Maxima

Customer Information Sheet

ApolloMunich HEALTH INSURANCE

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

The information mentioned below is illustrative and not exhaustive. Information must be read in conjunction with the product brochure and policy document. In case of any conflict between the Key Features Document and the policy document the terms and conditions mentioned in the policy document shall prevail.

TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
Product Name	Maxima Insurance	
What am I covered for:	**Out Patient Module**	
	a. Outpatient Consultations in Network/ Non-Network (on reimbursement basis only) by a general Medical Practitioner(s) or a specialist Medical Practitioner(s).	Part A, Section 1 a)
	b. Diagnostic Tests prescribed by a Medical Practitioner.	Part A, Section 1 b)
	c. Pharmacy (Medicines) prescribed in writing by a Medical Practitioner.	Part A, Section 1 c)
	d. Outpatient Dental Treatment (except cosmetic treatment).	Part A, Section 1 d)
	e. One pair of Spectacles or Contact lenses prescribed by a network Eye specialist.	Part A, Section 1 e)
	f. Annual Health Check Up within specified Network	Part A, Section 1 f)
	Inpatient Module	
	a. In-patient Treatment - Covers hospitalisation expenses for period more than 24 hrs.	Part B, Section 3 a)
	b. Pre-Hospitalisation - Medical Expenses incurred in 30 days before the hospitalisation, can be increased to 60 days if claim is intimated 5 days before hospitalisation.	Part B, Section 3 b)
	c. Post-Hospitalisation - Medical Expenses incurred in 60 days after the hospitalisation, can be increased to 90 days if claim is intimated 5 days before hospitalisation.	Part B, Section 3 c)
	d. Day-Care procedures - Medical Expenses for 140 listed Day care procedures.	Part B, Section 3 d)
	e. Domiciliary Treatment - Medical Expenses incurred for availing medical treatment at home which would otherwise have required hospitalisation.	Part B, Section 3 e)
	f. Daily Cash for choosing shared accommodation - Daily cash amount if hospitalised in Shared accommodation in Network Hospital and hospitalisation exceeds 48 hrs.	Part B, Section 3 f)
	g. Organ Donor - Medical Expenses for an organ donor's treatment for organ transplantation.	Part B, Section 3 g)
	h. Emergency Ambulance - Upto Rs. 2,000 per hospitalisation for utilizing ambulance service for transporting Insured Person to hospital in case of an emergency.	Part B, Section 3 h)
	i. Daily Cash for accompanying an insured child - Daily cash amount for 1 accompanying adult if insured child aged 12 years or less is hospitalised and hospitalisation exceeds 72 hrs.	Part B, Section 3 i)
	j. Maternity Expenses - Medical Expenses for maternity including pre-natal and post-natal expenses after a waiting period of 4 years.	Part B, Section 3 j)
	k. Newborn baby - Optional Coverage for newborn from birth (day 1-90) for In-patient Treatment benefit, subject to acceptance of proposal and premium payment in full.	Part B, Section 3 k)
	Critical Illness (Optional Benefit) for listed Critical Illness, subject to first diagnosed during the policy period and the Insured Person survives 30 days after such diagnosis.	Part B, Section 5
What are the major exclusions in the policy:	Following is a partial list of the policy exclusions. Please refer to the policy wording for the complete list of exclusions.	Part B, Section 6
	Outpatient Module - Nil	
	Inpatient Module - War or any act of war, nuclear, chemical & biological weapons, radiation of any kind, breach of law with criminal intent, attempted suicide, participation or involvement in naval, military or air force operation, adventurous sports, abuse of intoxicants or hallucinogenic substances, treatment of obesity, Psychiatric, mental disorders, congenital internal or external diseases, defects or anomalies, genetic disorders; sleep apnoea, HIV or AIDs and related diseases, treatment of Sterility, infertility, fertility, sub-fertility, surrogate or vicarious pregnancy, birth control, plastic surgery or cosmetic surgery, any non allopathic treatment.	
	Critical Illness - Any Critical Illness within 90 days of the commencement of the policy.	Part B, Section 5

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Waiting Period	Outpatient Module - Nil Inpatient Module - • 30 days for all illnesses (except accident) • 24 months for specific illness and treatment • Pre-existing diseases will be covered after a waiting period of 36 months.	Part B, Section 6 b) Part B, Section 6 c) Part B, Section 6 d)
Payout basis	**Outpatient Module -** Cashless or Reimbursement of covered expenses upto specified limits.. **Inpatient Module -** Cashless or Reimbursement of covered expenses upto specified limits. **Critical Illness -** Lumpsum amount on the occurrence of a covered event.	Part A Part B, Section 3 Part B, Section 5
Cost Sharing	**Outpatient Module -** Not applicable. **Inpatient Module -** Not applicable.	
Renewal Conditions	• Policy is ordinarily life-long renewable, subject to application for renewal and the renewal premium in full has been received by the due dates and realisation of premium. • For Optional Benefit of Critical Illness, renewal is allowed till the age of 70 years. • Grace period of 30 days for renewing the policy is provided, any claim incurred during break-in period will not be payable under this policy.	Part C q)
Renewal Benefits	**Outpatient Module -** Carry forward 50% of the unutilised Entitlement Certificates to the next policy year except for Annual Health CheckUp benefit. **Inpatient Module -** 10% increase in your annual inpatient benefit sum insured for every claim free year, subject to a maximum of 50%. In case a claim is made during a policy year, the cumulative bonus would reduce by 10% in the following year.	Part A, Section 2 Part B, Section 4
Cancellation	This policy would be cancelled, and no claim or refund would be due to if (1) You have not correctly disclosed details about your current and past health status OR (2) Have otherwise encouraged or participated in any fraudulent claims under the policy.	Part C u), v), w), x)

Apollo Munich Health Insurance Company Limited will provide the insurance cover detailed in the Policy to the Insured Person up to the Sum Insured subject to the terms and conditions of this Policy, Your payment of premium, and Your statements in the Proposal, which is incorporated into the Policy and is the basis of it.

Part A - Out-patient Module

Claims made in respect of any of the benefits in this Part A will not be subject to the Sum Insured and will affect the entitlement to a Carry Forward Bonus.

However, Our maximum liability for each benefit in Section 1 to this Part A shall be limited to the amount specified in the Schedule of Benefits against such benefit. An Insured Person shall only be eligible to take the treatment, consultation or procedure under a Part A, Section 1 benefit if all of the following requirements are satisfied :

a) We have issued an Entitlement Certificate to the Insured Person for the specific treatment, consultation or procedure; and
b) The Entitlement Certificate is used for the specific treatment, consultation or procedure specified in it; and
c) Any conditions or limitations specified in the Entitlement Certificate are strictly adhered to; and
d) The Entitlement Certificate is used (and will only be effective) at only a Network service provider; and
e) The Insured Person gives the Entitlement Certificate to the Network service provider before receiving or undergoing the treatment, consultation or procedure specified in it.
f) The treatment, consultation or procedure specified in the Entitlement Certificate is taken or undergone by the Insured Peson during the Policy Period.
g) The payment of premium in full and in time.
h) If an Entitlement Certificate has been used and results in treatment to which Part B responds, then it is agreed and understood that We would be refunding the Entitlement Certificate used for pre-hospitalisation by issuing fresh Entitlement Certificate.

