Activ Health Policy Terms and Conditions

Section A. PREAMBLE

This Policy has been issued on the basis of the Disclosure to information norm, including the information provided by You in respect of the Insured Persons in the Proposal Form and any other details submitted in relation to the Proposal Form. This Policy is a contract of insurance between You and Us which is subject to the receipt of premium in full and the terms, conditions and exclusions of this Policy.

Key Notes:
The terms listed in Section D (Definitions) and which have been used elsewhere in the Policy in Initial Capital letters shall have the meaning set out against then in Section D, wherever they appear in the Policy.

Section B. BENEFITS UNDER THE POLICY

Section I: Basic Covers:
The Benefits listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the applicable Plan as specified in the Policy Schedule.

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

Benefits under this Section are subject to the terms, conditions and exclusions of this Policy and the availability of the Sum Insured and subject always to any sub-limits for the Benefit as specified in the Policy Schedule.

All claims must be made in accordance with the procedure set out in Section C(C). Claims paid under this Section will impact the Sum Insured and eligibility for Cumulative Bonus.

(a) In-patient Hospitalization:

What is covered

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

(1) Room Rent and other boarding charges;
(2) Intensive Care Unit charges;
(3) Operation theatre expenses;
(4) Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
(5) Qualified Nurses charges;
(6) Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
(7) Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized
(8) Anaesthesia, blood, oxygen and blood transfusion charges;
(9) Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Conditions

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

Sub-limits

For Essential Plan, treatment-wise sub-limits will apply as below, these limits are applicable per Policy Year.

	Disease Category	Zone I	Zone II	Zone III
1	Cataract (including cost of lens) per eye	Rs 40,000	Rs 30,000	Rs 20,000
2	Angioplasty (including cost of stent)	Rs 3,00,000	Rs 2,50,000	Rs 2,00,000
3	Knee replacement (including revision Surgery)	Rs 3,00,000	Rs 2,50,000	Rs 2,00,000
4	Hip replacement (including revision Surgery)	Rs 3,00,000	Rs 2,50,000	Rs 2,00,000
5	Cholecystectomy (open or lap)	Rs 60,000	Rs 45,000	Rs 35,000
6	Lap / open / vaginal hysterectomy (with / without Salpigo-oophorectomy)	Rs 60,000	Rs 45,000	Rs 35,000

(b) Pre – hospitalization Medical Expenses:

What is covered

We will cover on a reimbursement basis, the Insured Person's Pre-hospitalization Medical Expenses incurred in respect of an Illness or Injury that occurs during the Policy Period.

Conditions

(i) We have accepted a claim for In-patient Hospitalization under Section B(I)(a) above;
(ii) The date of admission to Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to Any One Illness.

(c) Post – hospitalization Medical Expenses:

What is covered

We will cover on a reimbursement basis, the Insured Person's Post-hospitalization Medical Expenses incurred following an Illness or Injury that occurs during the Policy Period.

Conditions
(i) We have accepted a claim for In-patient Hospitalization under Section B(I)(a) above;
(ii) The date of discharge from Hospital for the purpose of this Benefit shall be the date of the Insured Person's last discharge from Hospital in relation to Any one Illness.

(d) Day Care Treatment:
What is covered
We will cover the Medical Expenses incurred on the Insured Person's Day Care Treatment during the Policy Period following an Illness or Injury that occurs during the Policy Period. The list of such Day Care Treatment is mentioned in Annexure IV.
Conditions
(I) The Day Care Treatment is Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
(ii) The Medical Expenses are incurred, including for any procedure which requires a period of specialized observation or care after completion of the procedure undertaken by an Insured Person as Day Care Treatment.
(iii) If We have accepted a claim under this Benefit, We will also cover the Insured Person's Pre-hospitalization and Post-hospitalization Medical Expenses in accordance with Section B(I)(b) and (c) above.
What is not covered
OPD treatment is not covered under this Benefit.

Any one Illness means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
Post-hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:
i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and
ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.
Day Care Treatment means medical treatment, and/or *surgical procedure* which is:
i. undertaken under General or Local Anaesthesia in a *hospital/day care centre* in less than 24 hrs because of technological advancement, and
ii. which would have otherwise required hospitalization of more than 24 hours.
Treatment normally taken on an out-patient basis is not included in the scope of this definition.

(e) Domiciliary Hospitalization:
What is covered
We will cover the Medical Expenses incurred for the Insured Person's Domiciliary Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period.
Conditions
(i) The Domiciliary Hospitalisation continues for at least 3 consecutive days in which case We will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalisation;
(ii) The treating Medical Practitioner confirms in writing that Domiciliary Hospitalization was medically necessary and the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital OR the Insured Person satisfies Us that a Hospital bed was unavailable;
(iii) If a claim is accepted under this Benefit, then We shall pay Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses under Section B.I.(b) and Section B.I.(c) respectively for the same Illness/Injury.
What is not covered
We shall not be liable to pay for any claim in connection with:
(1) Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
(2) Arthritis, gout and rheumatism;
(3) Chronic nephritis and nephritic syndrome;
(4) Diarrhea and all type of dysenteries, including gastroenteritis;
(5) Diabetes mellitus and insipidus;
(6) Epilepsy;
(7) Hypertension;
(8) Psychiatric or psychosomatic disorders of all kinds;
(9) Pyrexia of unknown origin.

(f) Road Ambulance Cover:
What is covered
We will cover the costs incurred up to the limits as specified in the Policy Schedule, on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period.

Coverage shall also be provided under the below circumstances, if the Medical Practitioner certifies in writing that:
(i) it is medically necessary to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.
(ii) it is medically necessary to transfer the Insured Person to another Hospital during the course of Hospitalization due to lack of super speciality treatment in the existing Hospital.
Conditions
(I) The Ambulance/ healthcare service provider is registered;
(ii) We have accepted a claim for In-patient Hospitalization under Section B(I)(a) above;
What is not covered
Any expenses in relation to transportation of the Insured Person from Hospital to the Insured Person's residence are not payable under this Benefit.

Domiciliary Hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a *hospital* but is actually taken while confined at home under any of the following circumstances:
i) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
ii) the patient takes treatment at home on account of non-availability of room in a hospital.

(g) Organ Donor Expenses:
What is covered
We will cover the Medical Expenses incurred for an organ donor's treatment for the harvesting of the organ donated.
Conditions
(i) The donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;
(ii) The organ transplant is medically necessary for the Insured Person as certified by a Medical Practitioner;
What is not covered
(1) Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
(2) Screening expenses of the organ donor.
(3) Any other Medical Expenses as a result of the harvesting from the organ donor.
(4) Costs directly or indirectly associated with the acquisition of the donor's organ.
(5) Transplant of any organ/tissue where the transplant is experimental or investigational.
(6) Expenses related to organ transportation or preservation.
(7) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

(h) Reload of Sum Insured:

What is covered

Once in the Policy Year, We will provide for a 100% reload of the Sum Insured specified in the Policy Schedule, in case available Sum Insured inclusive of earned Cumulative Bonus (if any) is insufficient as a result of previous claims in that Policy Year. Reload of Sum Insured will be available only once during a Policy Year.

Conditions

(i) A claim will be admissible under this Benefit only if the claim is admissible under In-patient Hospitalization under Section B(I)(a) or Day Care Treatment under Section B(I) (d).
(ii) The reload of Sum Insured shall not apply to the first claim in the Policy Year unless related to an Injury due to a road traffic Accident where the claim amount exceeds the Sum Insured.
(iii) The reload of Sum Insured shall be available only for future claims and not in relation to any Illness/ Injury (including its complications) for which a claim has been admitted for the Insured Person during that Policy Year.
(iv) The reload of Sum Insured shall not be available for any claims under Section B(II) (Additional Benefits), Section B(III) (Value Added Benefits) and Section B(IV) (Optional Covers).
(v) The reloaded Sum Insured will not be considered while calculating the Cumulative Bonus.
(vi) In case of an Individual Policy, reload is available to each Insured Person and can be utilised by Insured Persons who stand covered under the Policy before the Sum Insured was exhausted.
(vii) If the Policy is issued on a floater basis, the reload of Sum Insured will be available on a floater basis for all Insured Persons in the family.
(viii) If the reload of Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.
(ix) During a Policy year, any single claim amount payable, (except a claim against road traffic accident) subject to admissibility of claim, shall not exceed the sum of:
  (1) The Sum Insured
  (2) Cumulative Bonus (if earned)
(x) During a Policy Year, the aggregate claim amount payable, subject to admissibility of the claim, shall not exceed the sum of:
  (1) The Sum Insured
  (2) Cumulative Bonus (if earned)
  (3) Reloaded Sum Insured
  (4) HealthReturns™ (please refer to HealthReturns™ clause under Section B(III)(s) for details)
  (5) Optional Covers
  (6) Chronic Management Program
  (7) Additional Benefits

Please refer to the Annexure II 'Illustration of Benefits' Section D, for details on this benefit.

Trademarks- Health Returns, Healthy Heart Score and Active Dayz are owned by MMI Group Limited and used under license by Aditya Birla Health Insurance Co. Limited.

(I) Mandatory Co-payment (Applicable for Essential Plan only)

A mandatory Co-payment as specified in the Policy Schedule shall apply to all payable claims amount in respect of an Insured Person.

Conditions

For persons who have opted for a 'Waiver of Mandatory Co-payment' this Co-payment will not apply.

(j) Co-payment for treatment in a Higher Zone

In case of treatment taken in a city, in a Zone higher than the eligible Zone for the Insured Person, the Co-payment percentages as below shall apply:

Applicable Zone	Treatment taken at	Co-payment applicable
Zone II	Zone I	10%
Zone III	Zone II	15%
Zone III	Zone I	25%

(k) Co-payment for treatment in a Higher room category

In case of treatment taken in a higher room category than the eligible room category for the Insured Person, the Co-payment percentages as below shall apply:

Plan	Eligible Room Category	Room Category at which treatment taken	Co-payment applicable
Essential	General/ Economy Ward	Shared Room	15%
	General/ Economy Ward	Single Private Room	25%
	General/ Economy Ward	Any Room	50%
	Shared Room	Single Private Room	15%
	Shared Room	Any Room	40%
	Single Private Room	Any Room	25%
Enhanced	Shared Room	Single Private Room	15%
	Shared Room	Any Room	40%
	Single Private Room	Any Room	25%

Conditions applicable to benefits (i) (j) (k) above,

Under Essential Plan: wherever applicable Co-payment percentages under (i) (j) (k) shall apply in conjunction.
Under Enhanced Plan: wherever applicable Co-payment percentages under (j) (k) shall apply in conjunction

Note: Please refer to the Annexure II 'Illustration of Benefits', Section B for details on the applicable Co-payment under each Plan.

