POLICY WORDING – GROUP ASSURANCE HEALTH PLAN

Apollo Munich Health Insurance Company Limited will cover all the Insured Persons under this Policy upto the **Sum Insured**. The insurance cover is governed by, and subject to, the terms, conditions and exclusions of this Policy.

Section. 1. Inpatient Benefit

This section of benefits is applicable when

- An Insured Person suffers an Accident or Illness, which is covered under this Policy; AND
- Hospitalisation is necessary & is done for treatment OR
- Day care treatment is necessary and is done OR
- Domiciliary Hospitalization is necessary and is done for treatment

We will cover the Medical Expenses for:	**We will not cover treatment, costs or expenses for*:** *The following exclusions apply in addition to the waiting periods and general exclusions specified in Section 2.
a. **In-patient Treatment.** This includes • Hospital room rent or boarding • Nursing; • Intensive Care Unit • Medical Practitioners (Fees) • Anesthesia • Blood • Oxygen • Operation theatre • Surgical appliances; • Medicines, drugs & consumables; • Diagnostic procedures.	Any hospitalisation or treatment which is not **Medically necessary**
b. **Pre-Hospitalisation** Medical Expenses for consultations, investigations and medicines incurred upto 30 days before the date of admission to the Hospital This is applicable for both In patient and Day Care treatment.	i) Claims which have NOT been admitted under 1 a) ,1d) or 1 e) ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
c. **Post-Hospitalisation** Medical Expenses for consultations, investigations and medicines incurred upto 60 days after discharge from the Hospital. This is applicable both for In patient and Day Care treatment.	i) Claims which have NOT been admitted under 1 a) ,1 d) or 1e) ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.
d. **Day Care Treatment :** Medical treatment or surgical procedure which is undertaken under general or local anaesthesia, which require	i) Treatment that can be and is usually taken on an out-patient basis is not covered.

Important terms You should know

Sum Insured means the sum shown in the Schedule/Certificate of Insurance which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.

Inpatient care means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.

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 its scope and jurisdiction of license.

Important terms You should know

Day Care Treatment means medical treatment, and/or *surgical procedure listed in Annexure 1* which is:

i. undertaken under General or Local

admission in a Hospital/Day Care Centre for stay less than 24 hours because of technological advancement. Treatment normally taken on out-patient basis is not included in the scope of this definition. Refer to Annexure 1 for complete list of Day Care Treatments/Procedures	ii) Treatment NOT taken at a Hospital or a Day Care centre.
e. **Domiciliary Hospitalisation:** 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 Pre Hospitalisation expenses for consultations, investigations and medicines incurred upto 30 days before hospitalisation	i) Treatment of less than 3 days. ii) Expenses for treatment for first three days only will be covered if treatment period is greater than 3 days iii)
f. **Organ Donor:** Medical and surgical Expenses of the organ donor for harvesting the organ where an Insured Person is the recipient. IMPORTANT: Expenses incurred by an Insured Person while donating an organ is NOT covered.	i) Claims which have NOT been admitted under 1a) for the insured person. ii) Admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended). iii) The organ donor's Pre and Post-Hospitalisation expenses.
g. **Ambulance Cover:** Expenses incurred on transportation of Insured Person to a Hospital for treatment in case of an Emergency, subject to a maximum of Rs. 2000 per Hospitalisation.	i) Claims which have NOT been admitted under Section 1a) and 1d) ii) Healthcare or ambulance service provider not registered with road traffic authority.

Any claims made under the above mentioned benefit is subject to Inpatient Sum Insured

Section 2. Special Terms and Conditions

A. Waiting Period

All Illnesses, treatments and their associated complications shall be covered subject to the waiting periods specified below:

i) We are not liable for any claim arising due to condition for which, consultation, investigation, treatment or admission started within 30 days from Policy Commencement Date, except for the claims arising due to an Accident.

However if the condition is one of the illnesses / diagnoses or surgical procedures mentioned in section 2 A ii) below, then such coverage within 30 days would not be available even if arising out of an Accident.

ii) A waiting period of 24 months from the first Policy Commencement Date will be applicable to the medical and surgical treatment of illnesses / diagnoses or surgical procedures mentioned in the following table. However this waiting period will not be applicable where the underlying cause is cancer(s) .

Sl No	Organ / Organ System	Illness/diagnoses (irrespective of treatments medical or surgical)	Surgeries/procedures (irrespective of any illness / diagnosis other than cancers)
a.	Ear, Nose and Throat (ENT)	▪ Sinusitis ▪ Rhinitis ▪ Tonsillitis	▪ Adenoidectomy ▪ Mastoidectomy ▪ Tonsillectomy ▪ Tympanoplasty ▪ Surgery for nasal septum deviation ▪ Surgery for Turbinate hypertrophy ▪ Nasal concha resection ▪ Nasal polypectomy
b.	Gynaecological	▪ cysts, polyps including breast lumps ▪ Polycystic ovarian disease ▪ Fibromyoma ▪ Adenomyosis ▪ Endometriosis ▪ Prolapsed Uterus	▪ Hysterectomy
c.	Orthopaedic	▪ Non infective arthritis ▪ Gout and Rheumatism ▪ Osteoarthritis ▪ Ligament, Tendon and Meniscal tear ▪ Prolapsed inter vertebral disk	▪ Joint replacement surgeries
d.	Gastrointestinal	• Cholelithiasis • Cholecystitis • Pancreatitis • Fissure/fistula in anus, Haemorrhoids, Pilonidal sinus • Gastro Esophageal Reflux Disorder (GERD), Ulcer and erosion of stomach and duodenum • Cirrhosis (However Alcoholic cirrhosis is permanently excluded) • Perineal and Perianal Abscess	• Cholecystectomy ▪ Surgery of hernia

e.	Urogenital	▪ Rectal Prolapse • Calculus diseases of Urogenital system including Kidney, ureter, bladder stones • Benign Hyperplasia of prostate ▪ Varicocele ▪ Cataract	• Surgery on prostate ▪ Surgery for Hydrocele/ Rectocele
f.	Eye	▪ Retinal detachment ▪ Glaucoma	▪ NIL
g.	Others	▪ NIL	▪ Surgery of varicose veins and varicose ulcers
h.	General (Applicable to all organ systems/organs whether or not described above)	▪ Benign tumors of Non infectious etiologye.eg. cysts, nodules, polyps, lump, growth, etc.	▪ NIL

iii) 48 months waiting period from Policy Commencement Date for all Pre-existing Conditions declared and/or accepted at the time of application

Important terms You should know

Pre-existing Condition means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.

B. General Exclusions

We will not pay for any claim which is caused by, arising from or in any way attributable to following including their associated complications

Non Medical Exclusions	i) War or similar situations: Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind. ii) Any Insured Person committing or attempting to commit a breach of law with criminal intent. iii) Intentional self injury or attempted suicide while sane or insane. iv) Dangerous acts (including sports): An Insured Person's participation or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing in a professional or semi professional nature.
Medical Exclusions	v) Treatment of illness or injury due to the use of alcohol, tobacco, narcotic or psychotropic substances by the insured. vi) Prosthetic and other devices which are self detachable /removable without surgery involving anaesthesia vii) Treatment availed outside India viii) Treatment at a healthcare facility which is NOT a Hospital.

ix) Treatment of obesity and any weight control program.
x) Treatment for correction of eye sight due to refractive error
xi) Cosmetic, aesthetic and re-shaping treatments and surgeries:
   a. Plastic surgery or cosmetic surgery or treatments to change appearance unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, cancer or burns.
   b. Circumcisions (unless necessitated by Illness or injury and forming part of treatment); aesthetic or change-of-life treatments of any description such as sex transformation operations.
xii) Types of treatment, defined Illnesses/ conditions/ supplies:
   a. Non allopathic treatment.
   b. Conditions for which treatment could have been done on an outpatient basis without any Hospitalisation.
   c. Charges related to peritoneal dialysis, including supplies except under post hospitalisation expenses
   d. Experimental, investigational or unproven treatment devices and pharmacological regimens.
   e. Admission primarily for diagnostic and evaluation purposes only
   f. Any diagnostic expenses which is not related and not incidental to any illness which is not covered in this Policy
   g. Convalescence, rest cure, sanatorium treatment, rehabilitation measures, respite care, long-term nursing care, custodial care, safe confinement, de-addiction, general debility or exhaustion ("run-down condition").
   h. Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment);

   i. Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.
   j. Parkinson and Alzheimer's disease,
   k. Sleep-apnoea.External congenital diseases, defects or anomalies, genetic disorders.
   l. Stem cell therapy or surgery, or growth hormone therapy.
   m. Venereal disease, sexually transmitted disease or illness;
   n.
   o. Any expense attributable directly or indirectly to pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or child birth (including caesarean section), except in the case of ectopic pregnancy in relation to a claim under 1a) for In-patient Treatment only.

   p. Treatment for sterility, infertility (primary or secondary), assisted conception or other related conditions and complications arising out of the same.

   q. Birth control, and similar procedures including complications arising out of the same.

   r. The expense incurred by the Insured Person on organ donation.

   s. 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. t. Dental treatment and surgery of any kind, unless requiring Hospitalisation. xiii)) . **Any expenses as per the List of Excluded items released by the Insurance Regulatory and Development Authority of India (IRDAI) will not be covered unless specifically mentioned in the Policy.** xiv) Healthcare providers (Hospitals /Medical Practitioners) a. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed. b. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover. xv) Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary. Drugs or treatments which are not supported by a prescription. xvi) Any kind of service charge, surcharge, admission fees, registration fee levied by Hospital.