Section. 1 Out-patient Benefits

An Entitlement Certificate may be obtained by the Insured Person for his own use for one of the specified treatments, consultations or procedures under a benefit mentioned in a) – f) below:

a) Out-patient Consultations
Out-patient consultation by a general Medical Practitioner or a specialist Medical Practitioner as further specified in the Entitlement Certificate in a Network Hospital.
   i. The non-network Out-patient consultations will be covered on reimbursement basis subject to the number of consultations and the amount specified in the Schedule of Benefits.
b) Diagnostic Tests
Out-patient diagnostic tests taken by the Insured Person from a diagnostic centre (not necessarily to be prescribed by Network Medical Practitioner).
c) Pharmacy
Medicines purchased by the Insured Person from a pharmacy, provided that such medicines have been prescribed in writing by a Medical Practitioner (not necessarily to be Network Medical Practitioner).
d) Out-patient Dental Treatment
Any necessary dental treatment taken by an Insured Person from dentist, provided that We will not pay for any dental treatment that comprises cosmetic treatment.
e) Spectacles, Contact lenses
Either one pair of spectacles or contact lenses, as specified in the Entitlement Certificate provided that these have been prescribed for the Insured Person by an eye specialist Medical Practitioner
f) Annual Health Check-Up within specified Network
A health check-up as specified in the Schedule of Benefits for the Insured Person within Network.
This benefit is not available to the Insured Persons below 18 years of age and above the age of 45 years in the first Policy Year with Us

Section. 2 Carry Forward Bonus

a) If the Policy is renewed with Us without any break and there are any available Entitlement Certificates not used by the Insured Person in a Policy Year, then We will carry forward 50% of these Entitlement Certificates to the next Policy Year.
b) It is expressly agreed and understood that:
   i) a carry forward will only apply in respect of any particular Entitlement Certificate for one Policy Year; and
   ii) there shall be no carry forward of any Entitlement Certificate for the benefit at Section 1f) of Part A.
   iii) there will be no Carry Forward Bonus unless the originals of all unused Entitlement Certificates are returned to Us before renewal (grace period of 15 days from the due date of renewal).
   iv) for the purpose of computing carry forward of any Entitlement Certificate; in the event of unused Entitlement Certificates received are in odd number, We will round them off to next increased number.
c) To obtain carry forward Entitlement Certificates, You have to send Us all unused Entitlement Certificates before renewal. After verifying the Entitlement Certificates and checking the admissibility of Carry Forward Bonus as mentioned above, fresh Entitlement Certificates will be issued within 30 days of the receipt of the unused Entitlement Certificates provided that the policy is renewed with Us without a break.

Part B - In-patient Module

Section. 3 In-patient Benefits

Claims made in respect of any of the benefits below will be subject to the Sum Insured and will affect the entitlement to a cumulative bonus.

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

a) In-patient Treatment The Medical Expenses for:

   i. Room rent, boarding expenses,
   ii. Nursing,
   iii. Intensive care unit,
   iv. Medical Practitioner(s),
   v. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances,
   vi. Medicines, drugs and consumable,
   vii. Diagnostic procedures,
   viii. The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure.

b) Pre-Hospitalisation

The Medical Expenses incurred in the 30 days immediately before the Insured Person was Hospitalised, provided that :

   i. such Medical Expenses were in fact incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and
   ii. We have accepted an in-patient Hospitalisation claim under Section 3 a).
   iii. We will pay the Medical Expenses incurred within the 60 days prior to the date of Hospitalisation, if we are provided with the following at least 5 days before the Hospitalisation:
      (1) medical documents with all details about the Illness; and
      (2) the date and the place of the proposed Hospitalisation.

c) Post-hospitalisation

The Medical Expenses incurred in the 60 days immediately after the Insured Person was discharged post Hospitalisation provided that:

   i) such costs are incurred in respect of the same condition for which the Insured Person's earlier Hospitalisation was required, and
   ii) We have accepted an in-patient Hospitalisation claim under Section 3 a).
   iii) We will pay the Medical Expenses in the 90 days immediately after the Insured Person was discharged if We were provided with the following at least 5 days before the Hospitalisation :
      (1) medical documents with all details about the Illness; and
      (2) the date and the place of the proposed Hospitalisation.

d) Day Care Procedures

The Medical Expenses for a day care procedure or surgery mentioned in the list of Day Care Procedures in this Policy where the procedure or surgery is taken by the Insured Person as an in-patient for less than 24 hours in a Hospital or standalone day care centre but not the out-patient department of a Hospital or standalone day care centre.

e) Domiciliary Treatment

The Medical Expenses incurred by an Insured Person for medical treatment taken at his home which would otherwise have required Hospitalisation because, on the advice of the attending Medical Practitioner, the Insured Person could not be transferred to a Hospital or a Hospital bed was unavailable, and provided that:

   i) The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the reasonable cost of any necessary medical treatment for the entire period, and

ii) If We accept a claim under this Benefit We will not make any payment for Post-Hospitalisation expenses but We will pay Pre-hospitalisation expenses for up to 60 days in accordance with b) above, and

iii) No payment will be made if the condition for which the Insured Person requires medical treatment is:
(1) Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza,
(2) Arthritis, Gout and Rheumatism,
(3) Chronic Nephritis and Nephritic Syndrome,
(4) Diarrhoea and all type of Dysenteries including Gastroenteritis,
(5) Diabetes Mellitus and Insupidus,
(6) Epilepsy,
(7) Hypertension,
(8) Psychiatric or Psychosomatic Disorders of all kinds,
(9) Pyrexia of unknown Origin.

f) Daily Cash for choosing Shared Accommodation

Note: Claims made in respect of this benefit will be subject to the Sum Insured and will affect the entitlement to a cumulative bonus.

A daily cash amount will be payable per day 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 exceeds 48 hours, provided that :

i) Our maximum liability shall be restricted to the amount mentioned in the Schedule of Benefits, and
ii) The days of admission and discharge shall not be counted, and
iii) This benefit shall not apply to time spent by the Insured Person in an intensive care unit, and
iv) We have accepted an in-patient Hospitalisation claim under Section 3 a).

g) Organ Donor

The Medical Expenses for an organ donor's treatment for the harvesting of the organ donated, provided that:

i) The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994 and the organ donated is for the use of the Insured Person, and
ii) We will not pay the donor's pre- and post-hospitalisation expenses or any other medical treatment for the donor consequent on the harvesting, and
iii) We have accepted an in-patient Hospitalisation claim under Section 3 a).

h) Emergency Ambulance

We will reimburse the expenses incurred on an ambulance offered by a healthcare or ambulance service provider used to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of health services following an emergency (namely a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention), provided that:

i) Our maximum liability shall be restricted to the amount mentioned in the Schedule of Benefits per Hospitalisation, and
ii) We have accepted an in-patient Hospitalisation claim under Section 3 a).
iii) The coverage includes the cost of the transportation of the Insured Person from a Hospital to the nearest Hospital which is prepared to admit the Insured Person and provide the necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person is situated, provided that transportation has been prescribed by a Medical Practitioner and is medically necessary.

i) Daily Cash for Accompanying an Insured Child

Note : Claims made in respect of this benefit will be subject to the Sum Insured and will affect the entitlement to a cumulative bonus.

If the Insured Person Hospitalised is a child Aged 12 years or less, We will pay a daily cash amount for 1 accompanying adult for each complete period of 24 hours if Hospitalisation exceeds 72 hours, provided that:

i) Our maximum liability shall be restricted to the amount mentioned in the Schedule of Benefits, and
ii) the days of admission and discharge shall not be counted, and
iii) We have accepted an in-patient Hospitalisation claim under Section 3 a).

j) Maternity Expenses

Note : Claims made in respect of this benefit will not be subject to the Sum Insured and will not affect the entitlement to a cumulative bonus.

We will pay the Medical Expenses for a delivery (including caesarean section) while Hospitalised or the lawful medical termination of pregnancy during the Policy Period limited to 2 deliveries or terminations or either during the lifetime of the Insured Person, provided that:

i) Our maximum liability per delivery or termination shall be limited to the amount specified in the Schedule of Benefits, and
ii) We will pay the Medical Expenses of pre-natal and post-natal expenses per delivery or termination upto the amount stated in the Schedule of Benefits, and
iii) We will cover the Medical Expenses incurred for the medically necessary treatment of the infant baby upto the amount stated in the Schedule of Benefits unless the infant baby is covered under Section 3k), and
iv) this benefit is not available for Dependents other than Your spouse under a Family Floater, and
v) pre- and post-hospitalisation expenses under Section 3b) and Section 3c) are not covered under this benefit, and
vi) the Insured Person must have been an Insured Person under Our Policy for the period of time specified in the Schedule of Benefits, and
vii) We will not cover ectopic pregnancy under this benefit (although it shall be covered under Section 3a).

k) Newborn baby

Note : This benefit is optional and effective only if noted as such in the Schedule of Benefits. The sum insured of this benefit is above the Maternity Sum Insured limit; will be equivalent to Individual Sum Insured [Rs. 300,000] under 1 Member plan and Floater Sum Insured [Rs.300,000] under 2 Adults & upto 2 Children plan.

We will cover the Medical Expenses of any medically necessary treatment described at Section 3a) while the Insured Person is Hospitalised during the Policy Period as an in-patient for a Newborn Baby provided that:

i) We have accepted a claim under Section 3j), and
ii) You have submitted a proposal for the insurance of the newborn baby within 30 working days after the birth, and We have in Our sole and absolute discretion accepted the same and received the premium sought.

New born Baby means those babies born to You and Your spouse during the Policy Period Aged between 1 day and 90 days.