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

(l) Benefit for Hospital Room Choice

What is covered

This Benefit is available to the Insured Person if he/she chooses to take admission in a Hospital room category that is lower than the eligible room category for that Insured Person. For this purpose the eligible room category shall be as specified in the Policy Schedule.
Under this Benefit, We will apply the percentage amounts (as specified under Column E of the below table) on payable claims. The amount so arrived will be credited as HealthReturns™ in respect of that Insured Person. Such credits shall be made once the claim has been settled.

Opted Plan (A)	Opted Plan (B)	Eligible Room Category (C)	Room Category at which treatment taken (D)	Benefit applicable as a % of payable claims (E)
Essential	Zone I	Shared Room	General/ Economy Ward	10%
		Single Private Room	General/ Economy Ward	20%

		Single Private Room	Shared Room	10%
Trademarks- Health Returns, Healthy Heart Score and Active Dayz are owned by MMI Group Limited and used under license by Aditya Birla Health Insurance Co. Limited				
	Zone II & III	Shared Room	General/ Economy Ward	5%
		Single Private Room	General/ Economy Ward	15%
		Single Private Room	Shared Room	5%
Enhanced	Zone I	Single Private Room	Shared Room	10%
		Any Room	Shared Room	30%
		Any Room	Single Private Room	20%
	Zone II & III	Single Private Room	Shared Room	5%
		Any Room	Shared Room	25%
		Any Room	Single Private Room	15%

Conditions

(i) This Benefit will only be invoked for Medical Expenses arising under Section B(I)(a) of the Policy.
(ii) The maximum amount under this Benefit shall be restricted to the difference between the Balance Sum Insured (including Cumulative Bonus, if any) and the payable claims amount.

Please refer to Illustration in Section A (2) (Case 3) of Annexure II 'Illustration of Benefits'

Section II: Additional Benefits

The Benefits listed below are in-built additional Policy benefits and shall be available to all Insured Persons in accordance with the applicable Plan as specified in the Policy Schedule.

Benefits under this Section are subject to the terms, conditions and exclusions of this Policy.
Claims under this Section will not impact the Sum Insured or the eligibility for Cumulative Bonus.

(m) **Cumulative Bonus:**

What is covered

We shall apply a Cumulative Bonus at such rates as specified in the Table of Benefits on the Sum Insured of the expiring Policy as specified for Section B(I) in the Policy Schedule provided that the Insured Person(s) has not made any claim under Section B(I) in a Policy Year, and has successfully Renewed the Policy with Us continuously and without any break. The Cumulative Bonus shall not exceed, 100% of the Sum Insured on the Renewed Policy and such accumulated Cumulative Bonus will not be reduced for claims made in the future, unless utilised.

Conditions

(i) If the Policy is a Family Floater Policy, then Cumulative Bonus will accrue only if no claims have been made in respect of the Insured Persons in the expiring Policy Year. Cumulative Bonus which is accrued during the claim free Policy Year will only be available to those persons who were insured in such claim free Policy Year and continue to be insured in the subsequent Policy Year.
(ii) Cumulative Bonus will not be accumulated in excess of the percentage applicable under the Plan in force for the Insured Person as stated in the Policy Schedule.
(iii) Wherever the earned Cumulative Bonus is used for payment of a claim during a particular Policy Year, the balance, if any, will be carried forward to the next Policy Year.
(iv) Cumulative Bonus will be not be added if the Policy is not Renewed with Us by the end of the Grace Period.
(v) If the Policy Period is two or three years, any Cumulative Bonus that has accrued for the first/second Policy Year will be credited at the end of the first/second Policy Year as the case may be and will be available for any claims made in the subsequent Policy Year.
(vi) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater Policy basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest among all the Insured Persons.
(vii) If the Insured Persons in the expiring Policy are covered on a Family Floater Policy basis and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater Policies/Individual Policies then the Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
(viii) If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be reduced in the same proportion to the Sum Insured.
(ix) If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
(x) The Cumulative Bonus is provisional and is subject to revision if a claim is made in respect of the expiring Policy Year, which is notified after the acceptance of Renewal premium. Such awarded Cumulative Bonus shall be withdrawn only in respect of the expiring year in which the claim was admitted.
(xi) In case of Family Floater Policies, children attaining Age 25 years at the time of Renewal will be moved out of the Family Floater Policy into an Individual Policy. However, all continuity benefits for such Insured Person on the Policy will remain intact. Cumulative Bonus earned on the Policy will stay with the Insured Person(s) covered under the original Policy.

Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
Grace Period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

(n) Health Check-up Program

What is covered

Each Insured Person above 18 years of Age on the Start date may avail a comprehensive health check-up in a Policy Year in accordance with the table below:

Essential	Enhanced
Age band < 45 years	
Health Assessment™ - MER (includes BP, BMI, HWR and smoking status) Fasting Blood Sugar Total Cholesterol	Health Assessment™ - MER (includes BP, BMI, HWR and smoking status) Fasting Blood Sugar Total Cholesterol
Urine Routine	Urine Routine
CBC with ESR	CBC with ESR
S. Creatinine	S. Creatinine

S. Albumin	S. Albumin
SGPT	SGPT
Thyroid Stimulating Hormone	Thyroid Stimulating Hormone
ECG	ECG
Age band 45 to 55 years	
Health Assessment™ - MER (includes BP, BMI, HWR and smoking status) Fasting Blood Sugar Total Cholesterol	Health Assessment™ - MER (includes BP, BMI, HWR and smoking status) Fasting Blood Sugar Total Cholesterol
Urine Routine	Urine Routine
CBC with ESR	CBC with ESR
S. Creatinine	S. Creatinine
S. Albumin	S. Albumin
SGPT	SGPT
Thyroid Stimulating Hormone	Thyroid Stimulating Hormone
ECG	Tread Mill Test (if < 55 years), 2D Echo (55 years or older)
	PSA (males only)
	Cervical Pap Smear (females only)
Age band > 55 years	
Health Assessment™ - MER (includes BP, BMI, HWR and smoking status) Fasting Blood Sugar Total Cholesterol	Health Assessment™ - MER (includes BP, BMI, HWR and smoking status) Fasting Blood Sugar Total Cholesterol
Urine Routine	Urine Routine
CBC with ESR	CBC with ESR
S. Creatinine	S. Creatinine
S. Albumin	S. Albumin
SGPT	SGPT
Thyroid Stimulating Hormone	Thyroid Stimulating Hormone
ECG	Tread Mill Test (if < 55 years), 2D Echo (55 years or older)
	PSA (males only)
	Cervical Pap Smear (females only)

Reference
MER - Medical Examiner's Report stamped and signed by an MD physician,
BMI - Body Mass Index,
HWR – Hip waist ratio
CBC - Complete Blood Count,
ESR – Erythrocyte sedimentation rate
ECG – Electrocardiogram,
S.Creat - Serum Creatinine,

Conditions

(i) The health check-ups will be arranged by Us only at Our Network Providers;
(ii) You can also avail the applicable tests according to your Age band and claim a reimbursement upto Rs 1000 under Essential Plan. Under Enhanced plan, you can claim a reimbursement upto Rs 1000 for Age band '< 45 years', and upto Rs 2500 for Age bands '45 to 55' and '> 55 years'.
(iii) The Insured Person will be eligible to avail a health check-up every Policy Year.
(iv) For calculation of Healthy Heart Score™ , tests under Health Assessment™ namely - MER (including BP, BMI, HWR and smoking status), Fasting Blood Sugar, Total Cholesterol will have to be carried out at one go (together) and at least once every Policy Year.
(v) Apart from the tests under Health Assessment™ mentioned under point iii) Insured Persons shall be entitled to avail the tests under the Health check-up program in one instance or at separate times during the Policy Year provided that the same test cannot be repeated during the same Policy Year.
(vi) If the Insured Person who has a covered chronic condition, has already undergone tests under Chronic Management Program within three months from date of availing this Benefit, then those specific tests shall not be permitted to be repeated under the Health Check-up Program in the same Policy Year.
(vii) Section C(A) (Permanent Exclusion 9), is not applicable in respect of coverage under this Benefit.
(viii) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider in relation to the health check-up.

(o) Recovery Benefit (Available for Enhanced Plan only)

What is covered

If the Insured Person is Hospitalized during the Policy Period for treatment of an Injury suffered due to an Accident where Hospitalisation continues for at least 10 consecutive days, then We will pay the lump sum amount specified in the Policy Schedule. This Benefit amount will not reduce the Sum Insured.

Conditions

This benefit is over and above the Sum Insured and is available only once per Insured Person, per Policy Year irrespective of Individual Policy or Family Floater Policy.

(p) Second E-Opinion on Critical Illnesses

What is covered

If an Insured Person is diagnosed with a Critical Illness during the Policy Period, the Insured Person may at his/her sole discretion choose to avail a E- opinion from Our panel of Medical Practitioners.

For the purpose of this Benefit, Critical Illness shall mean the following:

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

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

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

4. **OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES**
   - I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. **COMA OF SPECIFIED SEVERITY**
   - I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
     - i. no response to external stimuli continuously for at least 96 hours;
     - ii. life support measures are necessary to sustain life; and
     - iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
   - II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. **KIDNEY FAILURE REQUIRING REGULAR DIALYSIS**
   - I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

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

8. **MAJOR ORGAN/BONE MARROW TRANSPLANT**
   - I. The actual undergoing of a transplant of:
     - i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
     - ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
   - II. The following are excluded:
     - i. Other stem-cell transplants
     - ii. Where only islets of langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

10. MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS

I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE and HIV are excluded.

