ADITYA BIRLA CAPITAL
Health Insurance

Activ One
Prospectus

Section A. KEY HIGHLIGHTS

This policy is carefully crafted to offer complete protection against medical expenditures incurred due to an unforeseen Illness or Injury. Key features include Unlimited Super reload, Super credit, Health management program, Chronic care, Global coverages, Maternity Benefit and wide range of optional covers designed to extend the scope of base coverage and fixed pay-out benefit options like Critical Illness and Personal Accident.

Section B. ELIGIBILITY AND TERMS

1. **Policy Term:**
   The policy will be issued for a period of 1/2/3 year(s), the Sum Insured & benefits will applicable on policy year basis.

2. **Policy Type:**
   The policy can be purchased on an Individual basis or a Family floater basis.
   a) Individual Policy:
      - In case of an Individual policy, each Insured Person under the policy will have a separate Sum Insured.
      - Premium will be charged as per the age of Individual Insured Person

   b) Family Floater:
      - In case of a floater Policy, one family will share a single opted Sum Insured except under optional covers like Critical Illness or Personal Accident where the Individual SI's are applicable
      - In a family floater the age of the eldest member will be considered while computing premium for the family.

3. **Variants / Plan Name**
   1. **Plan: MAX**
   2. **Plan: VYTL**
   3. **Plan: NXT**
   4. **Plan: VIP**
   5. **Plan: VIP+**
   6. **Plan: MAX+**
   7. **Plan: SAVR**

4. **Entry Age (For all Variants)**

Individual	**Proposer**	**Adults**	**Child**
Minimum Entry Age	18 Years	18 Years	5 Years
Maximum Entry Age	No Capping	No Capping	No Capping
Family Floater / Multi Individual Policy	**Proposer**	**Adults**	**Child**
Minimum Entry Age	18 Years	18 Years	91 days
Maximum Entry Age	No Capping	No Capping	25 Years

Note:
1. Age is calculated on completed years on last birthday as on Commencement Date
2. Children up to 25 years can be covered under the floater policy as dependents. After age of 25 years, such Insured Person will be covered under a separate Individual Policy.
3. Individual Policy: Children beyond 25 years if dependent on the parents, can be covered under an individual policy.

5. **Maximum age on renewals:**
   There is no maximum cover ceasing age on renewals

6. **Relationship Covered**
   1. **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

   2. **Family Floater:**
      - Self, legally married spouse OR live-in partner (same or opposite sex), dependent Children (Natural/legally adopted), Parents and Parents-in-law)

      - Family Definition under Floater: Up to 2 Adult^ + 4 Children (2A4C)

      ^Under Family Floater policy of 2 Adults, the relationship between the Insureds will always have to be Primary Insured and their Spouse.

7. Sum Insured Options (Base Cover):

Sr. No	Variants	Base Sum Insured Option	
1	MAX	INR 2 Lacs, 3 Lacs, 4 Lacs, 5 Lacs, 7 Lacs, 10 Lacs,15 Lacs, 20 Lacs, 25 Lacs, 50 Lacs, 75 Lacs, 1 Crore, 2 Crores, 3 Crores, 4 Crores, 5 Crores, 6 Crores	
2	VYTL		
3	NXT		
4	VIP	**Domestic Sum Insured Option:** INR 50 Lacs and 75 Lacs **International Sum Insured:** INR 30 Lacs (Over and above Domestic Sum Insured)	**Domestic Sum Insured Option:** INR 1 Crore, 2 Crores, 3 Crores, 4 Crores, 5 Crores and 6 Crores **International Sum Insured:** INR 1 Crore (Over and above Domestic Sum Insured)
5	VIP+	**Base Sum Insured Option:** INR 50 Lacs, 75 Lacs, 1 Crore, 2 Crores, 3 Crores, 4 Crores, 5 Crores, 6 Crores **International Sum Insured:** Up to Base Sum Insured	
6	MAX+	INR 2 Lacs, 3 Lacs, 4 Lacs, 5 Lacs, 7 Lacs, 10 Lacs,15 Lacs, 20 Lacs, 25 Lacs, 50 Lacs, 75 Lacs, 1 Crore, 2 Crores, 3 Crores, 4 Crores, 5 Crores, 6 Crores	
7	SAVR	INR 2 Lacs, 3 Lacs, 4 Lacs, 5 Lacs, 7 Lacs, 10 Lacs,15 Lacs, 20 Lacs, 25 Lacs, 50 Lacs, 75 Lacs, 1 Crore, 2 Crores, 3 Crores, 4 Crores, 5 Crores, 6 Crores	

8. Premium payment options:

1. Monthly
2. Quarterly
3. Half yearly
4. Annual / Single

Section C. Benefits Covered Under the Policy

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

C.1 Hospitalization Treatment

C.1.1 In-Patient Treatment

The Company shall indemnify the following 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. **Road Ambulance**: We will pay up to Base Sum Insured
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 towards treatment taken by the Insured Person during In-patient Treatment or Day Care Treatment 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 under Hospitalization Treatment 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 under Hospitalization Treatment of the Insured Person, 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 under Hospitalization Treatment 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) in the Policy Document.