Section 3 General Conditions

a. Conditions to be followed

The fulfilment of the terms and conditions of this Policy including the payment of premium by the due dates mentioned in the Schedule/Certificate of Insurance and the correct disclosures in a complete manner in the proposal form insofar as they relate to anything to be done or complied with by You or any Insured Person shall be conditions precedent to Our liability. The premium for the Policy will remain the same for the Policy Period as mentioned in Policy Schedule/Certificate of Insurance. The Policy will be issued for a period for 1 year and the Sum Insured & benefits will be applicable on Policy Year basis.

b. Geography

This Policy only covers medical treatment taken within India. All payments under this Policy will only be made in Indian Rupees within India.

c. Insured Person

Only those persons named as Insured Persons in the Schedule/Certificate of Insurance shall be covered under this Policy. Any eligible person may be added during the Policy Period after his application has been accepted by Us and

additional premium has been received. Insurance cover for this person shall only commence once We have issued an endorsement confirming the addition of such person as an Insured Person.

Any Insured Person in the Policy has the option to migrate to similar indemnity health insurance Policy available with Us at the time of renewal subject to underwriting with all the accrued continuity benefits such as waiver of waiting period etc. provided the Policy has been maintained without a break as per portability guidelines.

If an Insured Person dies, he will cease to be an Insured Person upon Us/Administrator receiving all relevant particulars in this regard. We will return a rateable part of the premium received for such person IF AND ONLY IF there are no claims in respect of that Insured Person under the Policy.

d. Notification of Claim

	Treatment, Consultation or Procedure:	**We or Our TPA must be informed:**
i)	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation:	Immediately and in any event at least 48 hours prior to the Insured Person's admission.
ii)	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an Emergency:	Within 24 hours of the Insured Person's admission to Hospital.
iii)	For all benefits which are contingent on Our prior acceptance of a claim under Section 1)a):	Within 7 days of the Insured Person's discharge post-hospitalisation.

e. Claim Procedure

Please review your Group Assurance Health Plan and familiarize yourself with the benefits available and the exclusions.
To help us to provide you with fast and efficient service, We kindly ask you to note the following.

1. We recommend that you keep copies of all documents submitted Apollo Munich.
2. Please quote your member ID/policy number in all your correspondences.

Claim Procedure for Hospitalisation related benefits

What do I do in case of a claim or any assistance?

Intimation & Assistance	**Procedure for Reimbursement of Medical Expenses**	**Procedure to avail Cashless facility**
Please contact us atleast 48 hours prior to an event which might give rise to a claim. For any emergency situations, kindly contact us 24 hours of the event. We can be contacted through: - Website : www.apollomunichinsurance.com	• Please send the duly signed claim form and all the information/documents mentioned* therein to us within 15 days of the completion of the treatment. * Please refer to claim form for complete documentation. • If there is any deficiency in the documents/information submitted by you, We will send the deficiency letter within 7	• For any emergency Hospitalisation, We must be informed no later than 24 hours after hospitalization. • For any planned hospitalization, kindly seek cashless authorization from us atleast 48 hours prior to the hospitalization. • We will check your coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent, the same shall be

- Toll Free : 1800-102-0333 - Fax : 1800-425- 4077 - Courier : Claims Department, Apollo Munich Health insurance Co. Ltd Ground floor, Srinilaya – Cyber Spazio Suite # 101,102,109 & 110, Ground Floor, Road No. 2, Banjara Hills, Hyderabad-500 034 Or Claims Department, Apollo Munich Health Insurance Co. Ltd., 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana. Please use the Claim Intimation Form for intimation of a claim.	days of receipt of the claim documents. • On receipt of the complete set of claim documents, we will make the payment for the admissible amount, along with a settlement statement within 30 days. • The payment will be made in the name of the proposer. **Note: Payment will only be made for items covered under your policy and upto the limits therein.**	communicated to the hospital within 6 hours of receipt of documents. • Please pay the non-medical and expenses not covered to the hospital prior to the discharge. • In case the ailment /treatment is not covered under the policy a rejection letter would be sent to the provider within 6 hours. **Note:** • **Insured person is entitled for cashless only in our empanelled hospitals.** • **Please refer to the list of empanelled hospitals on our website Or the list provided in the welcome kit.** • **Please refer to the list of non-medical expenses not covered in the policy on http://www.apollomunichinsurance.com/download-forms/List-of-Non-Medical-Expenses.pdf** • **Rejection of cashless in no way indicates rejection of the claim.**

***For regulatory reference – The given section would be included in the policy wording if optional benefit of Personal Accident is opted**

Claim Procedure for Personal Accident related benefits

1. Provide Us a written notice with full particulars immediately.
2. Collect the claim form available at all our offices. You can also download the form from our website.
3. Submit Us the dully filled and signed claim form along with the documents mentioned in the claim form.

Note: The essential claim documents in original along with the claim form have to be submitted within 30 days of the occurrence of the incident, at any of our branch offices. Or

Claims Department,
Apollo Munich Health insurance Co. Ltd Ground floor
Srinilaya – Cyber Spazio
Suite # 101,102,109 & 110, Ground Floor,
Road No. 2, Banjara Hills,
Hyderabad-500 034

Or

Claims Department,
Apollo Munich Health Insurance Co. Ltd.,
2nd & 3rd Floor, iLABS Centre, Plot
No. 404-405, Udyog Vihar, Phase-III,
Gurgaon-122016, Haryana

For any doubt or clarifications and/or information, call our Toll Free Line at 1800-1020-333 or log on to our website www.apollomunichinsurance.com or email us at customerservice@apollomunichinsurance.com

f. Supporting Documentation & Examination

The Insured Person or someone claiming on Your behalf shall provide Us with any documentation, medical records and information. We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person. Such documentation will include to the following: Please note that in case of a non-disclosure or/and a fraud suspicion we may ask for additional documentation/reports which are not listed below:

i) Our claim form, duly completed and signed for on behalf of the Insured Person.
ii) Original Bills (including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.
iii) All reports and records, including but not limited to all medical reports, case histories/indoor case papers on case to case basis if required, investigation reports, treatment papers, discharge summaries.
iv) A precise diagnosis of the treatment for which a claim is made.
v) A detailed list of the individual medical services and treatments provided and a unit price for each (detailed break up).
vi) Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Doctor's invoice.
vii) All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made
viii) All investigation, treatment and follow up records pertaining to the past ailment(s) related to the claim since their first diagnoses or detection on a case to case basis.
ix) Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident
x) Copy of settlement letter from other insurance company or TPA
xi) Stickers and invoice of implants used during surgery
xii) Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident
xiii) Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements
xiv) Legal heir certificate

g. The Insured Person shall have to undergo medical examination by an independent Medical Practitioner, as and when We may reasonably require, to obtain an independent opinion for the purpose of processing any claim. We will bear the cost towards performing such medical examination of the Insured Person.

h. Claims Payment

i) We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We or Our TPA has requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.

ii) We will only make payment to Insured Person under this Policy. Receipt of payment by Insured Person shall be considered as a complete discharge of Our liability against the respective claim under this Policy. In the event of Insured Person's death, We will make payment to the Nominee (as named in the Schedule/Certificate of Insurance), payments under this Policy shall only be made in Indian Rupees within India.

iii) The assignment of benefits of the policy shall be subject to the applicable law.

iv) Cashless service: If any treatment, consultation or procedure for which a claim may be made is to be taken at a Network Hospital, then We will provide a cashless service by making payment to the extent of Our liability direct to the Network Hospital as long as We are given notice that the Insured Person wishes to take advantage of a cashless service accompanied by full particulars at least 48 hours before any planned treatment or Hospitalisation or within 24 hours after the treatment or Hospitalisation in the case of an emergency.