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

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

(q) Worldwide Emergency Assistance Services (Available for Enhanced Plan only)

What is covered

We will provide the Emergency medical assistance as described below when an Insured Person is travelling 150 (one hundred and fifty) kilometres or more away from his/her residential address as mentioned in the Policy Schedule for a period of less than 90(ninety) days.

(1) Emergency Medical Evacuation: When an adequate medical facility is not available in the proximity of the Insured Person, as determined by the Emergency service provider, the consulting Medical Practitioner and the Medical Practitioner attending to the Insured Person, transportation under appropriate medical supervision will be arranged, through an appropriate mode of transport to the nearest medical facility which is able to provide the required care.
(2) Medical Repatriation (Transportation): When medically necessary, as determined by Us and the consulting Medical Practitioner, transportation under medical supervision shall be provided in respect of the Insured Person to the residential address as mentioned in the Policy Schedule, provided that the Insured Person is medically cleared for travel via commercial carrier, and provided further that the transportation can be accomplished without compromising the Insured Person's medical condition.

Conditions

(i) No claims for reimbursement of expenses incurred for services arranged by Insured Person will be allowed unless agreed by Us or Our authorized representative.
(ii) Please call Our call centre with details on the name of the Insured and/ or Policyholder and Policy number, on the toll free number specified in the Policy Schedule for availing this Benefit.

What is not covered

We will not provide services in the following instances:

(1) Travel undertaken specifically for securing medical treatment.
(2) Injuries resulting from participation in acts of war or insurrection.
(3) Commission of an unlawful act(s).
(4) Attempt at suicide.
(5) Incidents involving the use of drugs unless prescribed by a Medical Practitioner.
(6) Transfer of the Insured Person from one medical facility to another medical facility of similar capabilities which provides a similar level of care.
(7) Trips exceeding 90 days from residential address without prior notification to Us.

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

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

Section III: Value Added Benefits

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

Claims under this Section III will not impact the Sum Insured or the eligibility for Cumulative Bonus.

(r) Chronic Management Program (Available for Platinum Plan only)

What is covered

Under the Chronic Management Program, the Insured Person will be entitled to manage Medical Expenses for out-patient treatment of Diabetes, Hypertension, Hyperlipidemia and Asthma, as specified in the Policy Schedule,

(i) Medical Practitioner's consultations;
(ii) Diagnostic test;
(iii) Pharmacy expenses

These services can be availed at Our Network Providers and empanelled service providers (such as Outpatient clinics or Physicians / Diagnostic centres / Pharmacy Stores) on a Cashless basis.

In case the Insured Person wishes to obtain a Medical Practitioner's consultation on a reimbursement basis, then We will reimburse costs as specified in the Policy Schedule or Endorsement Schedule, up to the limit set for each, against original invoices supported with a Medical Practitioner's prescription for management of the medical condition(s). Original invoices of such consultations along with prescription from the Medical Practitioner can be submitted each month. We will settle such claims on a monthly basis.

If the Insured Person wishes to obtain medicines and consumables for the conditions listed on a reimbursement basis, then, we will reimburse costs as specified in the Policy Schedule or Endorsement Schedule, up to the limit set for each, against original invoices supported with a Medical Practitioner's prescription for management of the medical condition(s). Original invoices of medicines and consumables along with prescription from the Medical Practitioner can be submitted each month. We will settle such claims on a monthly basis.

If the Insured Person wishes to conduct the diagnostics tests for the conditions listed on a reimbursement basis, then, We will reimburse costs as specified in the Policy Schedule or Endorsement Schedule, up to the limit set for each, against original invoices for management of the medical condition(s). Original invoices tests along with the test reports done can be submitted each month. We will settle such claims on a monthly basis.

The list of such Network Providers and empanelled service providers will be updated from time to time and can be obtained from Our website or by calling Our call centre. We will assist in scheduling appointments for consultation and diagnostic tests at a time convenient to the Insured Person.
Alternatively the Insured Person may also schedule his/her own appointment themselves by contacting the Network Provider.

In addition, We will also cover the costs of the Insured Person's Alternative Treatment of these conditions, provided that Our prior approval is obtained on case to case basis for such event of treatment.

For ease of understanding broad definitions of covered Chronic conditions are as below:
(i) 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.
(ii) 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.
(iii) 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.
(iv) 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

Eligibility to get benefit under the Chronic Management Program
The Insured Person will be eligible to avail the Benefits under the Chronic Management Program if either of one out of two conditions mentioned below is fulfilled:

1. <u>If the Insured Person has undergone a pre-Policy medical examination carried out before the Policy Start date:</u>
   (i) Based on the declarations and reports of the pre-Policy medical examination, if the Insured Person is found to be suffering from one or more chronic conditions, then We will manage such conditions from day 1 under the Chronic Management Program. In-patient Hospitalization for such conditions will be covered after 90 days from the Start of the Policy.
   (ii) In case the results of the pre-Policy medical examination indicates that the Insured Person does not have any such chronic conditions, then the Insured Person will be covered under the Chronic Management Program for if the Insured Person develops such conditions later in life.
   (iii) In case after the pre-Policy medical examination, the Insured Person is not detected with one or more aforementioned chronic conditions, but gets detected with other medical conditions, then coverage shall follow the general underwriting guidelines as specified in the Board approved underwriting policy.

2. <u>If the Insured Person chooses to undergo a Health Assessment™ carried out post the Start date :</u>
   (i) If the Insured Person did not undergo a pre-Policy medical examination, then to get the benefit under Chronic Management Program, the Insured Person must undergo a Health Assessment™ within 3months from the Start date. Health Assessment™ is a simple health exam that measures the Insured Person on the parameters of MER (including BP, BMI, HWR and smoking status), Fasting Blood Sugar and Total Cholesterol.
   (ii) If the results of the Health Assessment ™ indicate that the Insured Person does not have any of the aforementioned conditions, then the Insured Person will be entitled to avail the benefits under Chronic Management Program, if the Insured Person develops any such conditions later in life, without any waiting period.
   (iii) If the results of this Health Assessment ™ indicate that the Insured Person suffers from any of the aforementioned conditions then the Insured Person shall be entitled to avail the benefits under the Chronic Management Program, after 24 months of waiting period, provided that the detected chronic condition was not a Pre-Existing Disease, no additional premium shall be required to activate the benefits under the Chronic Management Program.
   (iv) If the Insured Person chooses not to undergo a Health Assessment™ within 3 months of the Policy Start date, a waiting period as per the opted plan shall be applicable for Chronic Management Program. After completion of the applicable waiting Period, if in case the Insured Person if found to be suffering from a covered chronic condition (through results of an Health Assessment™) then, We will activate Chronic Management Program, in respect of the Insured Person.
   This shall also be applicable in case of Portability cases that do not undergo Pre-Policy Medical Examination.

Chronic offering in case an Insured Person suffers from a combination of chronic conditions:
1. In case an Insured Person suffers from Diabetes or any combination of any of the covered chronic conditions, namely Diabetes, Asthma, Hypertension and Hyperlipidaemia, then the Insured Person will be charged the premium of a Diabetes plan with additional premium and as applicable for the particular combination. The Insured Person shall be managed under the Chronic Management Program as applicable for the particular combination.
2. In case an Insured Person suffers from Hypertension or any combination of any of the covered conditions apart from Diabetes, namely Hypertension, Asthma and Hyperlipidaemia, and such person does not suffer from Diabetes, then such Insured Person will be charged a premium for Hypertension management plan with additional premium as applicable for the particular combination. The Insured Person shall be managed under the Chronic Management Program as applicable for the particular combination.
3. In case an Insured Person suffers from Hyperlipidaemia, or from Asthma and Hyperlipidaemia , and such Person is not suffering from Diabetes or Hypertension, then the premium for the Hyperlipidaemia plan will be charged with additional premium as applicable for the particular combination. The Insured Person shall be managed under the Chronic Management Program as applicable for the particular combination.
4. In case an Insured Person suffers from Asthma, and such person is not suffering from Diabetes or Hypertension or Hyperlipidaemia or any combination of these, then the premium for the Asthma Chronic plan will be charged. The Insured Person shall be managed under the Asthma Chronic Management Program.

The coverage to the Insured Person under the Chronic Management Program during the Policy Period would be as eligible at the Start date. Any enhancement in the coverage due to further co-morbid conditions acquired by the Insured Person during the Policy Period would be effected only on Renewal subject to payment of additional premium as applicable. At the time of Renewal, no loading will be applied for such co-morbid conditions.

Note: Where an Insured Person purchases a Policy where he/she is suffering from an existing Chronic condition then he/she mandatorily will have to buy the Policy with Premium and loading (as applicable) for such condition. Deletion of coverage under Chronic Management Program for such condition shall not be allowed on subsequent Renewals of the Policy.

Conditions
(i) In order to avail Cashless Facilities benefits under this Program, the Insured Person is required to carry the health identification card issued by Us along with valid identity proof.

(ii) We shall retain the Insured Person's medical reports generated under this Program, subject to receipt of Your consent at the time of enrollment into the program, and a copy of the medical check-up reports shall be sent to You upon Your request.
(iii) In case a Person doesn't have a Chronic condition at the time of the first Health Assessment (done within 3 months of the Start date of the Policy) and eventually gets detected with a Chronic condition within 6 months of the Start date of the Policy or 6 months from the Policy anniversary, then the benefits under Chronic Management Program will be as specified in the Policy Schedule or Endorsement Schedule.
(iv) In case a Person doesn't have a Chronic condition at the time of the first Health Assessment (done within 3 months of the Start date of the Policy) and eventually gets detected with a Chronic condition after 6 months of the Start date of the Policy or after 6 months of the Policy anniversary, then the benefits under Chronic Management Program will be Prorated to such effect as specified in the Policy Schedule or Endorsement Schedule.
(v) In case a member is detected with a Chronic condition before the Start date of the Policy, then the member can only buy a Individual policy type, such member is not eligible for a floater policy.

(s) HealthReturns™

Ways of Earning HealthReturns™

1. Earned by way of a percentage of Premium through Healthy Heart Score™ and Active Dayz™ (Available for Platinum Plan only)

An Insured Person can earn HealthReturns™ by looking after his/her health, complying with Chronic Management Program (if applicable) and being physically active on a regular basis.