Section. 4 Cumulative Bonus

a) If no claim has been made in respect of Section 1 and 2 under this Policy and the Policy is renewed with Us without any break, We will apply a cumulative bonus to the next Policy Year by automatically increasing the Sum Insured for the next Policy Year by 10% of the Sum Insured for this Policy Year. The maximum cumulative bonus shall not exceed 50% of the Sum Insured in any Policy Year.
b) In relation to a Family Floater, 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.
c) If a cumulative bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the cumulative bonus by 10% of the Sum Insured in that following Policy Year. There will be no impact on the Inpatient Sum Insured, only the accrued cumulative bonus will be decreased.
d) Portability benefit will be offered to the extent of sum of previous sum insured and accrued cumulative bonus(if opted for), portability benefit shall not apply to any other additional increased sum insured.

Section. 5 Optional Benefit - Critical Illness

Claims made in respect of any of the benefits below will not be subject to the Sum Insured and will not affect entitlement to a cumulative bonus.

If the Schedule shows that the Critical Illness benefit is effective, then We will pay the Critcal Illness Sum Insured as a
lump sum in addition to Our payment under Section 3a), provided that:

i) the Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period, and
ii) the Insured Person survives for at least 30 days following such diagnosis.

We will not make any payment if:

i) the Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the commencement of the Policy Period and the Insured Person has not previously been insured continuously and without interruption under a Maxima Insurance Policy.

ii) the Insured Person has already made a claim for the same Critical Illness.

iii) a claim for this benefit has already been made 3 times under this Policy or any other policy issued by Us.

Section. 6 Exclusions [Applicable to Part B only]

Waiting Periods

a) We are not liable for any treatment which begins during waiting periods except if any Insured Person suffers an Accident.

30 days Waiting Period

b) A waiting period of 30 days (or longer if specified in any benefit) will apply to all claims unless:

i) the Insured Person has been insured under a Maxima Insurance Policy continuously and without any break in the previous Policy Year.

ii) the Insured Person was insured continuously and without interruption for at least 1 year under any other health insurance plan with an Indian non life insurer as per guidelines on portability issued by the Insurance Regulator.

iii) if the Insured person renews with Us or transfers from any other insurer and increases the Sum Insured (other than as a result of the application of Benefit 4a) upon renewal with Us), then this exclusion shall only apply in relation to the amount by which the Sum Insured has been increased.

Specific Waiting Periods

c) The Illnesses and treatments listed below will be covered subject to a waiting period of 2 years as long as in the third Policy Year the Insured Person has been insured under a Maxima Insurance Policy continuously and without any break:

i) Illnesses: arthritis if non infective; calculus diseases of gall bladder and urogenital system; cataract; fissure/fistula in anus, hemorrhoids, pilonidal sinus, gastric and duodenal ulcers; gout and rheumatism; internal tumors, cysts, nodules, polyps including breast lumps (each of any kind unless malignant); osteoarthritis and osteoporosis if age related; polycystic ovarian diseases; sinusitis and related disorders and skin tumors unless malignant.

ii) Treatments: benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty); dilatation and curettage (D&C); hysterectomy for menorrhagia or fibromyoma or prolapse of uterus unless necessitated by malignancy; joint replacement; myomectomy for fibroids; surgery of gallbladder and bile duct unless necessitated by malignancy; surgery of genito urinary system unless necessitated by malignancy; surgery of benign prostatic hypertrophy; surgery of hernia; surgery of hydrocele; surgery for prolapsed inter vertebral disk; surgery of varicose veins and varicose ulcers; surgery on tonsils and sinuses; nasal septum deviation.

iii) However, a waiting period of 2 years will not apply if the Insured Person was insured continuously and without interruption for at least 2 years under any other health insurance plan with an Indian non life insurer as per guidelines on portability issued by the Insurance Regulator.

iv) If the Insured person renews with Us or transfers from any other insurer and increases the Sum Insured (other than as a result of the application of Benefit 4a) upon renewal with Us), then this exclusion shall only apply in relation to the amount by which the Sum Insured has been increased.

d) Pre-existing Conditions will not be covered until 36 months of continuous coverage have elapsed, since inception of the first Maxima policy with us, but 1) If the Insured Person is presently covered and has been continuously covered without any lapses under:

a) any other health insurance plan with an Indian non life insurer as per guidelines on portability issued by the Insurance Regulator, OR

b) any other similar health insurance plan from Us,

then Section 6 (d) of the Policy stands deleted and shall be replaced entirely with the following:

i) The waiting period for all Pre-existing Conditions shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy; AND

ii) If the proposed Sum Insured for a proposed Insured Person is more than the Sum Insured applicable under the previous health insurance policy (other than as a result of the application of Benefit 4a), then the reduced waiting period shall only apply to the extent of the Sum Insured under the previous health insurance policy.

2) The reduction in the waiting period specified above shall be applied subject to the following:

a) We will only apply the reduction of the waiting period if We have received the database and claim history from the previous Indian insurance company (if applicable);

b) We are under no obligation to insure all Insured Persons or to insure all Insured Persons on the proposed terms, or on the same terms as the previous health insurance policy even if You have submitted to Us all documentation

c) We shall considered only completed years of coverage for waiver of waiting periods. Policy Extensions if any sought during or for the purpose of porting insurance policy shall not be considered for waiting period waiver

d) We will retain the right to underwrite the proposal as per Our underwriting guidelines.

e) We will not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy:

i) 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 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, or intentional self injury or attempted suicide while sane or insane.

iii) 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.

iv) The abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as drugs and alcohol, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services, or supplies.

v) Treatment of obesity and any weight control program.

vi) Psychiatric, mental disorders (including mental health treatments), Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down condition"); congenital internal or external diseases, defects or anomalies, genetic disorders; stem cell implantation or surgery, or growth hormone therapy; sleep apnoea.

vii) Venereal disease, sexually transmitted disease or illness; "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus) including but not limited to conditions related to or arising out of HIV/AIDS such as ARC (AIDS related complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis.

viii) Save as and to the extent provided for under Section 3j), pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or birth (including caesarean section) except in the case of ectopic pregnancy in relation to Section 3a) only.

ix) Sterility, treatment whether to effect or to treat infertility, any fertility, sub-fertility or assisted conception procedure, surrogate or vicarious pregnancy, birth control, contraceptive supplies or services including complications arising due to supplying services.

x) Save as and to the extent provided for under Section 1d), dental treatment and surgery of any kind, unless requiring Hospitalisation.

xi) Expenses for donor screening, or, save as and to the extent provided for in Section 3g), the treatment of the donor (including surgery to remove organs from a donor in the case of transplant surgery).

xii) 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 for treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.

xiii) Treatment of nasal concha resection; circumcisions [unless medically necessary]; laser treatment for correction of eye due to refractive

error; aesthetic or change-of-life treatments of any description such as sex transformation operations; treatments to do or undo changes in appearance or carried out in childhood or at any other times driven by cultural habits, fashion or the like or any procedures which improve physical appearance.

xiv) Plastic surgery or cosmetic surgery unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident or Illness.

xv) Save as and to the extent provided under Section 1b), experimental, investigational or unproven treatment devices and pharmacological regimens, or measures primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital.

xvi) Convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care,long-term nursing care or custodial care.

xvii) Any non allopathic treatment.

xviii) Save as and to the extent provided under Section 1b) and 1f), all preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment), any physical, psychiatric or psychological examinations or testing during these examinations; enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

xix) Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing.

xx) Items of personal comfort and convenience including but not limited to television (wherever specifically charged for), charges for access to telephone and telephone calls, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies, and vitamins and tonics unless vitamins and tonics are certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

xxi) Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; treatments rendered by a Medical Practitioner who shares the same residence as an Insured Person or who is a member of an Insured Person's family, however proven material costs are eligible for reimbursement in accordance with the applicable cover.

xxii) Save as and to the extent provided in Section 1e), the 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.

xxiii) Any treatment or part of a treatment that is not of a reasonable cost, not medically necessary; drugs or treatments which are not supported by a prescription.

xxiv) Artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively).

xxv) Any exclusion mentioned in the Schedule or the breach of any specific condition mentioned in the Schedule.

xxvi) Any non medical expenses mentioned in Annexure II.

Part C: General Conditions

Condition precedent

a) The fulfilment of the terms and conditions of this Policy (including the payment of premium by the due dates mentioned in the Schedule) in so far 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.

Insured Person

b) Only those persons named as an Insured Person in the Schedule shall be covered under this Policy. Any person may be added during the Policy Period after his application has been accepted by Us, additional premium has been paid and 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 cumulative bonus, waiver of waiting period etc. provided the policy has been maintained without a break as per portability guidelines issued by IRDA.

