	46	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER
12	MINERAL WATER	47	LUMBO SACRAL BELT
13	SANITARY PAD	48	NIMBUS BED OR WATER OR AIR BED CHARGES
14	TELEPHONE CHARGES	49	AMBULANCE COLLAR
15	GUEST SERVICES	50	AMBULANCE EQUIPMENT
16	CREPE BANDAGE	51	ABDOMINAL BINDER
17	DIAPER OF ANY TYPE	52	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES
18	EYELET COLLAR	53	SUGAR FREE TABLETS
19	SLINGS	54	CREAMS, POWDERS, LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
20	BLOOD GROUPING AND CROSS MATCHING OF DONOR'S SAMPLES	55	ECG ELECTRODES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	56	GLOVES
22	TELEVISION CHARGES	57	NEBULISATION KIT
23	SURCHARGES	58	ANY KIT WITH NO DETAILS MENTIONED (DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC)
24	ATTENDANT CHARGES		
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	59	KIDNEY TRAY
		60	MASK
26	BIRTH CERTIFICATE	61	OUNCE GLASS
27	CERTIFICATE CHARGES	62	OXYGEN MASK
28	COURIER CHARGES	63	PELVIC TRACTION BELT
29	CONVEYANCE CHARGES	64	PAN CAN
30	MEDICAL CERTIFICATE	65	TROLLY COVER
31	MEDICAL RECORDS	66	UROMETER, URINE JUG
32	PHOTOCOPIES CHARGES	67	AMBULANCE
33	MORTUARY CHARGES	68	VASOFIX SAFETY
34	WALKING AIDS CHARGES		

LIST II - ITEMS THAT ARE TO BE INCLUDED IN ROOM CHARGES

1	BABY CHARGES (UNLESS SPECIFIED / INDICATED)	20	LUXURY TAX
2	HAND WASH	21	HVAC
3	SHOE COVER	22	HOUSE KEEPING CHARGES
4	CAPS	23	AIR CONDITIONER CHARGES
5	CRADLE CHARGES	24	IM IV INJECTION CHARGES
6	COMB	25	CLEAN SHEET
7	EAU-DE-COLOGNE / ROOM FRESHENERS	26	BLANKET / WARMER BLANKET
8	FOOT COVER	27	ADMISSION KIT
9	GOWN	28	DIABETIC CHART CHARGES
10	SLIPPERS	29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
11	TISSUE PAPER	30	DISCHARGE PROCEDURE CHARGES
12	TOOTH PASTE	31	DAILY CHART CHARGES
13	TOOTH BRUSH	32	ENTRANCE PASS / VISITORS PASS CHARGES
14	BED PAN	33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
15	FACE MASK	34	FILE OPENING CHARGES
16	FLEXI MASK	35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
17	HAND HOLDER	36	PATIENT IDENTIFICATION BAND / NAME TAG
18	SPUTUM CUP	37	PULSE OXYMETER CHARGES
19	DISINFECTANT LOTIONS		

LIST III - ITEMS THAT ARE TO BE INCLUDED IN PROCEDURE CHARGES

1	HAIR REMOVAL CREAM	13	SURGICAL DRILL
2	DISPOSABLES RAZORS CHARGES (FOR SITE PREPARATIONS)	14	EYE KIT
3	EYE PAD	15	EYE DRAPE
4	EYE SHEILD	16	X-RAY FILM
5	CAMERA COVER	17	BOYLES APPARATUS CHARGES
6	DVD, CD CHARGES	18	COTTON
7	GAUZE SOFT	19	COTTON BANDAGE
8	GAUZE	20	SURGICAL TAPE
9	WARD AND THEATRE BOOKING CHARGES	21	APRON
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS	22	TORNIQUET
11	MICROSCOPE COVER	23	ORTHOBUNDLE, GYNAEC BUNDLE
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER		

LIST IV - ITEMS THAT ARE TO BE INCLUDED IN COSTS OF TREATMENT

1	ADMISSION / REGISTRATION CHARGES	10	HIV KIT
2	HOSPITALIZATION FOR EVALUATION / DIAGNOSTIC PURPOSE	11	ANTISEPTIC MOUTHWASH
3	URINE CONTAINER	12	LOZENGES
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	13	MOUTH PAINT
		14	VACCINATION CHARGES
5	BIPAP MACHINE	15	ALCOHOL SWABS
6	CPAP / CAPD EQUIPMENTS	16	SCRUB SOLUTION / STERILLIUM
7	INFUSION PUMP - COST	17	GLUCOMETER & STRIPS
8	HYDROGEN PEROXIDE / SPIRIT / DISINFECTANTS ETC	18	URINE BAG
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES, DIET CHARGES		