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 Hospitalization Treatment or Domiciliary Hospitalization or Home Health care or AYUSH treatment for up to 90 days immediately prior to the date of such Hospitalization as mentioned in the Policy Schedule.

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 Hospitalization Treatment or Domiciliary Hospitalization or Home Health care or AYUSH treatment for up to 180 days from the date of discharge from the Hospital as mentioned in the Policy Schedule.

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 Hospitalization Treatment or Domiciliary Hospitalization or Home Health care or AYUSH treatment or Organ Donor Expenses during the Policy Period as mentioned in the Policy Schedule.

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 subject to the conditions specified in the Policy Document.

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 and subject to meeting the conditions mentioned in the Policy Document.

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 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 mentioned in the Policy Document.

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 conditions mentioned in the Policy Document of this Policy.
Medical tests covered under this Benefit are as follows:

Sum Insured	INR 2 Lacs - 10 Lacs	INR 15 lacs - 25 Lacs	INR 50 Lacs - 6 Crores
Test	MER, CBC with ESR, Urine routine, Blood Group, Blood Sugar, Lipid Profile, Kidney Function Test, ECG	MER, CBC with ESR, Urine routine, Blood Group, Blood Sugar, Lipid Profile, TMT, Kidney Function 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.

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 conditions specified in the Policy Document.

C.11 Super Credit

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 and conditions as specified in the Policy Document.

C.12 Chronic Care (Day 1 In-patient Hospitalization)

The Company shall indemnify the Medical Expenses incurred related to an admissible Hospitalization of the Insured Person under Hospitalization Treatment due to the chronic condition(s) listed below from Day 1 of coverage, where any of the scenarios / situations are fulfilled, as applicable and written in the Policy Document.

For the Eligibility and Conditions to avail Chronic Care (Day 1 In-Patient Hospitalization) benefit, please refer Policy Schedule.

For the ease of understanding broad definitions of covered Chronic conditions are as below:

Asthma is a Chronic condition that affects the airways (bronchi) of the lungs, causing them to constrict (become narrow) when exposed to certain triggers which results in the symptoms of wheezing, coughing, tight chest and shortness of breath.

Hypertension is the term used to describe a persistent elevated blood pressure, commonly referred to as high blood pressure, and if this chronic disease is not treated appropriately, is a major risk factor for heart disease, stroke, kidney disease and even eye diseases.

Hyperlipidaemia is a chronic disease that refers to an elevated level of lipids (fats), including cholesterol and triglycerides, in the blood and if not treated appropriately, it is a major risk factor for increased risks of heart disease, heart attacks, strokes and other incidents of disease.

Diabetes mellitus is a chronic, progressive disease in which impaired insulin production leads to high blood glucose (sugar) levels, and without good self-management and proper treatment, the increased glucose (sugar) in the blood affects and damages every organ in the body, which causes serious health consequences.

Chronic Obstructive Pulmonary Disease (COPD) which includes chronic bronchitis and emphysema, is a long-term lung disease that causes progressive permanent damage to Lung leading to airway related symptoms.

Obesity where Obesity means abnormal or excessive fat accumulation that presents risk to the health (Body Mass Index i.e. BMI is less than or equal to 39.99).

Coronary Artery Disease with PTCA done prior to 1 year:

I. Coronary artery disease is the build-up of lipid-rich plaque in the arteries that supply oxygen-rich blood to the heart. Plaque causes a narrowing or blockage that could result in a heart attack.

II. PTCA (Coronary Angioplasty) is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

III. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

IV. Diagnostic angiography or investigation procedures without angioplasty / stent insertion are excluded from the scope of this definition.

C.13 Chronic Management Program (OPD)

Insured Person(s) who is aged 18 years and above will be entitled to avail access to a fixed number of (i) Medical Practitioner's consultations and (ii) diagnostic tests, for any declared chronic conditions listed under Chronic Care (Day 1 In-patient Hospitalization) and as specified in the Policy Schedule. For details of the applicability and number of consultations / tests available to the Insured Person, please refer Annexure IV of the Policy Document[$]. These services can be availed at our Network Providers and Empanelled Service Providers (such as outpatient clinics or physicians / diagnostic centres) for chronic conditions listed above, with a Cashless Facility basis only.

For the Eligibility criteria and Conditions to avail Chronic Management Program (OPD), please refer Policy Document.

[$]Annexure IV – Applicability Matrix of Chronic Management Program for listed and defined 7 Chronic conditions

C.14 Durable Medical Equipment Cover

The Company shall reimburse the expenses towards the cost of buying or renting any of the listed "Durable Medical Equipment", 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. For conditions and list of Durable Medical Equipment's under this Benefit, please refer Policy Document.

C.15 Advanced Health Check-up

Insured Person(s) Aged 18 years and above on the Commencement Date of the Policy may avail an advanced health check-up once in a Policy Year in accordance with the table below and conditions mentioned in the Policy Document of this Policy.