Step 1 – Complete Health questionnaire & Health Assessment™ (applicable for each individual Insured Person)- This is not applicable for individuals that have undergone pre-Policy medical examination before issuance of the Policy, for the first Policy Year.

(i) Complete the online health questionnaire through Our website or mobile application. If requested We would assist the Insured Person in completing the questionnaire over a call.
(ii) Undergo a Health Assessment™ that measures MER including BP, BMI, HWR and smoking status, Fasting Blood Sugar and Total Cholesterol. This is listed as a part of 'Health Check up Program' under Section B(II)(n), charges for which are borne by Us once a Policy Year.

Health Assessment ™ can be undertaken at Our Network Providers. An appointment for the medical examination can be scheduled at a time convenient to the Insured Person by calling Our call centre.

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

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

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

Charges for Health Assessment ™ as a part of 'Health Check up program' are borne by Us once a Policy Year. In case the Insured Person wants to undergo another Health Assessment™ at Our Network Providers, he/she can do so by payment of requisite charges at the Network Providers.

Conditions

For Healthy Heart Score™ to be calculated Health Assessment™ needs to be carried out each Policy Year.

Step 2 – Comply with Chronic Management program

If the Insured Person has been advised to follow specific treatments as part of the Chronic Management Program, then the Insured Person shall receive the monthly HealthReturns™ benefit, as long as the treatment protocols for that month specified by Us are complied with.

Step 3 – Earn Active Dayz™ by being physically active on an ongoing basis

(i) Active Dayz™ encourages and recognises all types of exercise/fitness activities by making use of activity tracking apps, devices and visits to the Fitness centre or yoga centres to track and record the activities members engage in.
(ii) One Active Dayz™ can be earned by:
  (1) completing a Fitness centre or yoga centre activity for a minimum of 30 minutes at Our panel of Fitness or yoga centers, OR;
  (2) Recording 10,000 steps in a day (tracked through Our mobile application or a wearable device linked to the Policy number) OR;
  (3) burning 300 calories in one exercise session per day OR;
  (4) participation in a recognized marathon/ walkathon/ cyclothon or a similar activity which offers a completion certificate with timing
(iii) In order to make it easier for the Insured Person to earn HealthReturns™, We provide two fitness assessments per Policy Year. These fitness assessments will measure the Insured Person's cardiovascular endurance, flexibility, strength, height to weight ratio and body fat percentage.
  The Insured Person will receive fitness assessment results based on his/her measurements.
(iv) The fitness assessment results will be valid for six months and the best of the fitness assessment result and number of Active Dayz™ will be used in a given month to calculate HealthReturns™.

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

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

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

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

How it works for a Family floater Policy
In case of a family floater policy, each Insured Person would be tracked separately and shall earn HealthReturns™ based on individual performance as per grid of Healthy Heart Score™ and Active dayz™. For the purpose of calculating HealthReturns™, We will allocate the overall premium to the adults in the Policy. The allocation ratio shall be 2:1 for Parents and Other Adults under the Policy. Weightages for allowed family combinations are as described in the table below.
(Family floater policy can cover maximum up to 6 Adults and 3 Children, however, dependent children upto 25 years are not eligible for HealthReturns™).

Family size	Weightage
Self , Spouse and Dependent Children (upto 25 yrs)	1:1:0:0
Self and Spouse	1:1
Self , Spouse and Parents	1:1:2:2
Self , Spouse and parents and Parents in –law	1:1:2:2:2:2

2. **Earned by way of Benefit for Hospital Room Choice (as per Section B(I)(I)).**
If the Insured Person chooses to avail admission in a Hospital room category that is lower than the eligible room category for that Insured Person then, We will apply allocated a percentage of the payable claims amounts into the HealthReturns™ account for the Insured Person

For Gold Plan - Total HealthReturns™ in a Policy Year shall be total of
- Benefit for Hospital Room Choice

For Platinum Plan - Total HealthReturns™ in a Policy Year shall be total of
- Percentage of Premium earned through Healthy Heart Score and Active Dayz™
- Benefit for Hospital Room Choice

Earned HealthReturns™ can be utilized by any covered member under a Policy.

How can one spend HealthReturns™:
Funds under HealthReturns™ may be utilized for:
(i) In-patient Medical Expenses and Day Care Treatment, provided that the Sum Insured, Cumulative Bonus and Reloaded Sum Insured (if applicable) are exhausted during the Policy Year.
(ii) Payment of Co-payment and Deductible (wherever applicable).
(iii) For non payable claims, in case of an In-patient Hospitalization or Day Care Treatment.
(iv) Non-Medical expenses under listed in Annexure I 'Non Medical Expenses' that would not otherwise be payable under the Policy.
(v) Out-patient expenses up to the value of accrued funds, subject to complete utilization of OPD Expenses (if opted under the Policy).
(vi) Alternative Treatments.

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

Alternatively funds can also be utilized to pay premium from 1st Renewal of the Policy.
Funds earned as HealthReturns™, once earned can be carried forward each month/ each Policy Year (as applicable) and as long as the Policy is Renewed with Us in accordance with the Renewal Terms under the Policy.

Permanent Exclusions and Waiting Periods do not apply under this Benefit.
Please refer to Annexure II: Illustration of Benefits, Section A for details on this benefit.
If You wish to know the present value of the funds earned as HealthReturns™, then You may contact Us at our toll free number or through Our website. In any event, We shall send You an updated statement of the funds earned as HealthReturns™ on an Yearly basis or any other notifications/communication required to be sent hereunder on your registered email ID.

(t) Wellness Coach:
What is covered
In order to educate, empower and engage Insured Persons to become more aware of their health and proactively manage it, each Insured Person shall have access to wellness coaching in areas such as:
(i) Weight management
(ii) Activity and fitness
(iii) Nutrition
(iv) Tobacco cessation
These coaches will be available as a chat service on Our mobile application and website or as a call back service.

It is agreed and understood that Our Wellness coaches are not providing and shall not be deemed to be providing any Medical Advice, they shall only provide a suggestion for the Insured Person's consideration and it is the Insured Person's sole and absolute choice to follow the suggestion for any health related advice.

(v) Doctor on call
Upon the Insured Person's request, We shall also provide access to a general Medical Practitioner, available as a chat service on Our mobile application and website or as a call back service.

We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this benefit.

Section IV: Optional Covers

The Benefits listed below are optional additional benefits and shall be available to the Insured Person only if the additional premium has been received and the Benefit is specified to be in force for that Insured Person in the Policy Schedule. Benefits under this Section are subject to the terms, conditions and exclusions of this Policy and in accordance with the applicable Plan as specified in the Policy Schedule.

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

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

Claims under this Section IV will not impact the Sum Insured unless specified otherwise in the Policy.

(u) OPD Expenses

What is covered

We will cover costs incurred for medically necessary consultations, diagnostic tests and pharmacy expenses on an out-patient basis upto the amount specified in the Table of Benefits and Policy Schedule. Appointments can be scheduled through Our website or the mobile application; You can also call Our contact center toll free number specified in the Policy Schedule for scheduling an appointment.

We will cover the following expenses:

(i) Outpatient consultations by a general Medical Practitioner/ specialist Medical Practitioner where for every consultation, We will cover up to a maximum of 10% of the limit specified in the Table of Benefits and Policy Schedule for OPD Expenses.
(ii) Out-patient diagnostic tests and/or medicines purchased from a pharmacy as – prescribed by a general Medical Practitioner/ specialist Medical Practitioner in writing up to a maximum of 50% of the limit specified in the Table of Benefits and Policy Schedule for OPD Expenses.
(iii) Outpatient diagnostic procedures in case of road traffic Accident as prescribed by a General Medical Practitioner/ Specialist Medical Practitioner in writing to a maximum of Rs.10,000 over and above the OPD Limit as specified in the Table of Benefits and Policy Schedule

These services can be availed at Our Network Providers and empanelled service providers (such as Outpatient clinics or Physicians / Diagnostic centres / Pharmacy Stores) on a Cashless basis.
Reimbursement claims can be submitted quarterly in a Policy year.

If in a Policy Year an Insured Person does not utilize the complete limit under OPD Expenses, then the unutilized amount will be carried forward to the subsequent Policy Year, if the Policy has been Renewed with Us continuously without any break and shall be available for utilization within 12 months of such carry forward only. However, such carry forward is not applicable for unutilized limit for Road Traffic Accident Diagnostic as specified in the Table of Benefits and Policy Schedule

OPD Bonus on Unutilized OPD Expenses

We will add a OPD Bonus of 5% to the unutilized OPD Expenses at the end of the Policy Year, if OPD Expenses have not been utilized completely by the Insured Person in the expiring Policy Year, provided that:

(i) This OPD Bonus will apply even if claims under other Benefits have been made under the Policy;
(ii) This OPD Bonus will be calculated based on the unutilised OPD Expenses, irrespective of any change in the Sum Insured or OPD Expenses opted in.
(iii) This OPD Bonus on the unutilized OPD Expenses limit shall not apply in case the Policy is not renewed within the Grace Period.
(iv) This OPD Bonus is not applicable on unutilized limit for Road Traffic Accident Diagnostic

Unutilized OPD Expenses along with earned OPD Bonus shall be carried forward to the subsequent Policy Year, if the Policy has been is Renewed with Us continuously without any break and shall be available for utilization within 12 months of such carry forward only. Unutilized OPD Expenses along with earned OPD Bonus shall not be carried forward, if the Policy has not been Renewed with Us continuously without any break.

Permanent exclusions and waiting periods do not apply in respect of this Benefit.

Conditions

Benefits under this Section shall be available on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule for an Individual Policy and Family Floater Policies. The limit for OPD Expenses for each Insured Person(s) covered under this Policy shall remain the same in case of a family floater policy.

(v) Deductible

What is covered

The Deductible specified in the Policy Schedule shall be applicable in each Policy Year on the aggregate of all admissible claims in that Policy Year.
Wherever a Deductible option is selected, such deductible amount will be applied on each Policy Year on the aggregate of all admissible claims in that Policy Year.

Conditions

(i) The Deductible shall not apply on claims under Section B(II), B(III), and B(IV).
(ii) The applicable Deductible shall be applied separately and on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule for an Individual Policy and shall be available on a floater basis for all eligible Insured Persons up to the limits specified in the Policy Schedule for Family Floater Policies.