We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis / medical condition and an overall risk loading of over 150% per person. These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured). We will inform You about the applicable risk loading through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 15 days, we shall cancel your application and refund the premium paid within next 7 days. Please note that We will issue Policy only after getting Your consent.

c) **Notification of Claim**

	Treatment, Consultation or Procedure:	Apollo Munich must be informed:
1)	If any treatment under Part B 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.
2)	If any treatment under Part B 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.
3)	For all benefits which are contingent on Our prior acceptance of a claim under Section 3a):	Within 7 days of the Insured Person's discharge post-Hospitalisation.
4)	If any treatment, consultation or procedure under Part B for which a claim may be made is required in an emergency:	Within 7 days of completion of such treatment, consultation or procedure.
5)	In all other cases:	Of any event or occurrence that may give rise to a claim under Part B of this Policy at least 7 days prior to any consequent treatment, consultation or procedure and Apollo Munich must pre-authorise such treatment, consultation or procedure.

Please note that:

a) If any time period is specifically mentioned in Part B, then this shall supersede the time periods mentioned in 1)-5) above.

b) Emergency means a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention.

Cashless Service

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure taken at:	Cashless Service is available:	We must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars:

1)	If any planned treatment, consultation or procedure for which a claim may be made under Part B:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	At least 48 hours before the planned treatment or Hospitalisation.
2)	If any treatment, consultation or procedure for which a claim may be made under Part B is to be taken in an emergency:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Within 24 hours after the treatment or Hospitalisation.

Please note that emergency means a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention.

Supporting Documentation & Examination

d) The Insured Person shall provide Us with any documentation and information Apollo Munich may request to establish the circumstances of the claim under Part B, 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. Such documentation will include but is not limited to the following:
   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, including but not limited to all medical reports, case histories, 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.
   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 Medical Practitioner's invoice if fees have been paid to that Medical Practitioner and are being claimed under the Policy.
   vii) Obs history/ Antenatal card
   viii) Previous treatment record along with reports, if any
   ix) Indoor case papers
   x) Treating doctors certificate regarding the duration & etiology
   xi) MLC/ FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent, in case of Accidental injury

e) The Insured Person additionally hereby consents to:
   i) The disclosure to Us of documentation and information that may be held by medical professionals and other insurers.
   ii) Being examined by any doctor We authorise for this purpose when and so often as We may reasonably require and at Our cost.

Claims Payment

f) We shall be under no obligation to make any payment under Part B unless We have received all premium payments in full and in time and all payments have been realised and We have been provided with the documentation and information requested to establish the circumstances of the claim under Part B, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy. We shall be under no obligation to provide any benefit through an Entitlement Certificate under Section 1 Part A unless We have received all premium payments in full and in time and all payments have been realised and the Insured Person has given a valid and relevant Entitlement Certificate to the Network Service Provider before receiving any treatment, consultation or procedure under that Section. If the Entitlement Certificate has been used in any manner contrary to the requirements set out in the introduction to Part A, then We shall be entitled to deduct from any payment that is or may be due under Part B or any policy issued by Us and/or any premium subsequently received in respect of any policy issued by Us the value of the Entitlement Certificate and the costs and expenses as deducted by Us which We have incurred due to the unauthorised use of the Entitlement Certificate. It is agreed and understood that if We make any recovery from premium subsequently received then that premium shall be deemed to have been received short and it is further agreed and understood that the terms of this clause shall survive the termination of the Policy.

g) We will only make payment under Part B to or at Your direction. If an Insured Person submits the requisite claim documents and information along with a declaration in a format acceptable to Us of having incurred the expenses, this person will be deemed to be authorised by You to receive the concerned payment. In the event of the death of You or an Insured Person, We will make payment to the Nominee (as named in the Schedule).

h) This Policy only covers medical treatment or that part of medical treatment which is taken within India, and payments under this Policy shall only be made in Indian Rupees within India.

i) We are not obliged to make payment for any claim under Part B or that part of any claim under Part B that could have been avoided or reduced if the Insured Person had taken reasonable care or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.

j) 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 submission of all necessary documents / 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 IRDA (Protection of Policyholders Regulation), 2002. 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 IRDA (Protection of Policyholders Regulation), 2002, we shall pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us. For the purpose of this clause, 'bank rate' shall mean the existing bank rate as notified by Reserve Bank of India, unless the extent regulation requires payment based on some other prescribed interest rate.

Fraud

k) 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 any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be void and all benefits paid under it shall be forfeited.

l) An Entitlement Certificate issued under Part A shall be used solely by the Insured Person named therein. The Insured Person shall not sell, exchange, trade, barter or transfer or allow any person to use his Entitlement Certificate. Any contravention of this condition shall be in addition to any remedies available to Us and shall also be deemed to constitute a failure to satisfy the requirements set out in Part A.

m) We will replace a lost Entitlement Certificate only when We are satisfied that it is lost. However, We reserve the right to make such investigations into and call for such evidence of the loss of the Entitlement Certificate at Your expense as We consider necessary before issuing a duplicate Entitlement Certificate. Any contravention of this condition shall be in addition to any remedies available to Us and shall also be deemed to constitute a failure to satisfy the requirements set out in Part A.

Other Insurance

n) If at the time when any claim is made under this Policy, insured 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 Policy holder shall have the right to require a settlement of his claim in terms of any of his policies. The insurer so chosen by the Policy holder 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 Policy holder, exceeds the sum insured under a single Policy after considering the deductibles or co-pay (if applicable), the Policy holder 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 claim by applying the Contribution clause . This clause shall only apply to indemnity sections of the policy.

Subrogation

o) You and/or any Insured Persons shall do or concur in doing or permit to be

done all such acts and things that may be necessary or reasonably required by Us for the purpose of enforcing and/or securing any civil or criminal rights and remedies or obtaining relief or indemnity from any other party to which We are or would become entitled upon Us making reimbursement under Part B (except in relation to a payment under Section 5), whether such acts or things shall be or become necessary or required before or after Our payment. Neither You nor any Insured Person shall prejudice these subrogation rights in any manner and shall provide Us with whatever assistance or cooperation is required to enforce such rights. Any recovery We make pursuant to this clause shall first be applied to the amounts paid or payable by Us under this Policy and Our costs and expenses of effecting a recovery, whereafter We shall pay any balance remaining to You.

Alterations to the Policy

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

Renewal

q) This Policy is ordinarily renewable for life unless the Insured Person or anyone acting on behalf of an Insured Person has acted in an improper, dishonest or fraudulent manner or there has been any misrepresentation under or in relation to this Policy or the renewal of the Policy poses a moral hazard.
We are NOT under any obligation to:
i. Send renewal notice or reminders.
ii. Renew it on same terms or premium as the expiring Policy. Any change in benefit or premium (other than due to change in Age) will be done with the approval of the Insurance Regulatory and Development Authority and will be intimated to You atleast 3 months in advance. In the likelihood of this policy being withdrawn in future, we will intimate you about the same 3 months prior to expiry of the policy. You 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 cumulative bonus, waiver of waiting period etc. provided the policy has been maintained without a break as per portability guidelines issued by IRDA.
iii. We will not apply any additional loading on your policy premium at renewal based on claim experience.
We shall be entitled to call for any information or documentation before agreeing to renew the Policy. Your Policy terms may be altered based on the information received.
All applications for renewal of the Policy must be received by Us 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.

Change of Policyholder

r) If You do not renew the Policy the Insured Persons may apply to renew the Policy within 7 days of the end of the Policy Period provided that they have identified a new adult policyholder who is a member of their immediate family. If We accept such application and the premium for the renewed policy is paid on time, then the Policy shall be treated as having been renewed without any break in cover.

Notices

s) Any notice, direction or instruction under this Policy shall be in writing and if it is to:
i) Any Insured Person, then it shall be sent to You at Your address specified in the Schedule and You shall act for all Insured Persons for these purposes
ii) Us, it shall be delivered to Our address specified in the Schedule. No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on Our behalf unless We have expressly stated to the contrary in writing.

Dispute Resolution Clause

t) 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.