Medical tests covered under this Benefit are as follows:

Sr.no.	List of Advanced Health Check-up Tests
1	Computed tomography angiography (CTA)
2	Positron emission tomography (PET) Scan

C.16 Hospital Cash Cover for Parents OR Parents-in-law

The Company shall pay the Daily Cash Benefit as specified in the Policy Schedule for each continuous and completed 24 hours of Hospitalization during the Policy Year related to an admissible Hospitalization of any or both Parents/Parents-in-law of the Primary Insured Person subject to the conditions mentioned in the Policy Document.

C.17 Global Cover (Emergency Only)

The Company shall indemnify the Insured Person for Emergency Medical Expenses which are diagnosed and incurred outside India, but within those regions as specified in the Policy Schedule, related to the Benefits mentioned below, subject to the conditions mentioned in the Policy Document:

Emergency Hospitalisation	The Company shall indemnify the Medical Expenses incurred for the Hospitalization of the Insured Person until they reach a Medically Stable Condition during the Policy Period subject to the conditions mentioned in the Policy Document.
Emergency Medical Evacuation	Our Service Provider will arrange, and the Company 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.
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.
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 and conditions as specified in the Policy Document against this Cover.
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.
Return of mortal remains	The Company shall 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.
Medical referral	Insured Person(s) will have tele-access to an operations centre 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.
Medical Repatriation	Our Service Provider will arrange, and the Company 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
OPD Cover	The Company shall indemnify the Medical Expenses, for an Insured Person on foreign land who suffers an Injury or is diagnosed with an Illness requiring Out-patient Treatment, up to the amount as specified in the Policy Schedule and the condition specified in the Policy Document.
Loss of Passport	The Company 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 subject to the condition mentioned in the Policy Document.
Loss of checked-in baggage	The Company 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 in the Policy Document.
Trip Cancellation & Interruption	**Trip Cancellation:** 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 due to any of the reasons specified in the Policy Schedule, then the Company 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 subject to the conditions mentioned in the Policy Document. **Trip Interruption:** If the Insured Person's overseas stay is unavoidably curtailed after the commencement of the Period of Insurance due to any of the reasons/conditions as specified in the Policy Document, then the costs of economy airfare of the Insured Person shall be Reimbursed by the Company to return to the country of residence subject to the conditions mentioned in the Policy Document.

Trip Delay	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 subject to the conditions mentioned in the Policy Document.
Delay of Checked-in Baggage	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 subject to the conditions mentioned in the Policy Document.

C.18 Specified Illness Cover (For listed 27 Major Illness - Diagnosis in India and Planned treatment abroad)

The Company shall indemnify the Medical Expenses of the Insured Person incurred towards treatment of Specified Illness as listed below and defined under Section B (Definitions) that would otherwise have been payable under In-Patient Treatment subject to conditions mentioned in the Policy Document.

List of Specified Illness 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.19 Maternity Cover

The Company shall indemnify Maternity Expenses incurred during the Policy Period, subject to fulfilment of conditions mentioned in the Policy Document.

C.20 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 and subject to the conditions specified in the Policy Document.

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.17
Claim Protect	Refer Section C.4
Super Credit	Refer Section C.11

C.21 Health Management Program

C.21.1 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 or Physical Health Assessment at Our Network Providers / Empanelled Service Providers on a Cashless Facility. Health Assessment™ measures MER including BP, BMI, HWR and smoking status, Blood Sugar and Total Cholesterol. After the results of the Health Assessment are received, a Healthy Heart Score (HHS) will be generated. Charges for the same be borne by Us once in a Policy Year. All tests mentioned as a part of Health Assessment™ shall be conducted together.

Conditions to avail Health Assessments are specified in the Policy Document.

C.21.2 HealthReturns™

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

How to Earn HealthReturns™
Earned by way of a percentage of Premium through Healthy Heart Score and Active Dayz

Step 1 – Complete Health questionnaire & Health Assessment™ (applicable for each individual Insured Person)
Step 2 – Earn Active Dayz™ by being physically active on an ongoing basis
Step3- 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 grid mentioned in the Policy Document.

For the Eligibility and Conditions to avail HealthReturns™, please refer the Policy Document.

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. Expenses for OPD Treatment up to the value of rewards accrued.
ii. For expenses towards buying any health wearable device which can be used to track steps and Active Dayz™.

Note: For additional ways to utilize the rewards, please read the HealthReturns™ Section under the Policy Document carefully.

C.22 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, given 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.22.1 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 subject to conditions as mentioned in the Policy Document.

C.22.2 Reduction in Pre-Existing Disease waiting period

On availing this Optional Cover, at the inception of the first policy with Us, 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 subject to conditions as mentioned in the Policy Document.

C.22.3 Claim Protect (Non-Medical Expense Waiver)

Please refer section C.4 (Claim Protect (Non-Medical Expense Waiver)) for the terms and conditions applicable under this Benefit.