(w) Maternity Expenses

i. Maternity Expenses:

What is covered

Where Maternity Expenses is opted as an Optional Cover under this Policy, We will cover Maternity Expenses up to the Maternity Sum Insured specified in the Policy Schedule after a waiting period of 48 months from the inception of the 1st Policy where Maternity Expenses option is selected, if Renewed with Us continuously without any break and Maternity Expenses has been opted continuously as an Optional Cover under this Policy, for the delivery of a child and/ or Maternity Expenses related to a Medically Necessary Treatment and lawful medical termination of pregnancy up to a maximum of 2 events including (a) 2 deliveries (including twins) or (b) 2 terminations or (c) 1 delivery (including twins) and 1 termination during the lifetime of an Insured Person between the Ages of 18 years to 45 years where the mother is the Insured Person.

Coverage under this Benefit shall include:

(i) Medical Expenses for a delivery of a child (including caesarean section) or lawful medical termination of pregnancy
(ii) Pre or post natal Maternity Expenses;
(iii) Any claim under this benefit shall not impact the Opted Sum Insured or Cumulative Bonus.
(iv) Ectopic pregnancy shall not be covered under this Benefit, but any claims will be considered under In-patient Treatment under Section B(I)(a);

Conditions

- This benefit is available for You or Your spouse provided You and Your spouse, both are covered under the same Policy for a continues period of 48 months.
- Our maximum liability per pregnancy will be subject to the limits specified in the policy Schedule.

What is not covered

(i) Medical expenses for ectopic pregnancy. However, these expenses will be covered under In-patient Treatment under Section B(I)(a);.
(ii) Any Pre-hospitalization Medical Expenses or Post – hospitalization Medical Expenses under Section B(I)(b) and (c), above will not be covered under this Benefit,
(iii) Any Reloaded Sum Insured will not be available for coverage under this Benefit.

Note: Section C(A) (Permanent Exclusion 32), is not applicable if this Benefit is in force.

ii. New Born Baby Expenses

What is covered

We cover Medical Expenses towards the treatment of the New Born Baby as an In-patient, up to the limit of the Maternity Sum Insured, while

the Insured Person is Hospitalised as an in-patient for delivery, subject to a valid claim being accepted under Maternity Expenses.

(i) This would include in-patient hospitalisation expenses incurred on the New Born Baby while the Insured Person is Hospitalised as an in-patient for delivery.

(ii) Charges incurred on the New Born Baby during and post birth up to 90 days from the date of delivery, within the limits of Maternity Expenses.

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

Conditions

Any Reloaded Sum Insured will not be available for coverage under this Benefit

Maternity Expenses means:

a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

b) expenses towards lawful medical termination of pregnancy during the policy period.

New Born Baby means baby born during the Policy Period and is aged upto 90 days.

iii. Vaccination Expenses

What is covered

We will cover vaccination expenses listed below of a New Born Baby from birth to until the New Born Baby completes two years.

	Name of Vaccine	Time to be given
1	Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed	6wks, 10wks, 14wks; 16-18months;
2	Varicella Vaccine, live attenuated	15months,
3	Human Rotavirus Vaccine, Live Attenuated	6wks, 10wks, 14wks
4	Combined Measles, Mumps, and Rubella Vaccine (live attenuated)	9months, 15months,
5	BCG Vaccines	At Birth,
6	OPV	At Birth, 6months, 9months
7	Hepatitis B	At Birth, 6wks, 6months.
8	Haemophilus influenzae type b Vaccine (Hib)	6wks, 10wks, 14wks; 16-18months
9	Inactivated Hepatitis A virus Vaccine	12months, 18months.
10	Pneumococcal Polysaccharide and Non-Typeable Haemophilus influenzae (NTHi) Protein D Conjugate Vaccine, Adsorbed	14wks, 15months
11	Typhoid	9-12months, 18-2yrs.
12	IPV	6wks, 10wks, 14wks,

Conditions

i. Coverage will be subject to claims admitted under Maternity Expenses cover and will be up to the limits of Maternity Sum Insured.

ii. Vaccination expenses will be covered only if the Insured Person whose maternity claim has been accepted by Us continues to Renew the Policy with Us during the period. Reimbursement claims for vaccination expenses can be submitted quarterly in a Policy Year.

iii. Section C (A) (Permanent Exclusion 20), is not applicable if this Benefit is in force.

iv. Benefits under this Section shall be available separately and on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule for an Individual Policy and shall be available on a floater basis for all eligible Insured Persons up to the limits specified in the Policy Schedule for Family Floater Policies.

iv. Stem cell preservation

What is covered

We will cover onetime Medical Expenses up to the limit specified in the Policy Schedule towards the harvesting and storage of stem cells of the New Born Baby.

Conditions

i. The harvesting and storage of the stem cells of the New Born Baby is carried out as a preventive measure against possible future Illnesses.

ii. The stem cells of the New Born Baby are preserved in an India based Stem Cell Bank only.

iii. The payment under this Benefit is subject to a valid claim being accepted by Us under Maternity Expenses under section B(IV)(w)(I).

iv. The coverage under this Benefit will be over and above the Maternity Expenses limit, and up to the limits specified in the Policy Schedule and Table of Benefits.

v. We shall be covering stem cell preservation for a maximum upto 2 New Born Baby(s) during the lifetime of an Insured Person.

(x) Hospital Cash Benefit

What is covered

We will pay the Hospital Cash Benefit specified in the Policy Schedule, for each continuous and completed period of 24 hours of Hospitalisation, during the Policy Period for treatment of an Illness or Injury.

This Benefit shall be payable for a maximum limit of 30 days in a Policy Year and 10 days for each claim.

Conditions

(i) A deductible of 24 hours shall apply under this Benefit, thus the benefits shall become payable only after the completion of the first 24 hours of Hospitalization of the Insured Person.

(ii) Benefits under this Section shall be available on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule irrespective of the type of Policy.

(iii) Claim under this Benefit shall be payable only if in-patient claim has been settled by Us under this Policy under Section B(I)(a).

Please refer to the Annexure II 'Illustration of Benefits' for details on Hospital Cash Benefit.

(y) Waiver of Mandatory Co-payment (Applicable for Essential Plan only)

What is covered

If this Benefit is in force, the applicable Mandatory Co-payment under Essential Plan shall not apply on payable claims under the Policy.

Section C. Terms and Conditions

A. Waiting periods and Permanent Exclusions

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

i 30-day waiting period (Code- Excl03)

(i) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

(ii) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

(iii) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

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

(i) 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.
(ii) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
(iii) 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.
(iv) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
(v) 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.
(vi) List of specific diseases/procedures:

	Body System	**Illness**	**Treatment/ Surgery**
1	Eye	Cataract	Cataract Surgery
		Glaucoma	Glaucoma Surgery
2	Ear Nose Throat	Serous Otitis Media	
		Sinusitis	Sinus Surgery
		Rhinitis	Surgery for the nose
		Tonsillitis	Tonsillectomy
		Tympanitis	Tympanoplasty
		Deviated Nasal Septum	Surgery for Deviated Nasal Septum
		Otitis Media	Surgery or Treatment for Otitis Media
		Adenoiditis	Adenoidectomy
		Mastoiditis	Mastoidectomy
		Cholesteatoma	Resection of the Nasal Concha
3	Gynecology	All Cysts & Polyps of the female genito urinary system	Dilatation & Curettage
		Polycystic Ovarian Disease	Myomectomy
		Uterine Prolapse	Uterine prolapsed Surgery
		Fibroids (Fibromyoma)	Hysterectomy unless necessitated by malignancy
		Breast lumps	Any treatment for Menorrhagia
		Prolapse of the uterus	
		Dysfunctional Uterine Bleeding (DUB)	
		Endometriosis	
		Menorrhagia	
		Pelvic Inflammatory Disease	
4	Orthopedic / Rheumatological	Gout	Joint replacement Surgery Surgery for Prolapse of the intervertebral disc
		Rheumatism, Rheumatoid Arthritis	
		Non infective arthritis	
		Osteoarthritis	
		Osteoporosis	
		Prolapse of the intervertebral disc	
		Spondylopathies	
5	Gastroenterology (Alimentary Canal and related Organs)	Stone in Gall Bladder and Bile duct	Cholestectomy / Surgery for Gall Bladder
		Cholecystitis	Surgery for Ulcers (Gastric / Duodenal)
		Pancreatitis	
		Fissure, Fistula in ano, hemorrhoids (piles), Pilonidal Sinus, Ano-rectal & Perianal Abscess	
		Rectal Prolapse	
		Gastric or Duodenal Erosions or Ulcers + Gastritis & Duodenitis	
		Gastro Esophageal Reflux Disease (GERD)	
		Cirrhosis	
6	Urogenital (Urinary and Reproductive system	Stones in Urinary system (Stone in the Kidney, Ureter, Urinary Bladder)	Prostate Surgery
		Benign Hypertrophy / Enlargement of Prostate (BHP / BEP)	
		Hernia, Hydrocele,	Surgery for Hydrocele, Rectocele and Hernia
		Varicocoele / Spermatocoele	Surgery for Varicocoele / Spermatocoele

7	Skin	Skin tumour (unless malignant)	Removal of such tumour unless malignant
		All skin diseases	
8	General Surgery	Any swelling, tumour, cyst, nodule, ulcer, polyp anywhere in the body (unless malignant)	Surgery for cyst, tumour, nodule, polyp unless malignant
		Varicose veins, Varicose ulcers	Surgery for Varicose veins and Varicose ulcers
		Congenital Internal Diseases or Anomalies	

If any of the Illness/conditions listed above are Pre-Existing Diseases, then they will be covered only after the completion of the Pre-Existing Disease Waiting Period described below.

iii. Chronic Management Program Waiting Period

a. Where the Insured Person has under gone a Health Assessment™ (undergone within 3 months from the Policy Start date) and the results of the Health Assessment™ indicate that the Insured Person is suffering from a chronic condition, then a waiting Period of 24 months shall be applicable from the Start date of the Policy in respect of the Insured Person for Chronic Management Program. However Hospitalization related to these conditions will be covered after a Waiting Period as specified in section C(A) (i)

b. If the results of the Health Assessment™ indicate that the Insured Person does not have any of the aforementioned conditions, then the Insured Person will be entitled to avail the benefits under Chronic Management Program, if the Insured Person develops any such conditions later in life, without any waiting period. However Hospitalization related to these conditions will be covered after a Waiting Period as specified in section C(A) (i)

c. In case the Insured Person doesn't undergo a Health Assessment™ within 3 months from the Policy Start date, then a Waiting Period as applicable under the Plan in force is applicable in respect of the Insured Person for Chronic Management Program. However Hospitalization related to these conditions will be covered after a Waiting Period as specified in section C(A) (i)

d. Where the Insured Person has undergone a pre-Policy medical examination and is found to be suffering from a covered chronic condition under the policy, Chronic Management Program shall be available from day 1 for such condition(s). However Hospitalization related to these conditions will be covered after a Waiting Period of 90 days.

iv. Pre-Existing Diseases (Code- Excl01)

i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the number of months of continuous coverage after the date of inception of the first policy with Us, as specified in the Policy Schedule / Certificate of Insurance / Table of Benefit of this Policy.

ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

iii. 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.

iv. Coverage under the policy after the expiry of months specified in Policy schedule / Table of Benefit of this Policy for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

Pre-Existing Disease (PED) means any condition, ailment, injury or disease:

a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement

or

b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

v. Maternity Waiting Period

Any treatment arising from or traceable to pregnancy, childbirth including caesarean section will not be covered until 48 months of continuous coverage has elapsed for that particular Insured Person since the inception of the Maternity Expenses Benefit under the Policy for that Insured Person.

vi. Permanent Exclusions:

1. Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, uprising, revolution, insurrection, military or usurped acts, nuclear weapons / materials, chemical and biological weapons, ionizing radiation, contamination by radioactive material or radiation of any kind, nuclear fuel, nuclear waste.
2. 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.
3. Willful or deliberate exposure to danger, intentional self Injury, , participation or involvement in naval, military or air force operation.
4. 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.
5. Any Illness/Injury/Accident due to abuse of intoxicants, smoking cessation programs and the treatment of nicotine addiction, unless prescribed by a Medical Practitioner.
6. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code- Excl12)
7. 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
8. Refractive Error:(Code- Excl15) - Expenses related to the treatment for correction of eye sight due to refractive error less than 7 .5 dioptres.
9. All routine examinations and preventive health check-ups.
10. 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.
11. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment);
12. 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.

13. Non allopathic treatment.
14. Conditions for which treatment could have been done on an outpatient basis without any Hospitalization.
15. Experimental, investigational devices and pharmacological regimens.
16. Unproven Treatments:(Code- Excl16)
    Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
17. 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.
18. 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.
19. Convalescence, cure, sanatorium treatment, private duty nursing, long-term nursing care or custodial care.
20. Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing.
21. Admission for nutritional and electrolyte supplements unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
22. Hearing aids, spectacles or contact lenses including optometric therapy, multifocal lens.
23. Treatment for alopecia, baldness, wigs, or toupees, and all treatment related to the same.
24. Medical supplies including elastic stockings, diabetic test strips, and similar products.
25. Any expenses incurred on prosthesis, corrective devices external durable medical equipment of any kind, like wheelchairs crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively. Cost of artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intraoperatively)
26. Parkinson and Alzheimer's disease, general debility or exhaustion ("rundown condition"), sleep-apnea, stress.
27. Congenital external diseases, defects or anomalies.
28. Stem cell therapy (except Hematopoietic stem cells for bone marrow transplant for haematological conditions) or related Surgery, or growth hormone therapy.
29. Venereal disease, all sexually transmitted disease or Illness including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
30. "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus) including but not limited to conditions related to or arising out of HIV/AIDS such as ARC (AIDS Related Complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis.
31. Maternity Expenses (Code - Excl18):
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
    ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
32. 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
33. Expenses for organ donor screening, or save as and to the extent provided for in the treatment of the donor (including Surgery to remove organs from a donor in the case of transplant Surgery).
34. Admission for Organ Transplant but not compliant under the Transplantation of Human Organs Act, 1994 (amended)
35. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.
36. Dentures and artificial teeth, Dental Treatment and Surgery of any kind, unless requiring Hospitalization due to an Accident.
37. Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose.
38. Treatment such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.
39. Expenses which are medically not necessary such as items of personal comfort and convenience including but not limited to television (if specifically charged), charges for access to telephone and telephone calls (if specifically charged), food stuffs (save for patient's diet), cosmetics, hygiene articles, body care products and bath additives, barber expenses, beauty service, guest service as well as similar incidental services and supplies, vitamins and tonics unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
40. Treatment taken from a person not falling within the scope of definition of Medical Practitioner.
41. Treatment charges or fees charged by any Medical Practitioner acting outside the scope of license or registration granted to him by any medical council.
42. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, except if pre-approved by Us.
43. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.
44. 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).
45. Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing, including MRD charges (medical records department charges).
46. Non-Medical Expenses including but not limited to RMO charges, surcharges, night charges, service charges levied by the Hospital under any head and as specified in the Annexure for Non- Medical Expenses.
47. Treatment taken outside India
48. Excluded Providers: (Code- Excl11)
    Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer as per Annexure V of this policy and as disclosed in website (https://www.adityabirlacapital.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
49. 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).
50. In respect of the existing diseases, disclosed by the Insured Person and mentioned in the Policy Schedule (based on Insured Person's consent), Policyholder is not entitled to get the coverage for specified ICD codes.

B. Underwriting and Loadings

i. We may apply a risk loading on the premium payable (excluding statutory levies and taxes) based on the details of the Insured Persons, including the health status, habits and lifestyle, past medical records, declarations on the Proposal Form and the results of the pre-Policy medical examination.
ii. The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis or medical condition per Insured Person. Loadings will be applied from Start date of the first Policy including subsequent Renewal. There will be no loadings based on individual claims experience.
iii. We will inform You about the applicable risk loading or special condition 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.
v. Following loadings may be applied on the Policy for the medical conditions listed below if they are accepted at the time of underwriting as well as on Renewals.

Conditions/ Ailments	Amount
Iron Deficiency Anemia (in absence of Heart complications)	0 to 10%
Smoking	0 to 15%
Benign Prostatic Hyperplasia (BPH)	0 to 10%
Stone/Calculus in the urinary system (including kidney stone, ureteric stone or urinary bladder stone)	0 to 20%
Stones in the gall bladder	0 to 20%
Stones in the biliary system	0 to 20%
Hernia of all types	0 to 20%
Acid peptic disease / Peptic ulcer Disease	0 to 10%
Gastro Esophageal Reflux Disease (GERD)/Reflux esophagitis	0 to 10%
Cataract (not operated)	0 to 15%
Deviated Nasal Septum, Nasal Polyps	0 to 20%
Epilepsy	0 to 15%
Anal fissure	0 to 15%
Fistula-in-ano	0 to 15%
Hemorrhoids (Piles)	0 to 20%
Hydrocele	0 to 20%
Fibroadenoma Breast (non cancerous)	0 to 20%
Fibroids (Uterus)	0 to 15%
Ovarian Cysts	0 to 15%
Poliomyelitis	0 to 5%
Tuberculosis	0 to 15%
Perforated tympanic membrane	0 to 15%
Varicose Veins	0 to 15%
Hyperthyroidism (in absence of heart complications and thyrotoxic crisis)	0 to 15%
Hypothyroidism (in absence of heart complications and Myxoedema)	0 to 15%
Hyperlipidemia (Total Cholesterol > 250 but up to 300 mg/dl)*	0 to 10%
Hyperlipidemia (Serum Trigylcerides > 200 but up to 500 mg/dl)*	0 to 10%
Total Cholesterol > 300 mg/dl (applicable for Gold plan only)	0 to 15%
Serum Triglycerides > 500 mg/dl (applicable for Gold plan only)	0 to 15%
Diabetes Mellitus (applicable for Gold plan only)	0 to 20%
Hypertension (applicable for Gold plan only)	0 to 20%
Asthma (applicable for Gold plan only)	0 to 15%

Note:
a. If the Total Cholesterol is higher than 300 mg/dl, the prospect will be offered a Chronic Management Program for Hyperlipidemia
b. If Serum Triglycerides is higher than 500 mg/dl, the prospect will be offered a Chronic Management Program for Hyperlipidemia
c. If the above two conditions co-exist, the Insured Person will be offered a Chronic Management Program for Hyperlipidemia

C. Claims Administration & Process

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

(1) On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed.
(2) The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payments that are brought about or contributed to as a consequence of or failure to follow such directions, advice or guidance.
(3) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalisation records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
(4) We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

I. Claims Procedure

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

a. For Availing Cashless Facility

i. Cashless Facilities can be availed only at Our Network Providers. 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) 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

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

II. Claims Documentation:

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

(i) Claims for Pre-hospitalisation Medical Expenses and Post Hosptialisation Medical Expenses to be submitted to us within 30 days of the completion of the post hospitalisation 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 completed Claim Form
(2) Photo ID & Age Proof
(3) Original Discharge Card / Day Care Summary / Transfer Summary
(4) Original final Hospital Bill with all original Deposit & Final Payment Receipt
(5) 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.