v) We shall make the payment of claim that has been admitted as payable by Us under the Policy terms and conditions within 30 days of receipt of last necessary document(s) / information and any other additional information required for the settlement of the claim. All claims will be settled in accordance with the applicable regulatory guidelines, including IRDAI (Protection of Policyholders Regulation), 2017. In case of delay in payment of any claim that has been admitted as payable by Us under the Policy terms and condition, beyond the time period as prescribed under IRDAI (Protection of Policyholders Regulation), 2017, we shall pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document(s) to the date of payment of claim. For the purpose of this clause, 'bank rate' shall mean the bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

vi) Where the circumstances of a claim warrant an investigation in our Opinion, We shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, We shall settle the claim within 45 days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days, We shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

i. Non Disclosure or Misrepresentation:

If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured

Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

- cancelled ab initio from the inception date or the renewal date (as the case may be), at Our sole discretion, upon 30 day notice by sending an endorsement to Your address shown in the Schedule/Certificate of Insurance or the Policy may be modified with the consent of the customer
- the claim under such Policy if any, shall be rejected/repudiated forthwith

j. Dishonest or Fraudulent Claims:

If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or the Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be:

- cancelled ab-initio from the inception date or the renewal date (as the case may be), at Our sole discretion, upon 30 day notice by sending an endorsement to Your address shown in the Schedule/Certificate of Insurance or the Policy may be modified by Us with the consent of the customer without any refund of premium; and
- all benefits payable, if any, under such Policy shall be forfeited with respect to such claim.

k. Other Insurance

If at the time when any claim is made under this Policy, Insured Person has two or more policies from one or more Insurers to indemnify treatment cost, which also covers any claim (in part or in whole) being made under this Policy, then the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. The insurer so chosen by the Insured Person shall settle the claim, as long as the claim is within the limits of and according to terms of the chosen Policy.

Also where the Insured Person has two or more policies from one or more Insurers, then the Insured Person shall have the right to claim from other policy/ policies for the amounts which is disallowed under earlier chosen policy/ policies even if sum insured is not exhausted. The insurer so chosen by the Insured Person shall settle the claim, as long as the claim is within the limits of and according to terms of the chosen Policy.

Provided further that, If the amount to be claimed under the Policy chosen by the Insured Person, exceeds the Sum Insured under a single Policy after considering the deductibles or co-pay (if applicable), the Insured Person shall have the right to choose the insurers by whom claim is to be settled. In such cases, the respective insurers may then settle the balance of the claimed amount as per the limits and according to terms of the respective Policy . This clause shall only apply to indemnity sections of the Policy.

l. Endorsements

This Policy constitutes the complete contract of insurance. This Policy cannot be changed by anyone (including an insurance agent or broker) except Us. Any change that We make will be evidenced by a written endorsement signed and stamped by Us.

m. Renewal

This Policy is ordinarily renewable for life unless the Insured Person or anyone acting on behalf of an Insured Person has acted in a dishonest or in a fraudulent manner or there has been any misrepresentation, mis-description or non disclosure under or in relation to this Policy or the renewal of the Policy poses a moral hazard.

a) We are NOT under any obligation to:
   i) Send renewal notice or reminders.

ii) Renew it on the same terms or premiums as the expiring policy. In the likelihood of this Policy being withdrawn in future, the Insured Person will have the option to migrate to similar indemnity health insurance Policy available with Us at the time of renewal with all the accrued continuity benefits such as waiver of waiting period etc. provided the policy has been maintained without a break as per portability guidelines.

b) Sum Insured can be enhanced only at the time of renewal subject to no claim have been lodged/ paid under the policy. In case of increase in the Sum Insured waiting period will apply afresh in relation to the amount by which the Sum Insured has been enhanced. However, the quantum & acceptance of increase shall be subject to the norms and acceptability criteria of the Policy.

c) All applications for renewal of the Policy must be received by Us/Administrator before the end of the Policy Period. A Grace Period of 30 days for renewing the Policy is available under this Policy. Any disease/ condition contracted during the Grace Period will not be covered and will be treated as a Pre-existing Condition.

n. Notices

Any notice, direction or instruction under this Policy shall be in writing and if it is to:

i) Any Insured Person, it would be sent to You at the address specified in Schedule/endorsement/Certificate of Insurance.
ii) Us, shall be delivered to Our address specified in the Schedule/Certificate of Insurance.
iii) No insurance agents, brokers, other person/ entity unless authorised by Us is authorised to receive any notice on Our behalf.

o. Dispute Resolution Clause

Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law.

p. Termination

a) You may terminate this Policy at any time by giving Us/Administrator a written notice. The cancellation shall be from the date of receipt of such written notice. Premium shall be refunded as per table below IF AND ONLY IF no claim has been made under the Policy.

Length of time Policy in force	% of premium refunded
Upto 1 Month	75.00%
Upto 3 Months	50.00%
Upto 6 Months	25.00%
Exceeding 6 Months	Nil

b) We shall terminate this Policy for the reasons as specified under aforesaid section 3 i) (Non Disclosure or Misrepresentation) & section 3 j) (Dishonest or Fraudulent Claims) of this Policy and such termination of the Policy shall be ab initio from the inception date or the renewal date (as the case may be), upon 30 day notice, by sending an endorsement to Your address shown in the Schedule/endorsement/Certificate of Insurance. In case of Dishonest or Fraudulent claims the premium paid will not be refunded.

q. Free Look Period

You have a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You have the option of cancelling

the Policy stating the reasons for cancellation and You will be refunded the premium paid by You after adjusting the amounts spent on any medical check-up, stamp duty charges and proportionate risk premium. You can cancel Your Policy only if You have not made any claims under the Policy. All Your rights under this Policy will immediately stand extinguished on the free look cancellation of the Policy. Free look provision is not applicable and available at the time of renewal of the Policy.

Section 4. Other Important Terms You should know

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

Def. 1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.

Def. 2. **Administrator** means any entity/person(s) engaged by the Insurer for providing Policy and claims facilitation services to the Insured as well as to Us.

Def. 3. **Age** or **Aged** means completed years as at the Commencement Date.

Def. 4. **Any one illness** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

Def. 5. **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.

Def. 6. **Commencement Date** means the commencement date of this Policy as specified in the Schedule/Certificate of Insurance.

Def. 7. **Condition Precedent** means a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

Def. 8. **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

Def. 9. **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.

Def. 10. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 11. **Critical Illness means** any one of the following illnesses or conditions that occurs or manifests itself during the Policy Period as a first incidence and the insured survives the defined survival period

a) **Cancer of specified severity**

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded –

i) All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential,neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

ii) Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii) Malignant melanoma that has not caused invasion beyond the epidermis;

iv) All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v) All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi) Chronic lymphocytic leukaemia less than RAI stage 3

vii) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii) All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

ix) All tumors in the presence of HIV infection.

b) 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

c) Myocardial Infarction (First heart attack of specific 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.

d) 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.

e) 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

f) 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.

g) 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.

h) 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.

i) 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 diseaseaffected 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.

j) 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.

k) Motor Neuron 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.

l) Major Head Trauma

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:
   i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
   ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
   iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
   iv. Mobility: the ability to move indoors from room to room on level surfaces;
   v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
   vi. Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:
   i. Spinal cord injury;

Def. 12. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with 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.

Def. 13. **Day Care Treatment** means medical treatment, and/or *surgical procedure listed in Annexure 1* which is:

i) undertaken under General or Local Anesthesia 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.

Def. 14. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

Def. 15. **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.

Def. 16. **Dependents** means only the family members listed below:

i) Your legally married spouse as long as she continues to be married to You;
ii) Your children Aged between 91 days and 25 years if they are unmarried
iii) Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his initial participation in the Group Assurance Health Plan Insurance Policy.
iv) Your Parent -in-law as long as Your spouse continues to be married to You and were below 65 years at his initial participation in the Group Assurance Health Plan Insurance Policy.
v) All Dependent parents must be financially dependent on You.

Def. 17. **Dependent Child** means a child (natural or legally adopted), who is unmarried, Aged between 1 day and 25 years, financially dependent on the primary Insured or Proposer and does not have his / her independent sources of income.

Def. 18. **Disclosure to information norms** means that the Policy shall be void and all premiums paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def. 19. **Domiciliary Hospitalisation** 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.

Def. 20. **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.

Def. 21. **Medical Protocol-** means guidelines and protocols for any diagnosis or treatment derived from the following:

- Medical text books
- Standard treatment guidelines as stated in clinical establishment act of Government of India
- World Health Organisation (WHO) protocols
- Published guidelines by healthcare providers
- Guidelines set by medical societies like cardiological society of India, neurological society of India etc.
- Guidelines set by FDA
- Instructions of the manufacturers

Def. 22. **Family Floater** means a Policy described as such in the Schedule/Certificate of Insurance where under You and Your Dependents named in the Schedule/Certificate of Insurance are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule/Certificate of Insurance which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during the Policy Period.