C.22.4 Room Rent Type Options

On availing this Optional Cover, the Insured Person shall be eligible to modify the room type category eligibility as specified in the Policy Schedule / Product Benefit Table of the Policy.

C.22.5 Per Claim Deductible

On availing this Optional Cover, the Deductible specified in the Policy Schedule shall be applicable for each and every admissible claim made under this Policy, and the Insured Person shall bear on his / her own account an amount equal to the opted Deductible subject to the conditions mentioned in the Policy Document.

C.22.6 Preferred Provider Network (PPN) Discount

On availing this Optional Cover, the Policyholder will be entitled for a discount of 10% on the premium payable subject to the conditions mentioned in the Policy Document.

C.22.7 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 survival of the Insured Person for 15 days following the first diagnosis of the Critical Illness/undergoing the Surgical Procedure for the first time subject to the conditions as mentioned in the Policy Document.

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

C.22.8 Personal Accident Cover

On availing this Optional Cover, We will pay the amount specified in the Policy Schedule as a lump sum pay out in case of Accidental Death, Permanent Total Disablement and Permanent Partial Disablement up to the limit specified in the Policy Schedule subject to conditions mentioned in the Policy Document.

C.22.9 Super Credit

Please refer section C.11 **(Super Credit)** for the terms and conditions applicable under this Benefit.

C.22.10 Chronic Care (Day 1 In-patient Hospitalization)
Please refer section C.12 (Chronic Care (Day 1 In-patient Hospitalization)) for the terms and conditions applicable under this Benefit.

C.22.11 Chronic Management Program (OPD)
Please refer section C.13 (Chronic Management Program (OPD)) for the terms and conditions applicable under this Benefit.

C.22.12 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) of the Policy Document, provided such claim is admissible under Section C during the Policy Period Year. For terms and conditions applicable under this Benefit, please refer the Policy Document

C.22.13 Durable Medical Equipment Cover

Please refer section C.14 (Durable Medical Equipment Cover) for the terms and conditions applicable under this Benefit.

C.22.14 Chronic Care (Day 1 In-patient Hospitalization) Restriction

On availing this Optional Cover, the Insured Person(s) who are diagnosed with one or more of listed chronic conditions (as defined under Section C.12 – Chronic Care) will not get Day 1 In-patient coverage as per Chronic Care benefit subject to the conditions mentioned in the Policy Document.

C.22.15 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 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 subject to conditions mentioned in the Policy Document

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

C.22.16 Second Medical Opinion for listed Major Illness

On availing this Optional Cover, the Company shall indemnify the expenses incurred towards Second Medical Opinion for the Insured Person for any Major Illness as specifically listed below, if availed from a Medical Practitioner through the Network Provider, subject to the conditions mentioned in the Policy Document.

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.22.17 Annual Screening Package for Cancer Diagnosed Patients

On availing this Optional Cover, the Company 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 conditions mentioned in the Policy Document.

C.22.18 Annual Health Check-up

Please refer section C.9 (Annual Health Check-up) for the terms and conditions applicable under this Benefit.

C.22.19 "Geographical extension to include USA and Canada" for Global Cover (Emergency Only)

This Optional cover shall be subject to all guidelines and conditions mentioned under Section Global Cover, Specified Illness Cover and Maternity Cover with no geographical limitations in the USA and Canada, unlike those specified under Section Global Cover (Emergency Only) subject to the conditions mentioned in the Policy Document.

Section C.a Illustration for Utilization of Sum Insured:

An Insured Person with Activ One (MAX Plan), Tenure 1 Year, Second Policy Year in progress, one claim in Year 1, Base Sum Insured INR 10,00,000						
No. of Claim	**Claim Amount**	**Base Sum Insured** (BSI)	**Super Credit** (on 1st renewal)	**Super Reload** (unlimited times)	**Admissible claim amount**	**Utilisation of Sum Insured**
1st Claim	22,00,000	10,00,000	10,00,000	2,00,000	22,00,000	Base Sum Insured+ Super Credit+ Super Reload (partial)
2nd Claim	10,00,000	NIL	NIL	10,00,000	10,00,000	Super Reload (up to Base Sum Insured)
3rd Claim	8,00,000	NIL	NIL	8,00,000	8,00,000	Super Reload (partial)

Insured Person as above with Activ One (MAX Plan), Tenure 1 Year, Sixth Policy Year in progress, Base Sum Insured INR 10,00,000.						
No. of Claim	**Claim Amount**	**Base Sum Insured** (BSI)	**Super Credit** (on 5th renewal)	**Super Reload** (unlimited times)	**Admissible claim amount**	**Utilisation of Sum Insured**
1st Claim	30,00,000	10,00,000	50,00,000	Not Required	30,00,000	Base Sum Insured+ Super Credit
2nd Claim	40,00,000	NIL	30,00,000	10,00,000	40,00,000	Super Credit(Balance) + Super Reload (up to Base Sum Insured)
3rd Claim	10,00,000	NIL	NIL	10,00,000	10,00,000	Super Reload (Full)
4th Claim	8,00,000	NIL	NIL	8,00,000	8,00,000	Super Reload (partial)
5th Claim	10,00,000	NIL	NIL	10,00,000	10,00,000	Super Reload (Full)