(6) Treating Medical Practitioner letter stating:
   a) Presenting complaints with duration & past history
   b) Medical history of Co-morbidities e.g. Hypertension, Heart ailment etc.
   c) Treatment detail with name of drugs & route of administration
(7) All previous consultation papers indicating history & treatment details for current ailment
(8) All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription & invoice / bill with receipt from diagnostic center
(9) All Original Medicine / Pharmacy Bills along with Medical Practitioner's prescription
(10) MLC / FIR Copy – in Accidental Cases Only
(11) Copy of Death Summary & Copy Death Certificate (in Death Claims Only)
(12) Treating Medical Practitioner letter stating – in Accidental Cases Only
   a) Details of Accident/trauma
   b) whether patient was under the influence of alcohol or any intoxicating substance during incident / Accident
(13) Pre & 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, & patient's progress
(15) KYC documents

Additional documents in case of below covers

In case of Contribution claims:

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

OPD Expenses:

(i) Doctor Consultation
   (1) Duly filled claim form
   (2) Original prescription from treating general Medical Practitioner / specialist Medical Practitioner
   (3) Original invoice and payment receipt
(ii) Diagnostics
   (1) Duly filled claim form
   (2) Original investigation report(s)
   (3) Original invoice and payment receipt
   (4) Medical Practitioner's advice for such investigation / diagnostic test
   (5) Copy of Police Report in case of Road Traffic Accident
(iii) Pharmacy
   (1) Duly filled claim form
   (2) Original invoice and payment receipt
   (3) Copy of prescription from treating Medical Practitioner

Road Ambulance Cover:

(i) Photocopy of discharge card
(ii) Original Ambulance invoice & paid receipt

Hospital Cash Benefit & Recovery Benefit

(i) Photocopy of all the Hospitalization documents:-Discharge card, indoor case papers will be sought depending upon the requirement to ascertain the genuineness of claim
(ii) Any other document as per the check list for Hospitalization / In patient claims in order to ascertain the genuineness of claim

Vaccination Cover:

(i) Duly filled & signed claim form
(ii) Original Prescription from treating Medical Practitioner
(iii) Original Invoice for Vaccination and payment receipt

Stem cell preservation benefit

(i) Copy of stem cell banking receipt
(ii) Procedure note / confirmation of successful preservation of stem cells

III. 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) We shall settle or repudiate a claim within 30 days of the receipt of the last necessary information and documentation set out above. In case of any suspected fraud, the last "necessary" document will include the receipt of the investigation report from Our investigator/representatives.
(d) 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.
(e) In case of delay in payment, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us.
   For details on the claims process or assistance during the process, You may contact Us at Our call centre on the toll free number specified in the Policy Schedule or through the website. In addition, We will keep You informed of the claim status and explain requirement of documents. Such means of communication shall include but not be limited to mediums such as letters, email, SMS messages, and information on Our Website.

D. Portability & Continuity Benefits

The Insured Person will have the option to port an Indian individual retail health insurance policy (including this Policy) to any other Indian General/Health Insurer offering indemnity health insurance policies as per extant guidelines related to portability, "Guidelines on Migration and Portability of health insurance policies" of 1 January 2020, as may be amended from time to time ("Migration and Portability Guidelines"), by applying to such Indian 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 renewal date/premium due date of his/her existing Policy, as per the Migration and Portability Guidelines. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with any other Indian General/Health Insurer, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per Migration and Portability Guidelines. Portability shall be applicable to the extent of sum insured under the previous policy and the cumulative bonus, if any, acquired from the previous policies. Portability benefit shall not apply to any other additional increased Sum Insured. The waiting periods shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

Subject to the Migration and Portability Guidelines issued by the IRDAI, any application for portability to Us from another Insurer, shall be applied by Us within 15 days of receiving the Insured Person's completed application form and Portability Form subject to the following:

- The Insured Person shall give Us all additional documentation and/or information We request;
- The Insured Person shall pay Us the applicable premium in full;
- We may, subject to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be in Our sole and absolute discretion and in accordance with Our board approved underwriting policy;
- There is no obligation on Us to insure all the Insured Persons or to insure all the Insured Persons on the proposed terms, even if the Insured Person(s) have given Us all documentation;
- We have received necessary details of medical history and claim history from the previous insurance company for the Insured Person's previous health insurance policy through the IRDAI's web portal.
- No additional charges shall be applied by Us exclusively for porting the policy.

We reserve the right to modify or amend the terms and the applicability of the Portability benefit in accordance with the provisions of the regulations, circulars and guidelines issued by the IRDAI from time to time.

> **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

E. Migration

The Insured Person will have the option to migrate the Policy to other health insurance policies offered by Us by applying with Us to migrate the Policy along with all members of family, if any, at least 30 days before the the renewal date/premium due date of his/her existing Policy as per the Migration and Portability Guidelines, as may be amended from time to time. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by Us, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per the Migration and Portability Guidelines.

1. Any Insured Person (Individual Insured Person and all Individual Insured Person in case of family floater policy) will have the option to migrate
   a. To similar indemnity health insurance products / plans (individual or family floater policy) available with Us, or
   b. To a group health insurance policy available with Us, if the member complies with the norms relating to health insurance coverage under the concerned group insurance policy.
2. Any Insured Person, including family members covered under an indemnity based group health insurance policy with Us will have an option of migration at the time of exit from group or in the event of modification of the group policy (including the revision in the premium rates) or withdrawal of the group policy to an individual health insurance policy or a family floater policy.
3. Migration shall be applicable to the extent of sum insured under the previous policy and the cumulative bonus, if any, acquired from the previous policies,. Migration benefit shall not apply to any other additional increased Sum Insured.
4. The waiting periods shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
5. Migration may be subject to underwriting:
   a. For individual policies, if the insured person is continuously covered in the previous policy without any break for a period of four years or more, migration shall be allowed without subjecting the policyholder to any underwriting to the extent of the sum insured and benefits available in previous policy.
   b. Migration from group policies to individual policy will be subject to underwriting.
   c. Where underwriting is done, the insurance company shall convey its decision to the policyholder within 15 days.
   d. No additional charges shall be applied by Us exclusively for migrating the policy.

We reserve the right to modify or amend the terms and the applicability of the Migration benefit in accordance with the provisions of the regulations, circulars and guidelines issued by the IRDAI from time to time.

F. Free Look Period

(1) The Insured Person will be allowed a period of at least 15 days from the date of receipt of the Policy to review the terms and conditions of the Policy and to return the same if not acceptable.
Health insurance policy contracts with a term of 3 years offered over distance marketing mode shall have a free look period of 30 days from the date of receipt of the Policy.

(2) If the Insured Person has not made any claim during the free look period, the Insured Person shall be entitled to—
   (a) A refund of the premium paid less any expenses incurred by Us on medical examination of the Insured Persons and the stamp duty charges or;
   (b) where the risk has already commenced and the option of return of the policy is exercised by the Policyholder, a deduction towards the proportionate risk premium for period on cover or;
   (c) Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

(3) Free look period shall not be available on Renewals.

G. Fraudulent Claims

If any claim is found to be fraudulent, or if any false declaration is made, or if any fraudulent devices are used by You or the Insured Person or anyone acting on their behalf to obtain any Benefit under this Policy then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons. All sums paid under this Policy shall be repaid to Us by You on behalf of all Insured Persons who shall be jointly liable for such repayment.

H. 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 and if so on what terms. You must exercise the same duty to disclose those matters to Us before the Renewal, or endorsement of the contract and communicate the same to Us in the Change Request form. The policy terms and conditions will not be altered.

I. Alterations in the Policy

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

J. 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.

K. 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 Company 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.

L. Zone Classification:

Zone I: Bangalore, Gurgaon, Mumbai, Navi Mumbai, New Delhi, Thane
Zone II: Ahmedabad, Kolkata, Noida, Pune, Hyderabad, Chennai, Chandigarh, Mohali
Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II

Identification of Zone will be based on the city of the proposed Insured Persons.

(a) Persons paying Zone I premium can avail treatment all over India without any Co-payment.
(b) Persons paying Zone II premium
   i. Can avail treatment in Zone II and Zone III without any Co-payment (provided treatment is taken within eligible room category as specified in the Policy Schedule).
   ii. Availing treatment in Zone I will have to bear 10% of each and every claim (provided treatment is taken within eligible room category as specified in the Policy Schedule).
(c) Person paying Zone III premium
   i. Can avail treatment in Zone III, without any Co-payment
   ii. Availing treatment in Zone II will have to bear 15% of each and every claim (provided treatment is taken within eligible room category as specified in the Policy Schedule).
   iii. Availing treatment in Zone I will have to bear 25% of each and every claim (provided treatment is taken within eligible room category as specified in the Policy Schedule).

Note:
- Individual Policy: Your zone is based on the city mentioned in the Proposal form.
- In case of Family Floater Policy, a single Zone shall be applicable to all members covered under the Policy.
  You also have an option of selecting another Zone from the applicable Zone of any of the Insured Persons in the Policy.
- Option to select a Zone higher than that of the actual Zone is available on payment of relevant premium at the time of buying the Policy or at the time of Renewal.
- Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalisation due to an Accident.

M. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

N. 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.

O. Cancellation

In case You are not satisfied with the policy or our services, You can request for a cancellation of the policy by giving 15 days' notice in writing. Premium shall be refunded as per table below if no claim has been registered/ made under the Policy and no benefits under the Policy have been availed in full or in part and full premium has been received.

<table>
<tr><td></td><td colspan="3">Refund</td></tr>
<tr><td>In force Period-Up to</td><td>1 Year</td><td>2 Year</td><td>3 Year</td></tr>
<tr><td>1 Month</td><td>75.00%</td><td>85.00%</td><td>90.00%</td></tr>
<tr><td>3 months</td><td>50.00%</td><td>75.00%</td><td>85.00%</td></tr>
<tr><td>6 months</td><td>25.00%</td><td>60.00%</td><td>75.00%</td></tr>
<tr><td>12 months</td><td rowspan="6">NIL</td><td>50.00%</td><td>60.00%</td></tr>
<tr><td>15 months</td><td>30.00%</td><td>50.00%</td></tr>
<tr><td>18 months</td><td>20.00%</td><td>35.00%</td></tr>
<tr><td>24 months</td><td rowspan="3">NIL</td><td>30.00%</td></tr>
<tr><td>30 months</td><td>15.00%</td></tr>
<tr><td>30+ months</td><td>NIL</td></tr>
</table>

You further understand and agree that We may cancel the Policy by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material fact by You without any refund of premium. We may also cancel the Policy with refund of premium in case of non-cooperation by You.

All coverage, benefits, earning on HealthReturns™, shall automatically lapse upon cancellation of the Policy. However, any unclaimed and accrued

HealthReturns™ (from Previous Policy Year/ month) shall be available for a claim over the next 12 month period from the date of cancellation / termination.

P. Endorsements

The Policy will allow the following endorsements during the term of the Policy. Any request for endorsement must be made by You in writing. Any endorsement would be effective from the date of the request as received from You, or the date of receipt of premium, whichever is later.