Def. 23. **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.

Def. 24. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and 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;

Def. 25. **Hospitalisation** or **Hospitalised** 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.

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

(a) Acute condition - Acute condition 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

Def. 27. **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.

Def. 28. **In-patient Care** means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.

Def. 29. **Insured Person means** You and the persons named in the Schedule/Certificate of Insurance.

Def. 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.

Def. 31. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

Def. 32. **Maternity expenses** means —

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

c) expenses towards lawful medical termination of pregnancy during the Policy Period.

Def. 33. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

Def. 34. **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.

Def. 34. **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 its scope and jurisdiction of license. Medical Practitioner who is sharing the same residence with the Insured Person's and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

Def. 35. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

i) is required for the medical management of the illness or injury suffered by the insured;

ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;

iii) must have been prescribed by a medical practitioner;

iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Def. 36. **Network Provider** means hospital enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

Def. 37. **New born baby** means baby born during the Policy Period and is aged upto 90 days.

Def. 38. **Non Network mean**s any Hospital, day care centre or other provider that is not part of the Network

Def. 39. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

Def. 40. **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.

Def. 41. **Portability** means the right accorded to an individual health insurance Policyholder (including family cover) to transfer the credit gained for pre-existing conditions and time-bound exclusions, from one insurer to another or from one plan to another plan of the same insurer.

Def. 42. **Pre-existing Condition** means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first Policy issued by the insurer and renewed continuously thereafter.

Def. 43. **Pre-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:

i) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

ii) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Def. 44. **Post-hospitalization Medical Expenses** means medical expenses incurred during predefined 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 hospitalization was required, and

ii) The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

Def. 45. **Preventive Health Check-up** means a package of medical test(s) undertaken for general assessment of health status, it does not include any diagnostic or investigative medical tests for evaluation of illness or a disease.

Def. 46. **Policy** means Your statements in the proposal form (which are the basis of this Policy), this Policy wording (including endorsements, if any) and the Policy Schedule (as the same may be amended from time to time).

Def. 47. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule/Certificate of Insurance.

Def. 48. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 49. **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.

Def. 50. **Reasonable & 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.

Def. 51. **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.

Def. 52. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

Def. 53. **Shared Accommodation** means hospitalisation in a Hospital room with two or more In-patient beds

Def. 54. **Survival period** means the period after an insured event that the Insured Person has to survive before a claim is payable

Def. 55. **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.

Def. 56. **TPA** means the third party administrator that We appoint from time to time as specified in the Schedule/Certificate of Insurance.

Def. 57. **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.

Def. 58. **We/Our/Us** means the Apollo Munich Health Insurance Company Limited.

Def. 59. **You/Your/Policyholder** means the person named in the Schedule/Certificate of Insurance who has concluded this Policy with Us.

Section 5. Claim Related Information

For any claim related query, intimation of claim and submission of claim related documents, the Insured Person can contact Apollo Munich through:

- Website : www.apollomunichinsurance.com
- Toll Free : 1800-102- 0333
- Fax : 1800- 425- 4077
- Courier : Claims Department,
  Apollo Munich Health insurance Co. Ltd
  Ground floor, Srinilaya – Cyber Spazio
  Suite # 101,102,109 & 110, Ground Floor,
  Road No. 2, Banjara Hills,
  Hyderabad-500 034

  Or

  Claims Department

Apollo Munich Health Insurance Company Limited
iLABS Centre, 2nd & 3rd Floor, Plot No 404 - 405, Udyog Vihar, Phase – III,
Gurgaon -122016, HARYANA

Section 6. Grievance Redressal Procedure

If You have a grievance that You wish Us to redress, You may contact Us with the details of Your grievance through:

- Our website : www.apollomunichinsurance.com
- E-mail : customerservice@apollomunichinsurance.com
- Toll Free : 1800-102-0333
- Fax : +91-124-4584111
- Courier : Any of Our Branch office or Corporate office

You may also approach the grievance cell at any of Our branches with the details of Your grievance during Our working hours from Monday to Friday.

If You are not satisfied with Our redressal of Your grievance through one of the above methods, You may contact Our Head of Customer Service at:

The Grievance Cell, Apollo Munich Health Insurance Company Limited, iLABS Centre, 2nd & 3rd Floor, Plot No 404 - 405, Udyog Vihar, Phase – III, Gurgaon -122016, HARYANA

If You are not satisfied with Our redressal of Your grievance through one of the above methods, You may approach the nearest Insurance Ombudsman for resolution of Your grievance. The contact details of Ombudsman offices are mentioned below.

Office of The Executive Council of Insurers
(Monitoring Body for Offices of Insurance Ombudsman)
3rd Floor, Jeevan Seva Annexe, Santacruz(West), Mumbai – 400054. Tel no: 26106671/6889.
Email id: inscoun@ecoi.co.in website: www.ecoi.co.in
==========
If you have a grievance, approach the grievance cell of Insurance Company first.
If complaint is not resolved/ not satisfied/not responded for 30 days then
You can approach The Office of the Insurance Ombudsman(Bimalokpal)
Please visit our website for details to lodge complaint with Ombudsman.

Office of the Insurance Ombudsman, 6th Floor, Jeevan Prakash Bldg, Tilak Marg, Relief Road, AHMEDABAD - 380001. Tel nos: 079-25501201/02/05/06 email: bimalokpal.ahmedabad@ecoi.co.in	Office of the Insurance Ombudsman, 2nd Floor, Janak Vihar Complex, 6, Malviya Nagar, BHOPAL-462 003. Tel.:- 0755-2769201/9202 Fax : 0755-2769203 Email: bimalokpal.bhopal@ecoi.co.in
Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR-751 009. Tel.:- 0674-2596455/2596003 Fax : 0674-2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Office of the Insurance Ombudsman, SCO No.101-103,2nd Floor, Batra Building, Sector 17-D, CHANDIGARH-160 017. Tel.:- 0172-2706468/2772101 Fax : 0172-2708274 Email: bimalokpal.chandigarh@ecoi.co.in

Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI-600 018. Tel.:- 044-24333668 /24335284 Fax : 044-24333664 Email: bimalokpal.chennai@ecoi.co.in	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg.,Asaf Ali Road, NEW DELHI-110 002. Tel.:- 011-23234057/23232037 Fax : 011-23230858 Email: bimalokpal.delhi@ecoi.co.in
Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, S.S. Road, GUWAHATI-781 001 . Tel.:- 0361-2132204/5 Fax : 0361-2732937 Email: bimalokpal.guwahati@ecoi.co.in	Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD-500 004. Tel : 040-65504123/23312122 Fax: 040-23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., M.G. Road, ERNAKULAM-682 015. Tel : 0484-2358759/2359338 Fax : 0484-2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Office of the Insurance Ombudsman, Hindustan Building. Annexe, 4th Floor, C.R.Avenue, KOLKATA - 700072 Tel No: 033-22124339/22124346 Fax: 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road,Hazaratganj, LUCKNOW-226 001. Tel : 0522 -2231331/2231330 Fax : 0522-2231310 Email: bimalokpal.lucknow@ecoi.co.in	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe,S.V. Road, Santacruz(W), MUMBAI-400 054. Tel : 022-26106960/26106552 Fax : 022-26106052 Email: bimalokpal.mumbai@ecoi.co.in
Office of the Insurance Ombudsman, Ground Floor, Jeevan Nidhi II, Bhawani Singh Road, JAIPUR – 302005. Tel: 0141-2740363 Email: bimalokpal.jaipur@ecoi.co.in	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Darshan, N.C. Kelkar Road, Narayanpet PUNE – 411030. Tel: 020-32341320 Email: Bimalokpal.pune@ecoi.co.in
Office of the Insurance Ombudsman, 24th Main Road, Jeevan Soudha Bldg., JP Nagar, 1st Phase, Ground Floor BENGALURU – 560025. Tel No: 080-26652049/26652048 Email: bimalokpal.bengaluru@ecoi.co.in	Office of the Insurance Ombudsman, 4th Floor, Bhagwan Sahai Palace, Main Road, Naya Bans, Sector-15, NOIDA – 201301. Tel: 0120-2514250/51/53 Email: bimalokpal.noida@ecoi.co.in
Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, PATNA – 800006 Tel No: 0612-2680952 Email id : bimalokpal.patna@ecoi.co.in.	

IRDA REGULATION NO 12: This Policy is subject to regulation 12 of IRDAI (Protection of Policyholder's Interests) Regulations, 2017.