Section C.b Illustration of Super Credit (exclusive):

Policy year	**Policy Type**	**Base Sum Insured (BSI)**	**Claims**	**Super Credit (100% of SI) on next year renewal***	**Total Available Sum Insured**
1	Floater	10,00,000	No	NA	10,00,000
2	Floater	10,00,000	Yes	100% of BSI = 10,00,000	20,00,000
3	Floater	10,00,000	Yes	100% of BSI = 10,00,000	30,00,000
4	Floater	10,00,000	No	100% of BSI = 10,00,000	40,00,000
5	Floater	10,00,000	No	100% of BSI = 10,00,000	50,00,000
6	Floater	10,00,000	No	100% of BSI = 10,00,000	60,00,000
7	Floater	10,00,000	Yes	NA	60,00,000
8	Floater	10,00,000	No	NA	60,00,000

***Irrespective of claim in preceding policy year. The above illustration is for MAX Plan.**

Section C.c Super Reload Illustration

Policy Year	**Claim No**	**Policy Type**	**Claim Amount**	**Base Sum Insured**	**Super Reload (2X-Day 1 Cover and Unlimited Reload)**	**Super Credit**	**Admissible claim amount**	**Paid through**
1	1st Claim	Floater	20,00,000	10,00,000	10,00,000	NIL	20,00,000	Base Sum Insured + Super Reload (Full)
1	2nd Claim	Floater	10,00,000	NIL	10,00,000	NIL	10,00,000	Super Reload (Full)
1	3rd Claim	Floater	5,00,000	NIL	5,00,000	NIL	5,00,000	Super Reload(Partial)
1	4th Claim	Floater	5,00,000	NIL	5,00,000	NIL	5,00,000	Super Reload(Partial)
1	5th Claim	Floater	10,00,000	NIL	10,00,000	NIL	10,00,000	Super Reload (Full)

Section C.d Optional Cover Applicability - Variant wise

Sr No	Optional Covers	MAX	VYTL	NXT	VIP	VIP+	MAX+	SAVR
1	Reduction in Specific Disease waiting period	2 years to 1 year						
2	Reduction in PED waiting period	3 Years to 2 Years OR 3 Years to 1 Year		4 Years to 3 Years OR 4 Years to 2 Years OR 4 Years to 1 Year	3 Years to 2 Years OR 3 Years to 1 Year			
3	Claim Protect (Non-Medical Expense Waiver)	NA		Applicable (Annexure 1 covered)	NA			
4	Room Rent Type Options	Single Private Room OR Shared Accommodation			NA		Single Private Room OR Shared Accommodation	
5	Per Claim Deductible	INR 15,000 OR INR 25,000			NA		INR 15,000 OR INR 25,000	
6	Preferred Provider Network (PPN) Discount	10% discount applicable			NA		10% discount applicable	
7	Critical Illness cover	Critical Illness SI Options- 10 Lacs, 15 Lacs, 20 Lacs and 25 Lacs						
8	Personal Accident Cover	Personal Accident SI Options- 10 Lacs, 15 Lacs, 20 Lacs, 25 Lacs, and 50 Lacs						
9	Super Credit (up to Max of 3 Cr under this benefit)	NA		100% of BSI per year, up to 500% of Base Sum Insured	NA			
10	Chronic Care (Day 1 In-patient Hospitalization, PED and Initial WP waived)	Applicable for listed Chronic conditions	NA	Applicable for listed Chronic conditions	NA		Applicable for listed Chronic conditions	
11	Chronic Management Program (OPD)	Applicable (Cashless)	NA	Applicable (Cashless)	NA		Applicable (Cashless)	
12	Cancer Booster (Up to 100% of BSI)	Applicable	NA	Applicable				
13	Durable equipment cover	Combined Sum Insured of INR 5 Lacs or up to BSI, whichever is lower	NA	Combined Sum Insured of INR 5 Lacs or up to BSI, whichever is lower			NA	Combined Sum Insured of INR 5 Lacs or up to BSI, whichever is lower
14	Chronic Care (Day 1 In-patient Hospitalization) Restriction	NA	Applicable	NA				
15	Compassionate Visit	up to INR 50,000 for two-way travel fare if hospitalization exceeds 10 days						
16	Second Medical Opinion for listed Major Illness	Applicable						
17	Annual Screening Package for Cancer Diagnosed Patients	INR 10,000 / Member / Policy Year						
18	Annual Health Check up	NA		Listed & Cashless	NA			
19	Geographical extension to include USA and Canada	NA			Applicable	NA		

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

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 portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage

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

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:

Sr.No	Body System	Illness	Treatment / Surgery
1.	Eye	Cataract	Cataract Surgery
		Glaucoma	Glaucoma Surgery
		Refractive Error Correction	Correction Surgery
2.	Ear Nose Throat	Sinusitis	Medical & Surgical Treatment
		Rhinitis	Medical & Surgical Treatment
		Tonsillitis & Adenitis	Medical & Surgical Treatment
		Tympanitis & Non Traumatic Perforation	Medical & Surgical Treatment
		Deviated Nasal Septum	Medical & Surgical Treatment
		Otitis Media	Medical & Surgical Treatment
		Adenoiditis	Medical & Surgical Treatment
		Mastoiditis	Medical & Surgical Treatment
		Cholesteatoma	Medical & Surgical Treatment
3.	Gynecology	All Cysts, Mass, Swelling, Lump, Granulomas, Polyps, Fibroids & Benign Tumour of the female genito urinary system	Medical & Surgical Treatment
		Polycystic Ovarian Disease	Medical & Surgical Treatment
		Uterine Prolapse	Medical & Surgical Treatment
		Fibroids (Fibromyoma)	Medical & Surgical Treatment
		Breast lumps (excluding Malignant)	Medical & Surgical Treatment
		Dysfunctional Uterine Bleeding (DUB)	Medical & Surgical Treatment
		Endometriosis	Medical & Surgical Treatment
		Menorrhagia	Medical & Surgical Treatment
		Pelvic Inflammatory Disease	Medical & Surgical Treatment
4.	Orthopedic / Rheumatological	Gout	Medical & Surgical Treatment
		Rheumatism, Rheumatoid Arthritis	Medical & Surgical Treatment
		Non infective arthritis	Medical & Surgical Treatment
		Osteoarthritis	Medical & Surgical Treatment
		Osteoporosis	Medical & Surgical Treatment
		Prolapse of the intervertebral disc	Medical & Surgical Treatment
		Spondilosis, Spondioarthritis, Spondylopathies	Medical & Surgical Treatment
		Ankylosing Spondilitis / Spondylopathies	Medical & Surgical Treatment
		Psoriatic Arthritis / Arthropathy	Medical & Surgical Treatment
		Internal Derangement of Knee / Ligament or Tendon or Meniscus Tear	Medical & Surgical Treatment
		Joint Replacement Surgery	Medical & Surgical Treatment
		Non Specific Arthritis	Medical & Surgical Treatment
5.	Gastroenterology (Alimentary Canal and related Organs)	Stone in Gall Bladder, Bile duct & other parts of Biliary System	Medical & Surgical Treatment
		Cholecystitis	Surgical Treatment
		Pancreatitis	Surgical Treatment
		Fissure, Fistula in ano, hemorrhoids (piles), Pilonidal Sinus, Ano-rectal & Perianal Abscess	Medical & Surgical Treatment
		Rectal Prolapse	Medical & Surgical Treatment
		Gastric or Duodenal Erosions or Ulcers + Gastritis & Duodenitis & Colitis	Medical & Surgical Treatment
		Gastro Esophageal Reflux Disease (GERD)	Medical & Surgical Treatment
		Cirrhosis	Medical & Surgical Treatment
		Chronic Appendicitis	Surgical Treatment
		Appendicular lump, Appendicular abscess	Medical & Surgical Treatment

6	Urogenital (Urinary and Reproductive system)	Stones in Urinary system (Stone in the Kidney, Ureter, Urinary Bladder)	Medical & Surgical Treatment
		Benign Hypertrophy / Enlargement of Prostate (BHP / BEP)	Medical & Surgical Treatment
		Hernia, Hydrocele,	Medical & Surgical Treatment
		Varicocoele / Spermatocoele	Medical & Surgical Treatment
7	Skin	Skin tumour (unless malignant)	Medical & Surgical Treatment
		All skin diseases	Medical & Surgical Treatment
8	General Surgery	Any swelling, tumour, cyst, nodule, ulcer, polyp Mass , Swelling,	Medical & Surgical Treatment
		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.

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.

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.

D.1.6 Obesity / Weight Control (Code- Excl06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

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.

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.

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.

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.

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.

D.1.12. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**

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)**

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)**

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.

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.

D.1.17. Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

D.1.18. Maternity Expenses (Code - Excl18):

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

D.2 Specific Exclusions

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.
The Insured Person's direct participation in terrorist acts.

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
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)

D.2.3 Medical Exclusions

a) All routine examinations and Health Check-ups except as per terms and conditions specified under Annual Health Check-up and Advanced 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, restorative, 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 specified under AYUSH Treatment in Appendix A

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.

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.

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.

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.

D.2.8 Geographical Exclusion

Treatment taken outside India, unless specified to be covered in the Policy Schedule.

Section E. General Terms and Conditions

E.1. Standard General Terms and Clauses

E.1.1. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting / migrating the policy.

The Insured Person shall be allowed free look period of fifteen days (thirty days for policies with a term of 3 years, if sold through distance marketing) from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to:

i. refund of the premium paid, less any expenses incurred by the Company on medical examination of the Insured Person or
ii. where the risk has already commenced and the option of return of the policy is exercised by the Insured Person, a deduction towards the proportionate risk premium for period of cover or
iii. where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

E.1.2. Cancellation

i. The Policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired Policy Period as detailed below
Note: For Policies where premium is paid by instalment: In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year
ii. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the Policy.