ADITYA BIRLA CAPITAL
HEALTH INSURANCE

Activ One VIP+
Annexure II - Contact details of Insurance Ombudsman offices

In case of any disputes related to your health insurance policy, this list gives you details of the nearest offices that you can visit for seeking an un-biased resolution.

CONTACT DETAILS	JURISDICTION OF OFFICE
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru - 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal - 462 003. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chattisgarh
BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneswar - 751 009. Tel.: 0674 - 2596461 / 2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 - D, Chandigarh - 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai - 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.: 011 - 23232481 / 23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati - 781001 (Assam). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Puducherry
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@cioins.co.in	Rajasthan
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Puducherry
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands

LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 | Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P - 201301. Tel.: 0120 - 2514250 / 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612 - 2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune - 411 030. Tel.: 020 - 41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region)

The updated details of Insurance Ombudsman offices are available on the IRDAI website: www.irdai.gov.in, on the website of Executive Council of Insurers www.ecoi.co.in, Our website at: adityabirlahealth.com or can be obtained from any of our offices.

Aditya Birla Health Insurance Co. Limited
Product Name: Activ One, Product UIN: ADIHLIP24097V012324
1800 270 7000 | care.healthinsurance@adityabirlacapital.com | www.adityabirlahealthinsurance.com

Registered Office:
9th Floor, Tower1, One World Centre, Jupiter Mills Compound,
841, Senapati Bapat Marg, Elphinstone Road, Mumbai 400013.
CIN:U66000MH2015PLC263677
IRDA Registration No. 153

ADITYA BIRLA CAPITAL
HEALTH INSURANCE

Activ One VIP+
Annexure III - Product Benefit Table

This document will offer you a clear summary of your health insurance coverage including in-built and optional covers, details of our unique health management program as well as waiting period information.

Product Benefit Table

Benefits	VIP+	
Entry Age (Adult)	**Minimum** - 18 years **Maximum** - No capping	
Entry Age (Child)	**Dependent Child** (Floater/Multi individual) - 91 days to 25 years **Individual –** minimum age of entry - 5 years	
Policy Type	Individual & Floater	
Tenure	1/2/3 Years	
Family Definition	up to 2A4C	
Premium - 3 Zones	Zone 1, 2 & 3	
Premium Type	Age Banded	
Relationship Covered	**Individual** - Self, Legally Married Spouse OR Live-in Partner (Same Or Opposite Sex), Son, Daughter, Brother, Sister, Grandson, Granddaughter, Son in-Law, Daughter-in-Law, Brother-in-Law, Sister-in-Law, Nephew, Niece, Parents and Parents-in-Law **Floater** - Self, Legally Married Spouse Or Live-in Partner (Same Or Opposite Sex), Dependent Children (Natural/Legally Adopted), Parents and Parents-in-Law	
Base Sum Insured (BSI) INR	50 Lacs and 75 Lacs	1 Crore, 2 Crores, 3 Crores, 4 Crores, 5 Crores and 6 Crores
Trip Details	Multi Trip (max 15 days coverage per Insured person)	Annual Multi-Trip (max 45 days coverage in a single trip per Insured person)

In-built Cover

Domestic Covers		
Hospitalization Treatment	Room Rent	Actuals up to Sum Insured
	ICU Charges	Actuals up to Sum Insured
	Road Ambulance Cover (per hospitalization)	Actuals up to Sum Insured
	Day Care Treatments	Actuals up to Sum Insured
	Modern Procedures / Treatments	Actuals up to Sum Insured for listed procedures
	HIV / AIDS and STD Cover	Actuals up to Sum Insured
	Mental Illness Hospitalization	Actuals up to Sum Insured
	Obesity Treatment	Actuals up to Sum Insured
Pre-Hospitalization Expenses (up to Sum Insured)		90 Days
Post-Hospitalization Expenses (up to Sum Insured)		180 Days
Claim Protect (Non-Medical Expense Waiver)		Non-payable items will be covered (all 4 lists of Annexure I)
Domiciliary Hospitalization		Actuals up to Sum Insured
Home Health Care		Actuals up to Sum Insured
AYUSH Treatment		Actuals up to Sum Insured