Termination

u) You may terminate this Policy at any time by giving Us written notice, and the Policy shall terminate when such written notice is received. If no claim has been made under the Policy, then We will refund premium in accordance with the table below:

Length of time Policy in force	Refund of premium
up to 1 month	75%
up to 3 months	50%
up to 6 months	25%
exceeding 6 months	0%

v) If We believe that You or any Insured Person or anyone acting on Your behalf or on behalf of an Insured Person has acted in a dishonest or fraudulent manner under or in relation to this Policy or the continuance of the Policy poses a moral hazard then We may terminate this Policy upon 30 days notice by sending an endorsement to Your address shown in the Schedule. Premium shall be refunded pro-rata if no claim has been admitted under the Policy.

w) The Policy shall automatically terminate if:
i) You no longer reside in India, or in the case of Your demise. We shall on application refund premium in accordance with v) but Our obligation to do so is only in India and in Indian Rupees. However, the other Insured Persons may apply to continue the Policy within 30 days of Your death or move out of India provided that they have identified a new adult policyholder who is a member of Your immediate family. All relevant particulars in respect of such person (including their relationship to You) must be given to Us along with the application. If we accept such application, then the Policy shall be treated as having been renewed without any break in cover.
ii) In relation to an Insured Person, if that Insured Person dies or no longer resides in India.

x) If the Policy is terminated for any reason, You shall immediately return all Entitlement Certificates issued to all Insured Persons. Any unreturned Entitlement Certificates shall cease to be valid on the date of termination. You shall indemnify and keep Us indemnified and hold Us harmless from and against any claims, costs, expenses, awards or judgments arising out of or in relation to such Entitlement Certificates. This Policy is deemed to incorporate General Condition k) from any previous policy issued by Us.

Free Look Period

y) 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. 7 Interpretations & Definitions

The terms defined below 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** or **Accidental** means a sudden, unforeseen and involuntary event caused by external, violent and visible means

Def. 2. **Age** or **Aged** means completed years as at the Commencement Date.

Def. 3. **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 approved.

Def. 4. **Commencement Date** means the commencement date of this Policy as specified in the Schedule.

Def. 5. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def. 6. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position
(a) Internal Congenital Anomaly-which is not in the visible and accessible parts of the body
(b) External Congenital Anomaly-which is in the visible and accessible parts of the body

Def. 7. **Contribution** means essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion of sum insured.

Def. 8. **Cumulative Bonus** means any increase in the Sum Insured / Mallus granted by the insurer without an associated increase in premium.

Def. 9. **Day Care centre** means any institution established for day care treatment of sickness and / or injuries or a medical set -up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:- has qualified nursing staff under its employment has qualified medical practitioner (s) in charge; has a fully equipped operation theatre of its own where surgical procedures are carried out- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

Def. 10. **Critical Illness** means Cancer of specified severity, Open Chest CABG, First Heart Attack of specified severity, Kidney Failure requiring regular dialysis, Major Organ/Bone Marrow Transplant, Multiple Sclerosis with Persisting Symptoms, Permanent Paralysis of Limbs, Stroke resulting in Permanent Symptoms as defined below only:

i) Cancer of specified severity:

A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist.

The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded:

- Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as pre-malignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
- Any skin cancer other than invasive malignant melanoma
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.........
- Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
- Chronic lymphocyctic leukaemia less than RAI stage 3
- Microcarcinoma of the bladder
- All tumours in the presence of HIV infection.

ii) Open Chest CABG:

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The Diagnosis must be supported by coronary angiography and realisation of the surgery has to be confirmed by a specialist Medical Practitioner

The following are excluded:

- Angioplasty and / or Any other intra-arterial procedures
- Any Key-hole surgery or laser surgery

iii) First Heart Attack of Specified Severity:

The first occurrence of 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 this will be evidenced by all of the following criteria:

- A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain).
- New characteristic electrocardiogram changes.
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded :

- Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T.
- Other acute Coronary Syndromes.
- Any type of angina pectoris

iv) Kidney Failure requiring Regular Dialysis:

End stage renal disease presented 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.

The diagnosis has to be confirmed by a specialist Medical Practitioner

v) Major Organ/ Bone Marrow Transplant:

The actual undergoing of a transplant of:

- One of the following human organs - heart, lung, liver, pancreas, kidney, that resulted from irreversible end-stage failure of the relevant organ or;
- Human bone marrow using haematopoietic stem cells.

The undergoing of a transplant must be confirmed by specialist medical practitioner.

The following are excluded:

- Other Stem-cell transplants
- Where only islets of langerhans are transplanted

vi) Multiple Sclerosis with Persisting Symptoms:

The definite occurrence of Multiple Sclerosis.The diagnosis must be supported by all of the following:

- Investigation including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple Sclerosis.
- There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of atleast 6 months.
- Well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast 1 month apart.

Excluded is:

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

vii) Permanent Paralysis of Limbs:

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist Medical Practitioner (Physician / Neurologist) must be of the opinion that paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

viii) Stroke resulting in Permanent Symptoms:

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and embolisation from an extracranial source.

The 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 atleast 3 months has to be produced.

The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular diseases affecting only the eye or optic nerve or vestibular functions

Def. 11. **Day Care Procedures** means those medical treatment, and/or surgical procedure listed in Annexure 1

i. which is undertaken under General or Local Anaesthesia in a Hospital/day care centre in less than 24 hours because of technological advancement,

ii. which would have otherwise required a Hospitalisation of more than 24 hours

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

Def. 12. **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 21 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 Maxima Policy,

Def. 13. **Dependent Child** means a child (natural or legally adopted), who is financially dependent on the primary Insured or Proposer and does not have his / her independent sources of income.

Def. 14. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def. 15. **Domiciliary treatment** 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. 16. **Emergency Care** means management for a severe 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. 17. **Family Floater** means a Policy described as such in the Schedule where under You and Your Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during the Policy Period.

Def. 18. **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. 19. **Hospital** A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- has qualified nursing staff under its employment round the clock;
- 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;
- has qualified medical practitioner(s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

Def. 20. **Hospitalisation** or **Hospitalised** means admission in a Hospital for a minimum of 24 In patient care consecutive hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

Def. 21. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

a) 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) A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
  - it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
  - it needs ongoing or long-term control or relief of symptoms
  - it requires your rehabilitation or for you to be specially trained to cope with it-it continues indefinitely
  - it comes back or is likely to come back.

Def. 22. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

Def. 23. **In-patient Treatment** means treatment arising from Accident or Illness where Insured Person has to stay in a Hospital for more than 24 hours and includes Hospital room rent or boarding expenses, nursing, Intensive Care Unit charges, Medical Practitioner's charges, anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs, consumables, diagnostic procedures.

Def. 24. **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. 25. **Insured Person** means You and the persons named in the Schedule.

Def. 26. **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. 27. **Maternity Expense** shall include :

a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation).
b) Expenses towards lawful medical termination of pregnancy during the policy period.

Def. 28. **Medical Advise** means any consultation or advise from a Medical Practitioner including the issue of any prescription or repeat prescription.

Def. 29. **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.

a) Pre- Hospitalisation Medical Expenses means the Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:
  i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
  ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company
b) Post- Hospitalisation Medical Expenses means the Medical Expenses incurred immediately after the Insured Person is discharged from the hospital, provided that:
  i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
  ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

Def. 30. **Medically Necessary** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

- Is required for the medical management of the Illness or injury suffered by the Insured Person;
- Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity.
- Must have been prescribed by a Medical Practitioner.
- Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Def. 31. **Medical Practitioner** is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence.

Def. 32. **Network Provider** means Hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility

Def. 33. **Non Network** means any Hospital, day care centre or other provider that is not part of the Network

Def. 34. **Notification of Claim** means the process of notifying a claim to the insurer or TPA by specifying the timeliness as well as the address / telephone number to which it should be notified.

Def. 35. **OPD Treatment** is 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 daycare or inpatient.

Def. 36. **Portability** means the transfer by an individual health insurance policy holder (including family cover) of the credit gained by the insured for pre-existing conditions and time bound exclusions if the policyholder chooses to switch from one insurer to another.

Def. 37. **Pre-existing Condition** means any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice/ treatment, within 48 months prior to the first policy issued by the insurer.

Def. 38. **Policy** means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Appendix 1 and the Schedule (as the same may be amended from time to time).

Def. 39. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 40. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 41. **Sum Insured** means the sum shown in the Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.

Def. 42. **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India

Def. 43. **Reasonable & Customary Charges** means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/ injury involved

Def. 44. **Room Rent** means the amount charged by a hospital for the occupancy of a bed per day (24 hours) basis and shall include associated medical expenses.

Def. 45. **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 all waiting periods

Def. 46. **Shared accommodation** means a Hospital room with two or more patient beds

Def. 47. **Subrogation** means the the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

Def. 48. **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 of suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

Def. 49. **Unproven/Experimental treatment** means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven

Def. 50. **We/Our/Us** means the Apollo Munich Health Insurance Company Limited.