The below grid shall be applicable for 'Yearly / Annual / One Time' premium payment frequency.

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

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

iii. In case of death of an Insured Person, pro-rate 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

E.1.3. Renewal of Policy

The Policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person.

i. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding Policy Years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iv. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of 30 days (15 days in case of other than single premium policies) to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience

E.1.4. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

E.1.5. Nomination

The Policyholder is required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Policyholder, the Company will pay the nominee as named in the Policy Schedule (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

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.

E.1.7. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as Super Credit, waiver of waiting period as per IRDAI guidelines, provided the Policy has been 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/

E.1.9. Claim settlement (Provision for Penal interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document
iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

E.1.10. Moratorium Period

After completion of eight continuous years under the Policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first Policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits.
After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the Policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract.

E.1.11. Multiple Policies

i. In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this Policy.
iii. If the amount to be claimed exceeds the Sum Insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

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 policy by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product / plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.asp?page=PageNo3987&flag=1

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 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

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)

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

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.

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)

i. Grace Period of 30 days in case of single premium policies, and a period of 15 days in case of other than single premium policies, would be given to pay the instalment premium due for the policy.
ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
iii. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
vii. The Company has the right to recover and deduct all the pending instalments from the claim amount due under the Policy.

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 the table in 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, pro-rata refund of premium 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.

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.

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)

i. 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
ii. Loadings shall be applied from Commencement Date including subsequent Renewal(s), and on increased Sum Insured
iii. 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.

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.
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.

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.

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 as specified under Home Health Care 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.

Type of claim	Prescribed Time Limit
Reimbursement of Hospitalization, Day Care Treatment or Pre Hospitalization Expenses or Hospital Cash Cover for Parents OR Parents-in-law	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 (in all claims above Rs. 1 lakh) 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 health card We have issued to the Insured Person supported with the Insured Person's KYC documents.
2. The Policy Number;
3. Name of the Policyholder;
4. Name and address of Insured Person in respect of whom the request is being made;
5. Nature of the Illness / Injury and the treatment / Surgery required;
6. Name and address of the attending Medical Practitioner;
7. Hospital where treatment / Surgery is proposed to be taken;
8. Proposed date of admission.

ii. If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.
iii. When we have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim, applicable Deductibles and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.
iv. The Authorization letter shall be issued to the Network Provider within 24 hours of receiving the complete information.

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

i. We must be contacted to pre-authorise Cashless Facility within 24 hours of the Insured Person's Hospitalization if the Insured Person has been Hospitalized in an Emergency. Each request for pre-authorisation must be accompanied with all the following details:
   1. The health card We have issued to the Insured Person supported with the Insured Person's KYC documents.
   2. The Policy Number;
   3. Name of the Policyholder;
   4. Name and address of Insured Person in respect of whom the request is being made;
   5. Nature of the Illness / Injury and the treatment / Surgery required;
   6. Name and address of the attending Medical Practitioner;
   7. Hospital where treatment / Surgery is proposed to be taken;
   8. Proposed date of admission.

ii. If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.
iii. When we have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim, 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 Authorization letter shall be issued to the Network Provider within 24 hours of receiving the complete information.

d) For Reimbursement Claims:

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

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

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 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 & Final Payment Receipt
   7. 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.
   8. All previous consultation papers indicating history & treatment details for current ailment
   9. All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription & invoice / bill with receipt from diagnostic centre
   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 & Copy Death Certificate (in Death Claims Only)
   13. Pre & Post-Operative Imaging reports – for Accident Cases Only
   14. Copy of Indoor case papers with nursing sheet detailing medical history of the patient, treatment details, & patient's progress (if available)
   15. 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

16. 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

17. 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.
18. As per terms of IRDAI Circular ref: IRDA/SDD/GDL/CIR/020/02/2013 dated 08.02.2013, KYC shall be performed for the claims cases where the payment to the claimant is above Rs. 1 lakh or such revised limit as may be prescribed by the Authority from time to time in this regard.

Additional documents in case of below covers
In case of Multiple Policy claims:

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. 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. Claim intimation or claim reference number (if any);
4. Attested copy of medico legal certificate copy / first information report copy / Panchnama (spot / inquest);
5. Copies of consultation letters detailing the treatment taken immediately after Accident;
6. Radiological investigation reports like X ray, CT scan, MRI etc with films supporting the diagnosis of Injury;
7. Cancelled cheque for NEFT.

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)
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.)

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)

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.
ii. 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.
iii. The authorization letter shall be issued to the Network Provider within 24 hours of receiving the complete information.

c. For Reimbursement Claims:
   i. For all claims under 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, 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.

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
   17. As per terms of IRDAI Circular ref: IRDA/SDD/GDL/CIR/020/02/2013 dated 08.02.2013, KYC shall be performed for the claims cases where the payment to the claimant is above Rs. 1 lakh or such revised limit as may be prescribed by the Authority from time to time in this regard.