Annexure I Daycare Procedure

Daycare Procedures will include following Daycare Surgeries & Daycare Treatments

Microsurgical operations on the middle ear

1. Stapedotomy
2. Stapedectomy
3. Revision of a stapedectomy
4. Other operations on the auditory ossicles under general/spinal anesthesia
5. Myringoplasty (Type -I Tympanoplasty)
6. Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
7. Revision of a Tympanoplasty
8. Other microsurgical operations on the middle ear under general /spinal anesthesia

Other operations on the middle & internal ear

9. Myringotomy
10. Removal of a tympanic drain
11. Incision of the mastoid process and middle ear
12. Mastoidectomy
13. Reconstruction of the middle ear
14. Other excisions of the middle and inner ear
15. Fenestration of the inner ear
16. Revision of a fenestration of the inner ear
17. Incision (opening) and destruction (elimination) of the inner ear
18. Other operations on the middle and inner ear under general /spinal anesthesia
19. Removal of Keratosis Obturans

Operations on the nose & the nasal sinuses

20. Excision and destruction of diseased tissue of the nose
21. Operations on the turbinates (nasal concha)
22. Other operations on the nose under general/spinal anesthesia
23. Nasal sinus aspiration
24. Foreign body removal from nose

Operations on the eyes

25. Incision of tear glands
26. Other operations on the tear ducts
27. Incision of diseased eyelids
28. Excision and destruction of diseased tissue of the eyelid
29. Operations on the canthus and epicanthus
30. Corrective surgery for entropion and ectropion
31. Corrective surgery for blepharoptosis
32. Removal of a foreign body from the conjunctiva
33. Removal of a foreign body from the cornea
34. Incision of the cornea
35. Operations for pterygium
36. Other operations on the cornea
37. Removal of a foreign body from the lens of the eye
38. Removal of a foreign body from the posterior chamber of the eye
39. Removal of a foreign body from the orbit and eyeball
40. Operation of cataract
41. Retinal detachment
42. Correction of Eyelids Ptosis by Levator Palpebrae Superioris Resection (bilateral)
43. Correction of Eyelids Ptosis by Fascia Lata Graft (bilateral)
44. Diathermy/ Cryotherapy to treat retinal tear
45. Anterior chamber Pancentesis/ Cyclodiathermy/ Cyclocryotherapy / goniotomy/ Trabeculotomy and Filtering and Allied operations to treat glaucoma
46. Enucleation of the eye without implant
47. Dacryocystorhinostomy for various lesions of Lacrimal Gland
48. Laser photocoagulation to treat Retinal Tear

Operations on the skin & subcutaneous tissues

49. Incision of a pilonidal sinus
50. Other incisions of the skin and subcutaneous tissues
51. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
52. Local excision of diseased tissue of the skin and subcutaneous tissues
53. Other excisions of the skin and subcutaneous tissues
54. Simple restoration of surface continuity of the skin and subcutaneous tissues
55. Free skin transplantation, donor site
56. Free skin transplantation, recipient site
57. Revision of skin plasty
58. Other restoration and reconstruction of the skin and subcutaneous tissues
59. Chemosurgery to the skin
60. Destruction of diseased tissue in the skin and subcutaneous tissues
61. Reconstruction of deformity/defect in NailBed

Operations on the tongue

62. Incision, excision and destruction of diseased tissue of the tongue
63. Partial glossectomy
64. Glossectomy
65. Reconstruction of the tongue
66. Other operations on the tongue under general/spinal anesthesia

Operations on the salivary glands & salivary ducts

67. Incision and lancing of a salivary gland and a salivary duct
68. Excision of diseased tissue of a salivary gland and a salivary duct
69. Resection of a salivary gland
70. Reconstruction of a salivary gland and a salivary duct
71. Other operations on the salivary glands and salivary ducts

Other operations on the mouth & face

72. External incision and drainage in the region of the mouth, jaw and face
73. Incision of the hard and soft palate
74. Excision and destruction of diseased hard and soft palate
75. Incision, excision and destruction in the mouth
76. Plastic surgery to the floor of the mouth
77. Palatoplasty
78. Other operations in the mouth under general /spinal anesthesia

Operations on the tonsils & adenoids

79. Transoral incision and drainage of a pharyngeal abscess
80. Tonsillectomy without adenoidectomy
81. Tonsillectomy with adenoidectomy
82. Excision and destruction of a lingual tonsil
83. Other operations on the tonsils and adenoids under general /spinal anesthesia

Trauma surgery and orthopaedics

84. Incision on bone, septic and aseptic
85. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
86. Suture and other operations on tendons and tendon sheath
87. Reduction of dislocation under GA
88. Arthroscopic knee aspiration
89. Adenoidectomy

Operations on the breast

90. Incision of the breast
91. Operations on the nipple
92. Excision of single breast lump

Operations on the digestive tract

93. Incision and excision of tissue in the perianal region
94. Surgical treatment of anal fistulas
95. Surgical treatment of haemorrhoids
96. Division of the anal sphincter (sphincterotomy)
97. Other operations on the anus
98. Ultrasound guided aspirations

99. Sclerotherapy etc.
100. Laprotomy for grading Lymphoma with Splenectomy/ Liver/ Lymph Node Biopsy
101. Therapeutic laproscopy with Laser
102. Cholecystectomy and Choledocho - Jejunostomy/ Duodenostomy/ Gastrostomy/ Exploration Common Bile Duct
103. Esophagoscopy, gastroscopy, dudenoscopy with polypectomy/ removal of foreign body/ diathermy of bleeding lesions
104. Lithotripsy/ Nephrolithotomy for renal calculus
105. Excision of renal cyst
106. Drainage of Pyonephrosis/ Perinephric Abscess
107. Appendicectomy with/ without Drainage

Operations on the female sexual organs

108. Incision of the ovary
109. Insufflation of the Fallopian tubes
110. Other operations on the Fallopian tube
111. Dilatation of the cervical canal
112. Conisation of the uterine cervix
113. Other operations on the uterine cervix
114. Incision of the uterus (hysterotomy)
115. Therapeutic curettage
116. Culdotomy
117. Incision of the vagina
118. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
119. Incision of the vulva
120. Operations on Bartholin's glands (cyst)
121. Laser therapy of cervix for various lesions of Uterus
122. Salpino-Oophorectomy via Laproscopy

Operations on the prostate & seminal vesicles

123. Incision of the prostate
124. Transurethral excision and destruction of prostate tissue
125. Transurethral and percutaneous destruction of prostate tissue
126. Open surgical excision and destruction of prostate tissue
127. Radical prostatovesiculectomy
128. Other excision and destruction of prostate tissue
129. Operations on the seminal vesicles
130. Incision and excision of periprostatic tissue
131. Other operations on the prostate under general/spinal anesthesia

Operations on the scrotum & tunica vaginalis testis

132. Incision of the scrotum and tunica vaginalis testis
133. Operation on a testicular hydrocele
134. Excision and destruction of diseased scrotal tissue
135. Plastic reconstruction of the scrotum and tunica vaginalis testis
136. Other operations on the scrotum and tunica vaginalis testis

Operations on the testes

137. Incision of the testes
138. Excision and destruction of diseased tissue of the testes

139. Unilateral orchidectomy
140. Bilateral orchidectomy
141. Orchidopexy
142. Abdominal exploration in cryptorchidism
143. Surgical repositioning of an abdominal testis
144. Reconstruction of the testis
145. Implantation, exchange and removal of a testicular prosthesis
146. Other operations on the testis under general /spinal anesthesia

Operations on the spermatic cord, epididymis and ductus deferens

147. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
148. Excision in the area of the epididymis
149. Epididymectomy
150. Reconstruction of the spermatic cord
151. Reconstruction of the ductus deferens and epididymis
152. Other operations on the spermatic cord, epididymis and ductus deferens

Operations on the penis

153. Operations on the foreskin
154. Local excision and destruction of diseased tissue of the penis
155. Amputation of the penis
156. Plastic reconstruction of the penis
157. Other operations on the penis under general/spinal anesthesia

Operations on the urinary system

158. Cystoscopical removal of stones
159. Cathterisation of bladder

Other Operations

160. Lithotripsy
161. Coronary angiography
162. Haemodialysis
163. Radiotherapy for Cancer
164. Cancer Chemotherapy
165. Renal biopsy
166. Bone marrow biopsy
167. Liver biopsy
168. Biopsy of Termporal Artery for Various lesions
169. External Arterio-venus shunt
170. Endoscopic polypectomy
171. **Any drug which requires and is indicated to be transfused over 2 hours or more as per medical protocols will be covered**

Operation on bone and joints

172. Surgery for ligament tear
173. Surgery for meniscus tear
174. Surgery for hemoarthrosis/ pyoarthrosis
175. Removal of fracture pins/ nails

176. Removal of metal wire
177. Closed reduction on fracture, luxation
178. Reduction of dislocation under GA
179. Epiphyseolysis with Osteosynthesis
180. Excision of Bursitis
181. Tennis elbow release
182. Excision of various lesions in Coccyx
183. Arthroscopic knee aspiration

.