Def. 51. **You/Your/Policyholder** means the person named in the Schedule who has concluded this Policy with Us.

Claim Related Information

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

Website : www.apollomunichinsurance.com
Email : customerservice@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,
Road No. 2, Banjara Hills,
Hyderabad-500034, Andhra Pradesh.
or : Claims Department,
Apollo Munich Health Insurance Co. Ltd.,
Plot No.277, 2nd Floor, Udyog Vihar, Phase-IV
Gurgaon-122016, Haryana.

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:

Website : www.apollomunichinsurance.com
Email : 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 Ltd., Tenth Floor, Building No. 10, Tower - B, DLF Cyber City, DLF City Phase II, Gurgaon, Haryana - 122002**

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.

Ombudsman Offices

Jurisdiction	Office Address
Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu	Shri P. Ramamoorthy (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C.U. Shah College, Ashram Road, **AHMEDABAD-380 014.** Tel.:- 079-27546840 Fax : 079-27546142 Email: ins.omb@rediffmail.com
Madhya Pradesh & Chhattisgarh	Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, **BHOPAL(M.P.)-462 023.** Tel.:- 0755-2569201 Fax : 0755-2769203 Email: bimalokpalbhopal@airtelmail.in
Orissa	Shri B. P. Parija (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, **BHUBANESHWAR-751 009.** Tel.:- 0674-2596455 Fax : 0674-2596429 Email: ioobbsr@dataone.in
Jurisdiction	**Office Address**
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh	Shri Manik Sonawane (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D, **CHANDIGARH-160 017.** Tel.:- 0172-2706468 Fax : 0172-2708274 Email: ombchd@yahoo.co.in
Tamil Nadu, UT-Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, **CHENNAI-600 018.** Tel.:- 044-24333668 /5284 Fax : 044-24333664 Email: chennaiinsuranceombudsman@gmail.com
Delhi & Rajasthan	Shri Surendra Pal Singh (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, **NEW DELHI-110 002.** Tel.:- 011-23239633 Fax : 011-23230858 Email: iobdelraj@rediffmail.com
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Shri D.C. Choudhury (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road, **GUWAHATI-781 001 (ASSAM).** Tel.:- 0361-2132204/5 Fax : 0361-2732937 Email: ombudsmanghy@rediffmail.com

Andhra Pradesh, Karnataka and UT of Yanam - a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, **HYDERABAD-500 004**. Tel : 040-65504123 Fax: 040-23376599 Email: insombudhyd@gmail.com
Kerala, UT of (a) Lakshadweep, (b) Mahe - a part of UT of Pondicherry	Shri R. Jyothindranathan (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, **ERNAKULAM-682 015.** Tel : 0484-2358759 Fax : 0484-2359336 Email: iokochi@asianetindia.com
West Bengal , Bihar, Jharkhand and UT of Andeman & Nicobar Islands , Sikkim	Ms. Manika Datta (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindusthan Bldg. Annexe, 4, C.R.Avenue, **KOLKATTA - 700 072.** Tel: 033 22124346/(40) Fax: 033 22124341 Email: iombsbpa@bsnl.in
Uttar Pradesh and Uttaranchal	Shri G. B. Pande (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, **LUCKNOW-226 001.** Tel : 0522 -2231331 Fax : 0522-2231310 Email: insombudsman@rediffmail.com
Maharashtra , Goa	Insurance Ombudsman, Office of the Insurance Ombudsman, S.V. Road, Santacruz(W), **MUMBAI-400 054.** Tel : 022-26106928 Fax : 022-26106052 Email: ombudsmanmumbai@gmail.com

IRDA REGULATION NO 5: This policy is subject to regulation 5 of IRDA (Protection of Policyholder's Interests) Regulation.

Annexure I: Day Care Procedure

Day Care Procedures will include following Day Care Surgeries & Day Care Treatments

Microsurgical operations on the middle ear

1. Stapedotomy
2. Stapedectomy
3. Revision of a stapedectomy
4. Other operations on the auditory ossicles
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

Operations on the nose & the nasal sinuses

19. Excision and destruction of diseased tissue of the nose
20. Operations on the turbinates (nasal concha)
21. Other operations on the nose
22. Nasal sinus aspiration

Operations on the eyes

23. Incision of tear glands
24. Other operations on the tear ducts
25. Incision of diseased eyelids
26. Excision and destruction of diseased tissue of the eyelid
27. Operations on the canthus and epicanthus
28. Corrective surgery for entropion and ectropion
29. Corrective surgery for blepharoptosis
30. Removal of a foreign body from the conjunctiva
31. Removal of a foreign body from the cornea
32. Incision of the cornea
33. Operations for pterygium
34. Other operations on the cornea
35. Removal of a foreign body from the lens of the eye
36. Removal of a foreign body from the posterior chamber of the eye
37. Removal of a foreign body from the orbit and eyeball
38. Operation of cataract

Operations on the skin & subcutaneous tissues

39. Incision of a pilonidal sinus
40. Other incisions of the skin and subcutaneous tissues
41. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
42. Local excision of diseased tissue of the skin and subcutaneous tissues
43. Other excisions of the skin and subcutaneous tissues
44. Simple restoration of surface continuity of the skin and subcutaneous tissues
45. Free skin transplantation, donor site
46. Free skin transplantation, recipient site
47. Revision of skin plasty
48. Other restoration and reconstruction of the skin and subcutaneous tissues
49. Chemosurgery to the skin
50. Destruction of diseased tissue in the skin and subcutaneous tissues

Operations on the tongue

51. Incision, excision and destruction of diseased tissue of the tongue
52. Partial glossectomy
53. Glossectomy
54. Reconstruction of the tongue
55. Other operations on the tongue

Operations on the salivary glands & salivary ducts

56. Incision and lancing of a salivary gland and a salivary duct
57. Excision of diseased tissue of a salivary gland and a salivary duct
58. Resection of a salivary gland
59. Reconstruction of a salivary gland and a salivary duct
60. Other operations on the salivary glands and salivary ducts

Other operations on the mouth & face

61. External incision and drainage in the region of the mouth, jaw and face
62. Incision of the hard and soft palate
63. Excision and destruction of diseased hard and soft palate
64. Incision, excision and destruction in the mouth
65. Plastic surgery to the floor of the mouth
66. Palatoplasty
67. Other operations in the mouth under general /spinal anesthesia

Operations on the tonsils & adenoids

68. Transoral incision and drainage of a pharyngeal abscess
69. Tonsillectomy without adenoidectomy
70. Tonsillectomy with adenoidectomy
71. Excision and destruction of a lingual tonsil
72. Other operations on the tonsils and adenoids under general /spinal anesthesia

Trauma surgery and orthopaedics

73. Incision on bone, septic and aseptic
74. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
75. Suture and other operations on tendons and tendon sheath
76. Reduction of dislocation under GA
77. Arthroscopic knee aspiration

Operations on the breast

78. Incision of the breast
79. Operations on the nipple

Operations on the digestive tract

80. Incision and excision of tissue in the perianal region
81. Surgical treatment of anal fistulas
82. Surgical treatment of haemorrhoids
83. Division of the anal sphincter (sphincterotomy)
84. Other operations on the anus
85. Ultrasound guided aspirations
86. Sclerotherapy etc.

Operations on the female sexual organs

87. Incision of the ovary
88. Insufflation of the Fallopian tubes
89. Other operations on the Fallopian tube
90. Dilatation of the cervical canal
91. Conisation of the uterine cervix
92. Other operations on the uterine cervix
93. Incision of the uterus (hysterotomy)
94. Therapeutic curettage
95. Culdotomy
96. Incision of the vagina
97. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
98. Incision of the vulva
99. Operations on Bartholin's glands (cyst)

Operations on the prostate & seminal vesicles

100. Incision of the prostate
101. Transurethral excision and destruction of prostate tissue
102. Transurethral and percutaneous destruction of prostate tissue
103. Open surgical excision and destruction of prostate tissue
104. Radical prostatovesiculectomy
105. Other excision and destruction of prostate tissue
106. Operations on the seminal vesicles
107. Incision and excision of periprostatic tissue
108. Other operations on the prostate

Operations on the scrotum & tunica vaginalis testis

109. Incision of the scrotum and tunica vaginalis testis
110. Operation on a testicular hydrocele
111. Excision and destruction of diseased scrotal tissue
112. Plastic reconstruction of the scrotum and tunica vaginalis testis
113. Other operations on the scrotum and tunica vaginalis testis