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 and details 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 of the date of assigning the claim for investigation and not later than 6 months from the date of receipt of claim intimation. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals / entities that are authorised by Us in writing. If there are any deficiencies in the necessary, claim documents which are not met or are partially met. We will send a maximum of 3 (three) reminders following which We will send a rejection letter or make apart-payment if we have not received the deficiency documents after 45 days from the date of the initial request for such documents.
b. We may decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if We observe that such a claim is otherwise valid under the Policy. However, documents / details received beyond such period shall be considered if there are valid reasons for any delay.
c. Payment for reimbursement claims will be made to You. In the unfortunate event of Your death, We will pay the Nominee named in the Policy Schedule or Your legal heirs or legal representatives holding a valid succession certificate.

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

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.2.9. 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 within the permission of the IRDAI change or vary this Policy.

E.2.11. Zonal pricing

For the purpose of calculating premium, the country has been divided into the following 3 zones:

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.2.13. 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.2.16. 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.2.17. 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 transactions when done in adherence to and in compliance with Our terms and conditions for such facilities, as may be prescribed from time to time. Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Policyholder. A voice recording in case of tele-sales or other evidence for sales through the Internet shall be maintained and such consent shall be subsequently validated / confirmed by the Policyholder.

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

SECTION F. UNDERWRITING AND LOADINGS

i. We may apply a risk loading (additional premium) on the premium payable (excluding statutory levies and taxes) based on the details of the Insured Person, including the health status, habits and lifestyle, past medical records, declarations on the Proposal Form and the results of the pre-Policy medical examination.
ii. We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual shall not exceed above 150% per person.
iii. We will inform You about the applicable risk loading through a counter offer letter and We will only issue the Policy Once We receive your consent and applicable additional premium. In case, you neither accept the counter offer nor revert to Us within 10 working days, We shall cancel Your application and refund the premium paid.
iv. Your Policy shall not be issued unless We receive Your consent.

SECTION G. PRE-POLICY MEDICAL EXAMINATION

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

SECTION H. DISCOUNTS UNDER THE POLICY

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

Discounts		
Sr. Number	**Description**	**Percentage of Premium excluding GST**
1	**Family Discount**	
	for 2 or 3 members	5%
	for 4 members or more	10%
2	**Long term Policy Discount**	
	Policy Term-2 years	7.50%
	Policy Term-3 years	10%

3	**Employee Discount/ ABG Customers / ABG Employees / Direct Discount (All are mutually exclusive)**	10%
4	**Corporate GMC policy holder Discount**	5%
5	**Auto Debit Discount** - Discount on the premium from 1st renewal, if the premium is received through NACH or standing instruction (where payment is made either By direct debit of bank account or credit card)	2.5%
6	**Discount in lieu of Commission**	Maximum up to 15% of the policy premium

Maximum cap on discount will be 27.1% of policy premium.

SECTION I. List of Non preferred providers

Link: https://adityabirlacapital.com/healthinsurance/locate-care/hospital-listing

SECTION J. Benefit Illustration

Benefit Illustration in respect of policies offered on individual and family floater basis

Age of the members insured (Yrs)	Coverage opted on individual basis covering each member of the family separately (at a single point in time)			Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)							Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (Rs.) (Male)	Premium (Rs.) (Female)	Sum Insured (Rs.)	Premium (Rs.) (Male)	Discount, If any	Premium after discount (Rs.)	Premium (Rs.) (Female)	Discount, If any	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater discount, if any	Premium after discount (Rs.)	Sum Insured (Rs.)
17	5,748	5,748		5,748	575	5,173	5,748	575	5,173		NA	NA	NA	
22	6,800	6,800		6,800	680	6,120	6,800	680	6,120		NA	NA	NA	
41	11,182	11,182	5,00,000	11,182	1,118	10,063	11,182	1,118	10,063	5,00,000	NA	NA	NA	5,00,000
45	11,182	11,182		11,182	1,118	10,063	11,182	1,118	10,063		NA	NA	NA	
Total	**34,910**	**34,910**		**34,910**	**3,491**	**31,419**	**34,910**	**3,491**	**31,419**		**34,910**	**13,300**	**21,611**	
Total Premium for all members of the family is Rs. 34,910, when each member is covered separately.				Total Premium for all members of the family is Rs. 31,419, when they are covered under a single policy.							Total Premium when policy is opted on floater basis is Rs. 21,611.			
Sum insured available for each individual is Rs. 5,00,000.				Sum insured available for each family member is Rs. 5,00,000.							Sum insured of Rs. 5,00,000, is available for the entire family.			
Note: Premium rates specified in the above illustration are standard premium rates without considering any loading. The premium rates are exclusive of taxes applicable. This is for MAX plan for Zone 1.														

Statutory Warning - Prohibition of Rebates

(Under Section 41 of Insurance Act 1938)

1- No person shall allow or offer to allow, either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property, in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the Insurer.

2- Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Annexures to Prospectus:

Annexures A – Rate charts