Note: The standard exclusions and waiting periods are applicable to all of the above Daycare Procedures depending on the medical condition/ disease under treatment. Only 24 hours hospitalisation is not mandatory

Optional Benefits

On payment of additional premium the following benefits shall be added to the Policy coverage

Optional Benefit No. 1 – Room Rent Limit

Room and boarding expenses are subject to a limit as specified in the table below.

Options available

Options	Details
I	No room rent limit (Default option)
II	1% of Sum Insured Per day limit option and 2% of Sum Insured Per day limit option for ICU
III	2% of Sum Insured Per day limit option and 4% of Sum Insured Per day limit option for ICU

Applicable to Option II & III: If the Insured Person gets admitted to a room with daily rent higher than the room rent limit mentioned above then the total eligible Hospital bill will be settled on a pro rata basis in the same ratio as the ratio of the room rent limit allowed to the actual daily room rent.

Optional Benefit No. 2 – Pre-hospitalisation Expenses

The coverage under Pre-Hospitalisation benefit is as per limit specified in the table below.

Pre-hospitalisation Expenses	[XX] Days*

Optional Benefit No. 3 – Post-hospitalisation Expenses

Post - hospitalisation Expenses	[XX] Days*

The coverage under Post Hospitalisation benefit is subject to the limit as specified in the table below

Optional Benefit No. 4 – Hospital Daily Cash

If an Insured Person suffers an Illness or an Accident during the Policy Period that requires that Insured Person's Hospitalisation as an in-patient, then

i) We will pay Daily Cash amount for each continuous and completed period of 24 hours that the Insured Person is Hospitalised subject to maximum number of days as specified in the below table, and

Benefit	Description	
	Per Day Amount (Rs.)*	Maximum No. of Days *
Hospital Daily Cash	XXXX	XX

ii) Our maximum liability shall be restricted to the amount mentioned in the table above and limit for the benefit will apply on individual basis.

iii) We will pay twice the Daily Cash amount for each continuous and completed period of 24 hours that the Insured Person is admitted in an Intensive Care Unit, subject to maximum of 15 days per Policy Year. Whenever Intensive Care Unit benefit is admissible under the Policy, We will not pay for Daily Cash benefit in i) above for the period when the Insured Person is in Intensive Care Unit.

iv) Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to Cumulative Bonus or Health Check-up benefit, if applicable.

Optional Benefit No. 5 – Preventive Health Checkup (For every claim free Year)

We will reimburse the reasonable costs incurred by an Insured Person of obtaining a health check-up as per details below

i. If no claim has been made in respect of Section 1 under this Policy, then at each claim free renewal We will pay the amount mentioned below towards the cost of a preventive medical check-up
ii. This benefit is available ONLY to those Insured Persons who were insured in the previous Policy Year.
iii. In case of family floater, if any of the members have made a claim under this Policy, the health check-up benefit will not be offered to the whole family
iv. Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to a Cumulative Bonus, if applicable.

Option 1

Plan	1 L – 15.00 L
Individual Plan	Upto 1% of Sum Insured per Insured Person, at the end of every Policy Year subject to max of Rs 7500
Family Floater Plan	Upto 1% of Sum Insured per Policy, at the end of every Policy Year subject to max of Rs 7500

Option 2

Rs 500 to Rs 7500 (in multiples of 500) on per member basis for individual policy and policy basis for floater policies.

IMPORTANT: This benefit is not available for expenses incurred on a preventive health check-up in the first policy year. This benefit will NOT be carried forward if it is not claimed and would not be provided if the Group Assurance Health Plan Insurance Policy is not renewed further

Preventive Health Check-up means a package of medical test(s) undertaken for general assessment of health status, it does not include any diagnostic or investigative medical tests for evaluation of illness or a disease.

Optional Benefit No. 6 – Preventive Health Check-up Benefit (At every renewal irrespective of claim status)

We will reimburse the reasonable costs incurred by an Insured Person of obtaining a health check-up as per details below

i. At the end of each year We will pay upto the amount mentioned below towards the cost of a preventive medical check-up.
ii. This benefit is available ONLY to those Insured Persons who were insured in the previous Policy Year.
iii. Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to a Cumulative Bonus, if applicable.

Option 1

Plan	1 L – 15.00 L
Individual Plan	Upto 1% of Sum Insured per Insured Person, at the end of every Policy Year subject to max of Rs 7500
Family Floater Plan	Upto 1% of Sum Insured per Policy, at the end of every Policy Year subject to max of Rs 7500

Option 2

Rs 500 to Rs 7500 (in multiples of 500) on per member basis for individual policy and policy basis for floater policies.

IMPORTANT: This benefit is not available for expenses incurred on a preventive health check-up in the first policy year. This benefit will NOT be carried forward if it is not claimed and would not be provided if the Group Assurance Health Plan Insurance Policy is not renewed further
Preventive Health Check-up means a package of medical test(s) undertaken for general assessment of health status, it does not include any diagnostic or investigative medical tests for evaluation of illness or a disease

Optional Benefit No. 7 – Co-payment

If opted, a Co-payment of [X%] shall apply to all claims admitted under Section 1)a) of Policy. The Insured Person shall bear percentage as specified , of the eligible claim amount under the Policy and Our liability, if any, shall only be in excess of that sum and would be subject to the Sum Insured.

Optional Benefit No. 8 – Reduction / waiver of Pre-existing Disease waiting Period
The waiting period for Pre-existing Conditions have been reduced to [XX]* months instead of 48 months as provided under Section 2 A)iii) of Policy wording.

Optional Benefit No. 9 –Reduction / waiver of 24 months waiting period for listed conditions
The waiting period for listed disease/conditions under Section 2 A)ii) of Policy wordings have been reduced to [XX]* months instead of 24 months.

Optional Benefit No. 10 – 30 days waiting period waiver
Waiting period of 30 days under Section 2 A)i) of Policy wording has been waived .

Optional Benefit No. 11 – AYUSH Benefit
The coverage under this Policy is extended to reimburse the Medical Expenses incurred for In-patient treatment taken under Ayurveda, Unani, Sidha or Homeopathy provided that the treatment has been undergone in

i. government hospital or in any institute recognized by government and/or accredited by Quality Council of India or National Accreditation Board on Health; or

ii. Teaching hospitals of AYUSH colleges recognised by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH); or

iii. AYUSH Hospitals having registration with a Government authority under appropriate Act in the State/UT and complies with the following as minimum criteria

a. has at least fifteen in-patient beds;
b. has minimum five qualified and registered AYUSH doctors;
c. has qualified paramedical staff under its employment round the clock;
d. has dedicated AYUSH therapy sections;
e. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel

and exclusion 2 B. xii) a) stands deleted for all Insured Persons to this extent, provided that:

i. Our maximum liability will be limited to the amounts specified in the table below

Benefit	Description
AYUSH Benefit	[XX]% of In-patient Sum Insured*

ii. This limit will apply on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy

iii. We will not cover treatment, costs or expenses where hospitalisation is for evaluation and or for investigation purpose only, any treatment availed outside India.

Any claim made in respect of this benefit will be subject to In-patient Sum Insured and will affect entitlement to a Cumulative Bonus and Health Check-up benefit, if applicable.

Optional Benefit No. 12 – E-Opinion in respect of Critical Illness

We shall arrange and pay for a second opinion from Our panel of Medical Practitioners, if:

- The Insured Person suffers a Critical Illness during the Policy Period; and
- He requests an E-opinion; and

The Insured Person can choose one of Our panel Medical Practitioners. The opinion will be directly sent to the Insured Person by the Medical Practitioner.

"Critical Illness" includes Cancer of specified severity, Open Chest CABG, Myocardial Infarction (First Heart Attack of specific severity), Kidney Failure requiring regular dialysis, Major Organ/Bone Marrow Transplant, Multiple Sclerosis with persisting symptoms, Permanent Paralysis of Limbs and Stroke resulting in permanent symptoms,

We will not pay for:

i) More than one claim for this benefit in a Policy Year.
ii) More than one claim for the same Critical Illness.
iii) Any other liability due to any errors or omission or representation or consequences of any action taken in reliance of the E-opinion provided by the Medical Practitioner.

Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to a Cumulative Bonus and Health Checkup benefit, if applicable.

Optional Benefit No. 13 – Restore Benefit

Instant addition of 100% Basic Sum Insured on complete or partial utilization of Your existing Policy Sum Insured and Cumulative Bonus (if applicable) during the Policy Year. The Total amount (Basic sum insured, Cumulative Bonus and

Restore sum insured) will be available to all Insured Persons for all claims under In-patient Benefit during the current Policy Year and subject to the condition that single claim in a Policy Year cannot exceed the sum of Basic Sum Insured and the Cumulative Bonus (if applicable).