Operations on the testes

114. Incision of the testes
115. Excision and destruction of diseased tissue of the testes
116. Unilateral orchidectomy
117. Bilateral orchidectomy
118. Orchidopexy
119. Abdominal exploration in cryptorchidism
120. Surgical repositioning of an abdominal testis
121. Reconstruction of the testis
122. Implantation, exchange and removal of a testicular prosthesis
123. Other operations on the testis under general /spinal anesthesia

Operations on the spermatic cord, epididymis and ductus deferens

124. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
125. Excision in the area of the epididymis
126. Epididymectomy
127. Reconstruction of the spermatic cord
128. Reconstruction of the ductus deferens and epididymis
129. Other operations on the spermatic cord, epididymis and ductus deferens

Operations on the penis

130. Operations on the foreskin
131. Local excision and destruction of diseased tissue of the penis
132. Amputation of the penis
133. Plastic reconstruction of the penis
134. Other operations on the penis

Operations on the urinary system

135. Cystoscopical removal of stones

Other Operations

136. Lithotripsy
137. Coronary angiography
138. Haemodialysis
139. Radiotherapy for Cancer
140. Cancer Chemotherapy

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

Annexure II:

S NO.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
1	HAIR REMOVAL CREAM CHARGES	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/ INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	MOISTURISER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable

S NO.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
15	BELTS/ BRACES	Essential and should be paid at least specifically for cases who have undergone surgery of thoracic or lumbar spine
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Essential in bariatric and varicose vein surgery and may be considered for at least these conditions where surgery itself is payable.
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable

S NO.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable/ Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling in case of upper arm fractures may be considered
ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES		
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in policy unless otherwise specified
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Exclusion in policy unless otherwise specified
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Exclusion in policy unless otherwise specified
62	HORMONE REPLACEMENT THERAPY	Exclusion in policy unless otherwise specified
63	HOME VISIT CHARGES	Exclusion in policy unless otherwise specified
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in policy unless otherwise specified
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT	Exclusion in policy unless otherwise specified
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Exclusion in policy unless otherwise specified
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in policy unless otherwise specified
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in policy unless otherwise specified
69	DONOR SCREENING CHARGES	Exclusion in policy unless otherwise specified
70	ADMISSION/REGISTRATION CHARGES	Exclusion in policy unless otherwise specified

S NO.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in policy unless otherwise specified
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable - Exclusion in policy unless otherwise specified
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not payable as per HIV/ AIDS exclusion
74	STEM CELL IMPLANTATION/ SURGERY AND STORAGE	Not Payable except Bone Marrow Transplantation where covered by policy
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE5CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS		
75	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
77	MICROSCOPE COVER	Payable under OT Charges, not separately
78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not separately
79	SURGICAL DRILL	Payable under OT Charges, not separately
80	EYE KIT	Payable under OT Charges, not separately
81	EYE DRAPE	Payable under OT Charges, not separately
82	X-RAY FILM	Payable under Radiology Charges, not as consumable
83	SPUTUM CUP	Payable under Investigation Charges, not as consumable
84	BOYLES APPARATUS CHARGES	Part of OT Charges, not seperately
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
86	ANTISEPTIC OR DISINFECTANT LOTION	Not Payable - Part of Dressing charges
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
88	COTTON	Not Payable - Part of Dressing charges
89	COTTON BANDAGE	Not Payable - Part of Dressing charges
90	BLADE	Not Payable

S NO.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
91	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed, otherwise included as Dressing Charges
92	APRON	Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU charges
93	TORNIQUET	Not Payable (service is charged by hospitals, consumables cannot be separately charged)
94	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
95	URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE		
96	LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sub limits
97	HVAC	Part of room charge not payable separately
98	HOUSE KEEPING CHARGES	Part of room charge not payable separately
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
100	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
101	SURCHARGES	Part of Room Charge, Not payable separately
102	ATTENDANT CHARGES	Not Payable - Part of Room Charges
103	IM IV INJECTION CHARGES	Part of nursing charges, not payable
104	CLEAN SHEET	Part of Laundry/ Housekeeping not payable separately
105	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
106	BLANKET/WARMER BLANKET	Not Payable - Part of Room Charges
ADMINISTRATIVE OR NON-MEDICAL CHARGE		
107	ADMISSION KIT	Not Payable
108	BIRTH CERTIFICATE	Not Payable
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
110	CERTIFICATE CHARGES	Not Payable
111	COURIER CHARGES	Not Payable

112	CONVENYANCE CHARGES	Not Payable
113	DIABETIC CHART CHARGES	Not Payable
114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
115	DISCHARGE PROCEDURE CHARGES	Not Payable
116	DAILY CHART CHARGES	Not Payable
117	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
119	FILE OPENING CHARGES	Not Payable
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
121	MEDICAL CERTIFICATE	Not Payable
122	MAINTAINANCE CHARGES	Not Payable
123	MEDICAL RECORDS	Not Payable
124	PREPARATION CHARGES	Not Payable
125	PHOTOCOPIES CHARGES	Not Payable
126	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
127	WASHING CHARGES	Not Payable
128	MEDICINE BOX	Not Payable
129	MORTUARY CHARGES	Payable upto 24 hrs, shifting charges not payable
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES		
131	WALKING AIDS CHARGES	Not Payable
132	BIPAP MACHINE	Not Payable
133	COMMODE	Not Payable
134	CPAP/ CAPD EQUIPMENTS	Device not payable
135	INFUSION PUMP - COST	Device not payable
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
137	PULSEOXYMETER CHARGES	Device not payable
138	SPACER	Not Payable
139	SPIROMETRE	Device not payable
140	SPO2 PROBE	Not Payable
141	NEBULIZER KIT	Not Payable
142	STEAM INHALER	Not Payable
143	ARMSLING	Not Payable
144	THERMOMETER	Not Payable (paid by patient)
S NO.	**List of excluded expenses ("Non-Medical") under indemnity Policy**	**Expenses**
145	CERVICAL COLLAR	Not Payable
146	SPLINT	Not Payable
147	DIABETIC FOOT WEAR	Not Payable
148	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150	LUMBO SACRAL BELT	Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine.
151	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day
152	AMBULANCE COLLAR	Not Payable
153	AMBULANCE EQUIPMENT	Not Payable
154	MICROSHIELD	Not Payable
155	ABDOMINAL BINDER	Essential and should be paid at least in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION		
156	BETADINE \ HYDROGEN PEROXIDE\ SPIRIT\\DETTOL \SAVLON\ DISINFECTANTS ETC	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post hospitalization nursing charges not Payable
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES-DIET CHARGES	Patient Diet provided by hospital is payable
159	SUGAR FREE TABLET	Payable -Sugar free variants of admissable medicines are not excluded
160	CREAMS POWDERS LOTIONS (Toileteries are not payable,only prescribed medical pharmaceuticals payable)	Payable when prescribed

ApolloMunich HEALTH INSURANCE
10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

S NO.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
161	DIGENE GEL/ ANTACID GEL	Payable when prescribed
162	ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
163	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
164	HIV KIT	Payable - payable Pre operative screening
165	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
166	LOZENGES	Payable when prescribed
167	MOUTH PAINT	Payable when prescribed
168	NEBULISATION KIT	If used during hospitalization is payable reasonably
169	NOVARAPID	Payable when prescribed
170	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
171	ZYTEE GEL	Payable when prescribed
172	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE		
173	AHD	Not Payable - Part of Hospital's internal Cost
174	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
175	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
OTHERS		
176	VACCINE CHARGES FOR BABY	Not Payable
177	AESTHETIC TREATMENT / SURGERY	Not Payable
178	TPA CHARGES	Not Payable
179	VISCO BELT CHARGES	Not Payable
180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable

S NO.	List of excluded expenses ("Non-Medical") under indemnity Policy	Expenses
181	EXAMINATION GLOVES	Not Payable
182	KIDNEY TRAY	Not Payable
183	MASK	Not Payable
184	OUNCE GLASS	Not Payable
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable, except for telemedicine consultations where covered by policy
186	OXYGEN MASK	Not Payable
187	PAPER GLOVES	Not Payable
188	PELVIC TRACTION BELT	Should be payable in case of PIVD requiring traction as this is generally not reused
189	REFERAL DOCTOR'S FEES	Not Payable
190	ACCU CHECK (Glucometery/ Strips)	Not payable pre hospitilasation or post hospitalisation / Reports and Charts required/ Device not payable
191	PAN CAN	Not Payable
192	SOFNET	Not Payable
193	TROLLY COVER	Not Payable
194	UROMETER, URINE JUG	Not Payable
195	AMBULANCE	Payable-Ambulance from home to hospital or interhospital shifts is payable/ RTA as specific requirement is payable
196	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
197	URINE BAG	Payable where medicaly necessary till a reasonable cost - maximum 1 per 24 hrs
198	SOFTOVAC	Not Payable
199	STOCKINGS	Essential for case like CABG etc. where it should be paid.