(i) Non-Financial Endorsements – which do not affect the premium.
   (1) Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)
   (2) Rectification in gender of the Proposer/ Insured Person
   (3) Rectification in relationship of the Insured Person with the Proposer
   (4) Rectification of date of birth of the Insured Person (if this does not impact the premium)
   (5) Change in the correspondence address of the Proposer
   (6) Change/Updation in the contact details viz., Phone No., E-mail Id, alternate contact address of the Proposer etc.
   (7) Change in Nominee Details

(ii) Financial Endorsements – which result in alteration in premium
   (1) Addition of Insured Person (New Born Baby or newly wedded spouse)
   (2) Deletion of Insured Person on Death* or Separation or Policyholder/Insured Person leaving India
   (3) Change in Age/Date of Birth

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

Q. Grace Period

The Policy may be renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable to pay for any claim arising out of an Injury/ Accident/ Condition that occurred during the Grace Period. . The provisions of Section 64VB of the Insurance Act shall be applicable.

All policies Renewed within the Grace Period shall be eligible for continuity of cover.

R. Renewal Terms

(i) The Policy will automatically terminate at the end of the Policy Period. The Policy is ordinarily renewable on mutual consent for life, subject to realization of Renewal premium.
(ii) The premium payable on Renewal shall be paid to Us on or before the Policy Period end date and in any event before the expiry of the Grace Period. Policy would be considered as a fresh policy if there would be break of more than 30 days between the previous Policy expiry date and current Policy Start date.
(iii) We however shall not be liable for any claim arising out of an ailment suffered or Hospitalisation 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.
(iv) Any unutilised funds under HealthReturns™ (from the previous Policy year/ month) will be available for claims during the Grace Period.
(v) You shall not be able to earn HealthReturns™ during the Grace Period.
(vi) 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 12 months from the date of expiry of the Policy.
(vii) 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.
(viii) 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.
(ix) Renewals will not be denied except on grounds of misrepresentation, fraud, non-disclosure of material facts or non-co-operation by You.
(x) Where We have discontinued or withdrawn this product/plan You will have the option to renew under the nearest substitute Policy being issued by Us, however benefits payable shall be subject to the terms contained in such other Policy which has been approved by IRDAI.
(xi) 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. If an Insured Person is found to be suffering from a covered chronic condition post any waiting period (if applicable), then We shall manage such conditions under Chronic Management Program as per the terms and conditions laid out under Section B(III) (r).
(xii) We may revise the Renewal premium payable under the Policy or the terms of cover, provided that the Renewal premiums are approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premiums will not alter based on individual claims experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.
(xiii) Alterations like increase/ decrease in Sum Insured or Change in Plan/Product, addition/deletion of Insured Persons (except due to child Birth / Marriage or Death) will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the Proposal Form before the expiry of the Policy. We reserve Our right to carry out underwriting in relation to acceptance of request for changes on Renewal. The terms and conditions of the existing Policy will not be altered.
(xiv) Any enhanced Sum Insured during any Policy Renewals will not be available for an illness, disease, Injury already contracted under the preceding Policy Periods. All waiting periods as mentioned below shall apply afresh for this enhanced limit from the effective date of such enhancement.
(xv) 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.
(xvi) Where an Insured Person is added to this Policy, either by way of endorsement, all waiting periods under Section C(A) will be applicable considering such Policy Year as the first year of Policy with Us with respect to the Insured Person.
(xvii) Applicable Cumulative Bonus shall be accrued on each Renewal as per eligibility under the plan in force.
(xviii) 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. Cumulative Bonus earned on the Policy will stay with the Insured Persons(s) covered under the original Policy.

S. Communications & Notices

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

(i) The Policyholder's, at the address as specified in the Policy Schedule
(ii) To Us , at the address specified in the Schedule.
(iii) No insurance agents, brokers, other person or entity is authorised to receive any notice on the behalf of Us unless explicitly stated in writing by Us.
(iv) Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

T. Electronic Transactions

You agree to comply with all the terms and conditions of electronic transactions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as 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, in respect of this Policy including the monitoring and/or recording of your health status, HealthReturns™, health heart score, policy and/or claim related details, shall constitute legally binding when done in compliance with Our terms for such facilities.

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 You . A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated / confirmed by You.

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

V. Complete Discharge
We will not be bound to take notice or be affected by any Notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy. The payment made by Us to You/Insured Person or to Your Nominee/Legal Representative or to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete, valid and construe as an effectual discharge in favour of Us.

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

X. Redressal Procedure
In case of a grievance, You can contact Us with the details through:
Our website: https://www.adityabirlacapital.com/healthinsurance/
Toll Free : 1800 270 7000
Email: customercare.abh@adityabirlacapital.com
Address: Aditya Birla Health Insurance Co. Limited 9th Floor, Tower 1, One Indiabulls Centre, Jupiter Mills Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai 400013

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

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer.
For updated details of grievance officer, kindly refer the link https://www.adityabirlacapital.com/healthinsurance/

For senior citizens, please contact Our respective branch office or call at 1800 270 7000 or write an E-mail at seniorcitizen.abh@adityabirlacapital.com

The Insured Person/Policyholder can also walk-in and approach the grievance cell at any of Our branches. If in case the Insured Person/Policyholder is not satisfied with the response then they can contact Our Head of Customer Service at the following E-mail headcustomercare.abh@adityabirlacapital.com.

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.
The contact details of the Ombudsman offices are provided on Our website and in this Policy at Annexure III

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

Y. Assignment
The Policy and the benefits under this Policy cannot be assigned in whole or in part.

Section D. DEFINITIONS

1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Age** or **Aged** is the age as on last birthday, and which means completed years as at the Start date.
3. **Alternative Treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
4. **Any one Illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
5. **Any Room** means a room in a Hospital above a Single Private Room as defined under this Policy.
6. **Ambulance** means a motor vehicle operated by a licenced/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
7. **Annexure** means a document attached and marked as Annexure to this Policy
8. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.
9. **Contribution** is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured.
10. **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
11. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
12. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
    a. **Internal Congenital Anomaly** - Congenital anomaly which is not in the visible and accessible parts of the body.
    b. **External Congenital Anomaly** - Congenital anomaly which is in the visible and accessible parts of the body.
13. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
14. **Day Care Treatment** means medical treatment, and/or *surgical procedure* which is:
    i. undertaken under General or Local Anaesthesia in a *hospital/day care centre* in less than 24 hrs because of technological advancement, and
    ii. which would have otherwise required hospitalization of more than 24 hours.

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.
15. **Day Care Centre** - A day care centre means any institution established for day care treatment of illness and / or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under:-
    i) has qualified nursing staff under its employment;
    ii) has qualified medical practitioner/s in charge;
    iii) has fully equipped operation theatre of its own where surgical procedures are carried out;
    iv) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

16. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A Deductible does not reduce the Sum Insured.

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

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

19. **Disclosure to information norm:** 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.

20. **Domiciliary Hospitalization** means medical treatment for an *illness/disease/ injury* which in the normal course would require care and treatment at a *hospital* but is actually taken while confined at home under any of the following circumstances:
a) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
b) the patient takes treatment at home on account of non-availability of room in a hospital.

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

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

23. **Family Floater Policy** means a policy named as a Family Floater Policy in the Policy Schedule under which the family members named as Insured Persons in the Policy Schedule are covered.

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

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

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

27. **IRDAI** means the Insurance Regulatory and Development Authority of India.

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

    (a) Acute condition - Acute condition is a disease, illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery

    (b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
    1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
    2. it needs ongoing or long- term control or relief of symptoms
    3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
    4. it continues indefinitely
    5. it recurs or is likely to recur

29. **Individual Policy** means a policy named as an Individual Policy in the Policy Schedule under which one or more persons are covered as Insured Persons.

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

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

32. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

33. **Insured Person** means the person(s) named in the Policy Schedule who are covered under this Policy and in respect of whom the appropriate premium has been received.

34. **Maternity Expenses means:**
    a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
        i. expenses towards lawful medical termination of pregnancy during the policy period.

35. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow- up prescription.

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

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

38. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

39. **Migration** means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

40. **Monthly Premium shall** mean the applicable annual premium with respect to the Insured Person(s) split in 12 months in equal proportion only for the purpose of calculation of Benefit(s) under this Policy.

41. **New Born Baby** means baby born during the Policy Period and is aged upto 90 days.

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

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

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

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

46. **Policy** means this Terms & Conditions document, the Proposal Form, Policy Schedule, Add-On Benefit Details (if applicable) and Annexures which form part of the Policy contract including endorsements, as amended from time to time which form part of the Policy contract and shall be read together.

47. **Policy Period** means the period between the Start date and the expiry date of the Policy as specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.

48. **Policy Year** means a period of 12 consecutive months commencing from the Start date or any anniversary.

49. **Policy Schedule** means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

50. **Pre-Existing Disease (PED)** means any condition, ailment, injury or disease:
    a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
    b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

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

52. **Post-hospitalization Medical Expenses** means medical expenses
incurred during pre-defined number of days immediately after the insured person is discharged from the hospital, provided that
    i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and
    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

53. **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

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

55. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

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

57. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated Medical Expenses.

58. **Single Private Room** means a basic (cheapest) category of Single room in a Hospital with/without air-conditioning facility where a single patient is accommodated and which has an attached toilet (lavatory and bath).

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

60. **General Ward Or Economy Ward** means a cheapest category Hospital Room in a Hospital with more than three patient beds.

61. **Start date of the Policy** means the inception date of the current Policy Period as specified in the Policy Schedule.

62. **Sum Insured means:**
    i) For an Individual Policy, the amount specified in the Policy Schedule against an Insured Person which is Our maximum, total and cumulative liability for any and all claims arising during a Policy Year in respect of that Insured Person.
    ii) For a Family Floater Policy, the amount specified in the Policy Schedule which is Our maximum, total and cumulative liability for any and all claims arising during a Policy Year in respect of any and all Insured Persons.

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

64. **Third Party Administrator (TPA)** means a Company registered with the IRDAI, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services. The updated list of TPAs (along with complete address and contact numbers) shall be available on Our website.

65. **Unproven/Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

66. **We/Our/Us** means Aditya Birla Health Insurance Company Limited.

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

Aditya Birla Health Insurance Co. Limited. IRDAI Reg.153. CIN No. U66000MH2015PLC263677.
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