Conditions for Restore benefit:

a. The Sum Insured will be restored only once in a Policy Year.
b. If the Restored Sum Insured is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year.
c. In case of a Family Floater Policy, Restore Sum Insured will be available on floater basis for all Insured Persons in the Policy.
d. This benefit would only be offered where Base Sum Insured is 1 lac and above.
e. The Restore Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section 1

Optional Benefit No. 14 – Double Restore Benefit

i. Instant addition of 100% Basic Sum Insured on complete or partial utilization of Your existing Policy Sum Insured and Cumulative Bonus (if applicable) during the Policy Year. The Total amount (Basic sum insured, Cumulative Bonus and Restore Sum Insured when added) will be available to all Insured Persons for all claims under In-patient Benefit during the current Policy Year and subject to the condition that single claim in a Policy Year cannot exceed the sum of Basic Sum Insured and the Cumulative Bonus (if applicable).
ii. Post complete utilization of your Basic Sum Insured and Cumulative Bonus (if applicable), if You partially or completely utilize your Restore Sum Insured (as given in i above), another 100% of Basic sum insured would be added to Your Restored sum insured available to all Insured Persons for claims under In-patient Benefit during the current Policy Year and subject to the condition that single claim in a Policy Year cannot exceed the Basic Sum Insured.

a. The Restore or Double Restore Sum Insured will be applied only once for the Insured Person during a Policy Year
b. If the Restore or Double Restore Sum Insured is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year.
c. In case of a Family Floater Policy, Restore or Double Restore Sum Insured will be available on floater basis for all Insured Persons in the Policy.
d. This benefit would only be offered where Base Sum Insured is 1 lac and above.
e. The Restore or Double Restore Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section 1

Optional Benefit No. 15 – Cumulative Bonus

i. A Cumulative Bonus of 10% will be applied on the Sum Insured for next Policy Year by automatically increasing the Sum Insured under the Policy after every CLAIM FREE Policy Year, provided that the Policy is renewed with Us and without a break. The maximum Cumulative Bonus shall not exceed [XX%]* of the Sum Insured in any Policy Year.

ii. In relation to a Family Floater Policy, the Cumulative Bonus so applied will only be available in respect of claims made by those Insured Persons who were Insured Persons in the claim free Policy Year and continue to be Insured Persons in the subsequent Policy Year.

iii. If a Cumulative Bonus has been applied and a claim is made, then in the following Policy Year We will automatically decrease the Cumulative Bonus by 10% of the Sum Insured There will be no impact on the Inpatient Sum Insured, only the accrued Cumulative Bonus will be decreased.

iv. If the Insured Persons in the expiring Policy are covered on individual basis and thus have accumulated the No Claim Bonus for each member in the expiring Policy, and such expiring Policy is renewed with Us on a Family Floater basis, then the No Claim Bonus to be carried forward for credit in the Policy would be the least No Claim Bonus amongst all the Insured Persons.

Optional Benefit No. 16 – Daily Cash for choosing shared Accommodation

Daily cash amount will be payable per day as per table below, if the Insured Person is Hospitalised in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours if the Hospitalisation

Sum Insured	Limit (Rs)
[XXXX]	Rs. [XX] per day maximum of Rs. [XXXX]

exceeds 48 hours.

We will not pay for:

i) Daily Cash Benefit for time spent by the Insured Person in an intensive care unit
ii) Claims which have NOT been admitted under Section 1 a).
iii) Any other exclusion applied in Section 2A and Section 2B

Shared Accommodation means hospitalization in a Hospital room with two or more In-patient beds

Optional Benefit No. 17 – Critical Illness

We will pay the Critical Illness Sum Insured as a lump sum in addition to Our Payment under this Policy, provided that:

a) The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period, and
b) The Insured Person survives atleast 30 days following such diagnosis,
c) This benefit is payable once during the Policy Period and would terminate on the occurrence of the first Critical Illness. The Insured Person shall receive the sum insured as per applicable guidelines post which the benefit will cease and coverage under this benefit would not be renewed any further. However the other insured members (if any) will continue to be covered under this benefit if opted.
d) This benefit is offered only on Individual Sum Insured basis.
e) Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to a Cumulative Bonus and Health Checkup benefit, if applicable.

We will not make payment if:

a) The Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the Commencement Date and the Insured Person has not previously been insured continuously and without interruption under this Policy.

S.No*	Critical Illness*
Waiting Period Survival Period	90 days 30 days
Important terms You should know:	

Survival period means the period after an insured event that the insured person has to survive before a claim is payable

Please refer to Section 4 (Definition 12) of Policy wordings for the definitions of the Critical Illnesses and also exclusions specifically applicable to the critical illness covered

Optional Benefit No. 18 – Critical Illness (Indemnity based)
An additional limit of Rs [XX]* shall be available for coverage of expenses incurred on Inpatient and Day Care treatment of the below listed number of critical illnesses.

- [XX]*
- [XX]*

Optional Benefit No. 19 – Double Sum Insured for Critical Illness (Indemnity based)
We will increase the Sum Insured for an insured person by 100% if he is diagnosed as suffering from a critical Illness under this Policy, provided that:

i) The insured person is first diagnosed as suffering from a critical illness during the Policy period, and
ii) The benefit is utilised only by the insured person diagnosed with the critical illness, and
iii) We have accepted an inpatient hospitalisation claim under in-patient treatment benefit

For this benefit Critical Illness means :

- [XX]*
- [XX]*

Optional Benefit No. 20 – Double Sum Insured for Cancer of specified severity (Indemnity based)
We will increase the Sum Insured for an insured person by 100% if he is diagnosed as suffering from cancer of specified severity under this Policy, provided that:

i) The Insured Person is first diagnosed as suffering from a cancer during the Policy period, and
ii) The benefit is utilised only by the Insured Person diagnosed with the illness, and
iii) We have accepted an inpatient hospitalisation claim under in-patient treatment benefit

Cancer of specified severity means:

- 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.
- The following are excluded:
  I. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
  II. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
  III. Malignant melanoma that has not caused invasion beyond the epidermis;
  IV. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
  V. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
  VI. Chronic lymphocytic leukaemia less than RAI stage 3
  VII. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
  VIII. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
  IX. All tumors in the presence of HIV infection.

Optional Benefit No. 21 – Outpatient Benefit

The coverage under this Policy is extended to reimburse expenses incurred on Outpatient Treatment for the Insured Persons mentioned in the Policy Schedule, provided that

i. You have renewed the Policy consecutively without a break for the period as stated in the table below

Benefit	Maximum Sum Insured (Rs.)
Out-patient Benefit with waiting period of [X]years	XXXXXXX

ii. Our maximum liability shall be limited to the amount specified in the table above. This limit will apply on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy and

iii. The condition of minimum Hospitalisation of 24 hours as an in-patient under Benefit 1 a) stands deleted.

iv. For the purpose of this endorsement Out-patient Treatment means medical treatment taken by an Insured Person without him being Hospitalised for 24 hours.

v. The reimbursement of claims under this extension shall be done only once during each Policy Year of the Policy Period. No claim will be admissible which is made 30 days after the expiry of Policy.

vi. Any claim made in respect of this benefit will not be subject to In-patient Sum Insured and will not affect entitlement to a Cumulative Bonus and Health Check-up, if applicable.

Optional Benefit No. 22 – Health and Wellness Portal

Health and Wellness services to be offered to the Insured Person through an integrated portal providing solutions on healthy living, health and lifestyle information.

Optional Benefit No. 23 – Geographical Premium

For the purpose of policy issuance, the premium will be computed based on point of sale location
The premium that would be applicable zone wise and the cities defined in each zone are as under:
• Zone 1- Delhi NCR/Mumbai MMR- Delhi, Gurgaon, Noida, Faridabad, Ghaziabad, Greater Noida ,Mumbai, Navi Mumbai , Thane, Kalyan, Dombivali, Bhayandar, Ulhasnagar, Bhiwandi, Vasai,Virar
• Zone 2- Rest of India- All other cities The premium will be modified in case of mid-term address change involving migration from one zone to another and would be calculated on pro-rata basis. Also, We will not apply any co-payment where an Insured Person pays premium in Zone 2 and avails treatment in a Zone 1.

Optional Benefit No. 24 – Personal Accident

It is hereby agreed that in the event of any Accidental Bodily Injury we will provide the Benefits as detailed below for an event or occurrence described in any of the Benefits that occurs during the Policy Period.

Each Benefit is subject to its Sum Insured, but Our liability to make payment in respect of any and all Benefits shall be limited to the Accidental Death Sum Insured unless expressly stated to the contrary. Sum Insured limit for the benefit will apply on individual basis.