Organ Donor Expenses		Actuals up to Sum Insured
Annual Health Check-up (Listed & Cashless)		Covered
Super Reload (Unlimited Refill)	From 2nd claim of Policy Life - Unlimited times	Covered (up to Base Sum Insured)
Super Credit (increases irrespective of claim)		50% of BSI per year, up to 100% of Base Sum Insured (up to Max of INR 4 Cr under this benefit)

International Covers

Global Cover (Emergency Only)	Emergency Hospitalization	Actuals up to Sum Insured
	Emergency Medical Evacuation	Actuals up to Sum Insured
	Global Compassionate visit	Actuals up to Sum Insured
	Emergency Air Ambulance (Combined Sub-limit between Global and Global Enhanced Cover)	up to INR 5 Lacs
	Care and/or transportation of minor children	Actuals up to Sum Insured
	Return of mortal remains	Actuals up to Sum Insured
	Medical referral	Actuals up to Sum Insured
	Medical Repatriation	Actuals up to Sum Insured
	Loss of Passport	Covered up to INR 20,000
	Loss of checked-in baggage	Covered up to INR 10,000
	Trip Cancellation & Interruption	INR 25,000
	Trip Delay	INR 10,000
	Delay of Checked-in Baggage	INR 5,000
Global Enhanced (Any Illness / Injury - Diagnosis in India and Planned treatment abroad)	Hospitalization Expenses	Actuals up to Sum Insured
	AYUSH Treatment	Actuals up to Sum Insured
	Pre-Hospitalization cover	90 Days
	Post-Hospitalization cover	180 Days
	Organ Donor Expenses	Actuals up to Sum Insured
	Emergency Air Ambulance (Combined Sub-limit between Global and Global Enhanced Cover)	Up to INR 5 Lacs
	Claim Protect	Non-payable items will be covered (all 4 lists of Annexure I)
	Super Credit	50% of BSI per year, up to 100% of Base Sum Insured (up to Max of INR 4 Cr under this benefit)

Maternity Cover

Maternity Cover	Domestic Maternity Cover up to INR 1 Lac (within Base Sum Insured)	Worldwide Maternity Cover up to of INR 2 Lacs (within Base Sum Insured)

Health Management Program (In-built Covers)

Health Assessment™	Applicable once in a policy year undertaken at Our Network Providers / Empanelled Service Providers on a cashless basis or on digital basis
HealthReturns™	Applicable up to 100% of the premium

Optional Covers

Reduction in Specific Disease waiting period	2 years to 1 year
Reduction in Pre-Existing Disease waiting period	Option 1 - 3 years to 2 years | Option 2 - 3 years to 1 year
Critical Illness cover [Initial Waiting Period 60 Days and Survival Period - 15 Days]	Critical Illness SI Options- 10 Lacs, 15 Lacs, 20 Lacs and 25 Lacs
Personal Accident Cover [AD+PTD+PPD]	Personal Accident SI Options- 10 Lacs, 15 Lacs, 20 Lacs, 25 Lacs, and 50 Lacs
Cancer Booster i. Covers Pre and Post hospitalisation medical expense. ii. Covers Day Care Treatment upto Sum Insured	Up to 100% of Base Sum Insured
Durable equipment cover i. Ventilator ii. Wheelchair iii. Prosthetic device iv. Suction Machine v. Commode Chairs vi. Infusion pump vii. Continuous Passive motion devices in case of Knee Replacement viii. Oxygen concentrator	Combined Sum Insured of INR 5 Lacs or up to SI, whichever is lower
Compassionate Visit	up to INR 50,000 for two-way travel fare if hospitalization exceeds 10 days
Second Medical Opinion for listed Major Illness	Applicable
Annual Screening Package for Cancer Diagnosed Patients	INR 10000 / Member / Policy Year

Waiting Period - Inbuilt Cover

Pre Existing Disease (PED) Waiting Period	3 years
Specific Disease waiting period	2 years
Initial Waiting Period (Excluding Accidental Hospitalization)	30 Days