ApolloMunich
HEALTH INSURANCE
10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

SCHEDULE OF BENEFITS

Sum Insured per Policy	1 Member	2 Members	2 Adults + upto 2 Children
Part A- Outpatient Module			
a.) Outpatient Consultations*	4 Consultations	6 Consultations	8 Consultations
b.) Diagnostic Tests#	Rs. 5,000	Rs. 5,500	Rs. 7,000
c.) Pharmacy#			
d.) Outpatient Dental Treatment #			
e.) Spectacles, Contact Lenses #			
f.) Annual Health Check-up within specified Network^	1 Entitlement Certificate	2 Entitlement Certificates	2 Entitlement Certificates

* The reimbursement against non-network Outpatient Consultations is restricted up to lower of actual expenses or Rs. 400.
# The reimbursement against non-network Diagnostic Tests, Pharmacy, Outpatient Dental Treatment, Spectacles, Contact Lenses is restricted up to lower of actual expenses or the Sum Insured mentioned above.
^ One Entitlement Certificate of Annual Health Check-up includes following tests: Hb, PCV, RBC, MCHC, MCV, MCH, Total WBC, Differential Count, ESR, PLT, Peripheral Smear, Complete Urine Analysis, GTT,Serum Calcium, Serum Creatinine, Lipid Profile (Total Cholesterol, HDL Cholesterol, LDL Cholesterol, Triglycerides, Cardiac Risk Ratio), Liver Function Test (Total Protein, Albumin, Globulin, Total bilirubin, ALT, AST, GGTP), Blood group, ECG (Resting), X-ray (chest), Ultrasound (Upper abdomen screening), Consultation by General Physician, Consultation by Gynecologist.

Part B - Inpatient Module		
	Sum Insured per Policy (Rs)	300,000
a)	In-patient Treatment	Covered
b)	Pre-Hospitalization	30 days; can be increased to 60 days
c)	Post-Hospitalization	60 days; can be increased to 90 days
d)	Day Care Procedures	Covered
e)	Domiciliary Treatment	Covered
f)	Daily Cash for choosing Shared Accommodation	Rs 500 per day, Maximum Rs 3,000
g)	Organ Donor	Covered
h)	Emergency Ambulance	upto Rs 2000 per hospitalisation
i)	Daily Cash for accompanying an insured child	Rs 300 per day; Maximum Rs 9,000
j)	Maternity Expenses ** Waiting Period 4 years	Normal Delivery- Rs 15,000; Caesarean Delivery-Rs 25, 000 (Including Pre/Post Natal limit of Rs 1,500 and infant baby limit of Rs 2,000)
k)	Newborn baby	Optional
Optional Benefit		
a)	Critical Illness ** [Offered on Individual basis]	Optional, if opted then the Critical Illness Sum Insured is Rs 300,000
** Benefits do not dip into inpatient Sum Insured		

Maxima
Claim Procedure

ApolloMunich HEALTH INSURANCE

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

Thank You for choosing MAXIMA, India's first comprehensive Health Plan, Please take a few minutes and familiarize yourself with the details of your policy as given in your MAXIMA kit on:

1. The coverage details and claims eligibility under MAXIMA policy.
2. The exclusions under MAXIMA policy.

Claim Procedure for Out-patient Benefits [Part A]

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

Assistance	How to avail cashless facility for benefits under part A [Out-patient] of the policy?	Can I avail OPD benefits in Non-network providers? (Reimbursement Procedure)	Where do I submit a claim?
• Please call us on our toll free line at 1800-102-0333 for any doubts/ clarifications /information. • You can also log on to our website www.apollomunichinsurance.com or email us at customerservice@ apollomunichinsurance.com	• Please select a provider from the list provided to you for the service required by you. The updated list of providers is also available at www. apollomunichinsurance.com • Please visit the provider along with your Entitlement Certificates and Membership card. In case of non-photo ID card please carry a valid photo ID proof like driving license/ PAN card etc. • Declare the type of Entitlement Certificates available with you to the administration/billing counter. • Handover the required Entitlement Certificates to the concerned person at the administration/ billing counter and avail the service mentioned in the entitlement certificate. Please sign at the back of the entitlement certificate before handing them over. • In case you avail of services more than the eligibility, kindly pay the difference directly to the provider. • In case any service is availed that is less than the denomination of the entitlement certificate, the difference cannot be reimbursed from Apollo Munich Health or the provider. For example, if you buy medicines worth Rs. 80 and use a Rs. 100 entitlement certificate, the difference of Rs. 20 is not reimbursable. • This Entitlement Certificate cannot be combined with any other schemes offered by the provider.	• Reimbursement of expenses for OPD consultation, Diagnostic Tests, Pharmacy, Out-patient Dental Treatment, and Spectacles/Contact Lenses would be done in cases where the member visits a non-network provider. Annual Health Check-Up benefit can be availed only at network provider. • Please submit the duly signed Original Entitlement Certificate along with the original payment receipt, prescription and ID card to Apollo Munich on completion of service. • Only original copies of the Entitlement Certificate shall be valid. • The Entitlement Certificate may be used by the Insured Person(s) whose name is mentioned on the entitlement certificate. • You will be reimbursed the fixed amount as mentioned in Entitlement Certificate or actual payment made, whichever is lower.	• Please submit all claims to the local office of the Apollo Munich. Apollo Munich can be contacted through: - **24 x 7 Toll free:** 1800 - 102 - 0333 - **E-mail at:** customerservice@ apollomunichinsurance. com - **Fax at:** 1800 - 425 - 4077 - **Post and Courier to the nearest claims hub:** Claims Department, Apollo Munich Health Insurance Co. Ltd., Ground Floor, Srinilaya - Cyber Spazio, Road No. 2, Banjara Hills, Hyderabad-500034, Andhra Pradesh. or : Claims Department, Apollo Munich Health Insurance Co. Ltd., Plot No.277, 2nd Floor, Udyog Vihar, Phase-IV Gurgaon-122016, Haryana.

ApolloMunich HEALTH INSURANCE
10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

Claim Procedure for In-patient Benefits [Part B]

Please review your Maxima policy 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 to Apollo Munich Health Insurance Co. Ltd.
2. Quote your member ID/policy number in all your correspondences.

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 Apollo Munich atleast 48 hours prior to an event which might give rise to a claim. • For any emergency situations, kindly contact Apollo Munich within 24 hours of the event. Apollo Munich can be contacted through: - **24 x 7 Toll free:** 1800 - 102 - 0333 - **E-mail at:** customerservice@apollomunichinsurance.com - **Fax at:** 1800 - 425 - 4077 - **Post and Courier to the nearest claims hub:** Claims Department, Apollo Munich Health Insurance Co. Ltd., Ground Floor, Srinilaya - Cyber Spazio, Road No. 2, Banjara Hills, Hyderabad-500034, Andhra Pradesh. or : Claims Department, Apollo Munich Health Insurance Co. Ltd., Plot No.277, 2nd Floor, Udyog Vihar, Phase-IV Gurgaon-122016, Haryana. **Note:** **Please use a Claim Intimation Form for intimation of a claim.**	• Please send the duly signed Claim Form and all the information/documents mentioned* therein to Apollo Munich within 15 days of earlier of our request or the Insured person's discharge from the hospital or completion of treatment. *Please refer to Claim Form for complete documentation. • If there is any deficiency in the documents/ information submitted by you, Apollo Munich will send the deficiency letter within 7 days of receipt of the claim documents. • On receipt of the complete set of claim documents, Apollo Munich will send the cheque for the admissible amount, along with a settlement statement within 30 days. • The cheque will be sent in the name of the proposer. **Note:** **Payment will only be made for items covered under your policy and upto the limits therein.**	• For any emergency Hospitalisation, Apollo Munich must be informed no later than 24 hours after hospitalization. • For any planned hospitalization, kindly seek cashless authorization from Apollo Munich atleast 48 hours prior to the hospitalization. • Apollo Munich 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 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 enclosed CD or call us on our toll free number at 1800-102-0333.** • **Rejection of cashless in no way indicates rejection of the claim.**

For any doubt or clarifications and/or information, call our Toll Free Line at 1800-102-0333 or log on to our website www.apollomunichinsurance.com or email us at customerservice@apollomunichinsurance.com

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