Optional Benefit No. 24.1 – Accidental Death

1) Accidental Death
   If an Insured Person suffers an Accident during the Policy Period and this is the sole and direct cause of his death within 365 days from the date of the Accident, then We will pay the Sum Insured.

2) Transportation of Mortal Remains
   If We have accepted a claim under 1), then We will in addition reimburse the lower of 2% of the Sum Insured under Benefit 1 above and the actual amount incurred in transporting the mortal remains of the Insured Person from the place of the Accident or the Hospital to his residence or Hospital or to a cremation or burial ground.

3) Cremation Ceremony
If We have accepted a claim 1), then We will in addition pay the lumpsum Sum Insured towards the costs of the cremation or burial of the Insured Person.

Optional Benefit No. 24.2 – Permanent Total Disablement

- If an Insured Person suffers an Accident during the Policy Period and within 365 days from the date of the Accident which is the sole and direct cause of his permanent total disablement in one of the ways detailed in the table below, then We will pay the percentage of the Sum Insured shown in the table.

	% of Sum Insured
Loss of 2 Limbs (both hands or both feet or one hand and one foot)	100%
Loss of a Limb and an eye	100%
Complete and irrecoverable loss of sight of both eyes	100%
Complete and irrecoverable loss of speech & hearing of both ears	100%
Loss of a Limb	50%
Complete and irrecoverable loss of sight of an eye	50%

- In this Benefit:
  a. Limb means a hand at or above the wrist or a foot above the ankle.
  b. Loss of Limb means:
     i. the physical separation of a Limb above the wrist or ankle respectively, or
     ii. the total loss of functional use of a Limb for at least 365 days from the date of onset of such disability provided that We must be satisfied at the expiry of the 365 days that there is no reasonable medical hope of improvement.

Optional Benefit No. 24.3 – Permanent Partial Disablement

- If an Insured Person suffers an Accident during the Policy Period and within 365 days from the date of the Accident which is the sole and direct cause of his permanent partial disablement in one of the ways detailed in the table below, then We will pay the percentage of the Sum Insured shown in the table.

Loss of:	**% of Sum Insured**
Each arm at the shoulder joint	70%
Each arm to a point above elbow joint	65%
Each arm below elbow joint	60%
Each hand at the wrist	50%
Each thumb	20%
Each index finger	10%
Each other finger	5%
Each leg above center of the femur	70%
Each leg up to a point below the femur	65%
Each leg to a point below the knee	50%
Each leg up to the center of tibia	45%
Each foot at the ankle	40%
Each big toe	5%
Each other toe	2%
Each eye	50%
Hearing in each ear	30%
Sense of smell	10%

Sense of taste	5%

- In this Benefit:
  a) Loss means:
    i. the physical separation of a body part, or
    ii. the total loss of functional use of a body part or organ provided this has continued for at least 365 days from the onset of such disability provided that We are satisfied at the expiry of the 365 days that there is no reasonable medical hope of improvement.

- If an Insured Person suffers a Loss not mentioned in the table above, then We will assess the degree of disablement with an independent medical advisors and determine the amount of payment to be made.

- If a claim in respect of a whole member (any organ, organ system or a limb) also encompasses some or all of its parts, Our liability to make payment will be limited to the member only and not any of its parts or constituents.

Optional Benefit No. 24.4 – Emergency Ambulance
If We have accepted a claim under this Policy and following the Accident it is necessary to immediately transfer the Insured Person to the nearest Hospital by ambulance offered by a healthcare or ambulance service provider, then We will in addition reimburse the actual expenses of the transfer using the shortest route upto Rs 2000.

Optional Benefit No. 24.5 – Out-patient Accident Treatment
If any Insured Person suffers an Accident during the Policy Period that requires Outpatient Treatment, then We will in addition reimburse the Medical Expenses incurred for such Insured Person provided that the Treatment commences within the Policy Period. Our liability to meet Medical Expenses caused by such Accident will be upto Benefit Sum Insured as mentioned in Policy Schedule.

Optional Benefit No. 24.6 – Broken Bones
If an Accident causes an Insured Person to suffer a fracture (a break in the continuity of a bone) and this is certified by a Doctor and also confirmed by imaging investigations such as by X-ray, then We will pay the percentage of the Sum Insured specified in the table below.

	% of Sum Insured
Injury to vertebral body resulting in spinal cord damage	100%
Pelvis	100%
Skull (excluding nose and teeth)	30%
Chest (all ribs and breast bone)	50%
Shoulder (collar bone and shoulder blade)	30%
Arm	25%
Leg	25%
Vertebra – vertebral arch (excluding coccyx)	30%
Wrist (collies or similar fractures)	10%
Ankle (Potts or similar fracture)	10%
Coccyx	5%
Hand	3%

Finger	3%
Foot	3%
Toe	3%
Nasal bone	3%

Special Exclusions applicable with Personal Accident Benefit: Following exclusions will be applicable only for Personal Accident Benefit.

a. Special Exclusions to Optional Benefit No 24.1 – 24.5
   i. Bacterial infections (except pyogenic infection which occurs through an Accidental cut or wound).
   ii. Medical or surgical treatment except as necessary solely and directly as a result of an Accident.

b. Special Exclusion to Optional Benefit No 24.6
   i. Sickness or disease.
   ii. Any fracture due to osteoporosis or a malignant disease.
   iii. Any hair line fracture.

c. General Exclusion applicable to all Benefits
   i. Any Pre-existing Condition or any complication arising from the same.
   ii. Intentional self injury, suicide or attempted suicide, while sane or insane.
   iii. AIDS (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human immunodeficiency virus), venereal disease, sexually transmitted disease or illness,
   iv. Any Insured Person's participation or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing.
   v. Arising or resulting from the insured person(s) committing any breach of law with criminal intent.
   vi. The abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as drugs and alcohol.
   vii. 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, revolution, insurrection, military or usurped acts, chemical, radioactive or nuclear contamination.
   viii. Pregnancy or childbirth or in consequence thereof.
   ix. External congenital diseases, defects or anomalies or in consequence thereof.
   x. Treatments rendered by a Doctor who shares the same residence as an Insured Person or who is a member of an Insured Person's family.
   xi. Any non-allopathic treatment.

Special Conditions applicable with Personal Accident Benefit: In addition to the General Conditions mentioned in the Section 3 of policy wordings, the below mentioned conditions are applicable for Personal Accident Benefit as and when applicable.

a. Notification of claim
   i. We must be informed of any event or occurrence that may give rise to a claim under this Policy within 30 days of it happening
   ii. For all benefits contingent on Our prior acceptance of a claim under Optional Benefit 24.1 – 24.3, We must be informed within 30 days of the event or occurrence that may give rise to a contingent benefit claim.

iii. If any time period is specifically mentioned in Optional Benefit 24, then this shall supersede the time periods mentioned at i) and ii) above.

b. Claims Payment Supporting Documentation & Examination

i. We must be provided with any documentation and information We may request to establish the circumstances of the claim, its quantum or Our liability for it including, Our claim form duly completed and all reports, including death certificate, post mortem report , disability certificate, medical reports, case histories, investigation reports, treatment papers and discharge summaries. Please note that in case of a non-disclosure or/and a fraud suspicion we may ask for additional documentation/reports.

ii. The Insured Person additionally hereby consents to:

a) The disclosure to Us of documentation and information that may be held by medical professionals and other insurers.

b) The Insured Person shall be examined by any medical practitioner We authorise for this purpose when and so often as We may reasonably require.

c. Claims Payment

i) If We accept a claim and become liable to make payment under Permanent Total Disablement Benefit, Permanent Partial Disablement Benefit and Broken Bones (the first claim) and there is a subsequent claim under other Benefit or Accidental Death Benefit in respect of the same Insured Person and the same Accident within 365 days of the date of the Accident (the second claim), then We will only be liable to pay the difference between the amount payable for the first claim and the amount payable for the second claim.

ii) Payments under this Benefit shall only be made in Indian Rupees irrespective of the location of accident which has given rise to the claim.

d. Insured Person

If an Insured Person opts for Optional Benefit No. 24, then We will cover any Insured Persons from the age of 91 days onwards and there is no cover ceasing age for this benefit.

e. Change of Occupation

You will give Us a written notice in the format prescribed by Us of any change in the business or occupation of any Insured Person within 30 days of such change and We will issue an endorsement to this effect.

If at the time a claim arises under this Policy the Insured Person has changed his occupation without Us being notified, then Our maximum liability will be limited to the amount that would have been payable for the premium paid and the new occupation.

f. Geography

This Benefit of Personal Accident applies to events or occurrences taking place anywhere in the world unless limited by Us in a particular Benefit or definition or through an endorsement.

g. Nomination

You can change the nominee to whom such payment is to be made at any time during the Policy Period, provided that such change shall only be effective when You have notified Us and We have recorded the change by an endorsement to this effect.