Health Add-ons - Policy Terms and Conditions

I. PREAMBLE

The Add-on covers specified herein can only be purchased along with the Base Policy and cannot be bought in isolation or as a separate product.

This Policy has been issued on the basis of the Disclosure to Information Norm, including the information and declarations provided by You in respect of the Insured Persons in the Proposal Form and any other information or details submitted in relation to the Proposal Form.

This Policy is a contract of insurance between You and Us which is subject to the receipt and acceptance of premium in full by Us in respect of the Insured Persons, the terms, conditions and exclusions stated in this Policy for the Add-on covers below, and also the terms, conditions, exclusions and applicable endorsements of the Base Policy, as specified in the Policy/ Policy Schedule / Product Benefit Table of this Policy.

These Add-on covers shall be available only if the same are opted and specifically mentioned in the Policy Schedule.

These Add-on covers shall not be applicable in case if the same cover is offered as Optional Cover/Base Cover in the Base Policy.

Same Add-on covers are allowed to be taken with multiple Base Policies, subject to Underwriting.

If any claim arising as a result of an Injury or Illness that occurs during the Policy Period becomes payable, then We shall pay the Benefits specified under this Policy in accordance with the terms, conditions and exclusions of this Policy and the Base Policy.

II. DEFINITIONS

A. Standard Definitions

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

2. **Cashless facility:** Cashless facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

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

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

5. **Cumulative Bonus (No Claim Bonus):** Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

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

7. **Day Care Treatment:** Day care treatment means medical treatment, and/or surgical procedure which is:
   (i) undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
   (ii) which would have otherwise required hospitalization of more than 24 hours.

   Treatment normally taken on an out-patient basis is not included in the scope of this definition. (Insurers may, in addition, restrict coverage to a specified list.

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

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

10. **Grace Period:** 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

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11. **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 Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:
    i) Has qualified nursing staff under its employment round the clock;
    ii) Has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    iii) Has qualified medical practitioner(s) in charge round the clock;
    iv) Has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v) Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel

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

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

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

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

16. **Intensive Care Unit:** 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.

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

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

19. **Medical Expenses:** 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Specific Definitions

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

37. **Add-on covers:** Benefits as specified in Section III of this Policy terms and conditions.

38. **Base Policy:** Retail Indemnity Health Insurance issued by Us including its terms and conditions, any annexure thereto and the Policy Schedule (as amended from time to time), the information statements in the proposal form and the Policy wording (including endorsements, if any) and to which this Add-on cover is attached

39. **Benefit:** Any benefit shown in the Policy.

40. **Consumer Price Index(CPI) –** CPI is a measure of inflation changes in CPI are used to assess price changes associated with the cost of living. It is a measure that examines the weighted average of prices of a basket of consumer goods and services, such as transportation, food and medical care. It is calculated by taking price changes for each item in the predetermined basket of goods and averaging them.

41. **Expiry Date:** Date on which this Add-on expires as specified in the Policy Schedule.

42. **Family Floater Policy:** Policy named as a Family Floater Policy in the Policy Schedule under which the family members named as Insured Persons in the Policy Schedule are covered.

43. **Hazardous or adventurous sports** means sport or activity, which is potentially dangerous to the Insured Person. This activity consists of speed, height and elevated level of physical exhaustion combined with highly specialized gear or spectacular stunts and such sport/activity includes without limitation stunt activities, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/obstacle riding, bobsleighing/using skeletons, bouldering, boxing, canyoning, cavin/pot holing, cave tubing, rock climbing/trekking/mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labour, marathon running, martial arts, micro-lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo riding, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling any type.

44. **Individual Policy:** Policy named as an Individual Policy in the Policy Schedule or Certificate of Insurance under which one or more persons are covered as Insured Persons.

45. **Inflation:** A rise in general level of prices, as measured against some baseline of purchasing power. Inflation measures how much more expensive a set of goods and services has become over a certain period usually a year.

46. **Insured Person:** Person(s) named in the Policy Schedule who is/are covered under this Policy and in respect of whom the appropriate premium has been received.

47. **National Statistical Office (NSO):** A government agency in India under the Ministry of Statistics and Programme Implementation responsible for co-ordination of statistical activities in India, and evolving and maintaining statistical standards

48. **Policy:** Policy document containing the terms and conditions, the Proposal Form, Policy Schedule, Add-On Benefits as specified herein and any Annexures which form a part of this and the Base Policy, including endorsements, as amended from time to time which shall form a part of the Policy and shall be read together.

49. **Policy Period:** The period between the Start Date and the Expiry Date as specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.

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

51. **Policy Year:** Period of 12 consecutive months commencing from the Start Date.

52. **Start Date:** The inception date of the add-ons specified under this Policy as specified in the Policy Schedule.

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

54. **Waiting Period:** Time bound exclusion period related to condition(s) specified in the Policy Schedule or Certificate of Insurance or Policy which shall be served before a claim related to such condition(s) becomes admissible

55. **We/Our/Us** means Aditya Birla Health Insurance Co. Limited.

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

III. BENEFIT

Benefits under this Section III are subject to the terms, conditions and exclusions under this Policy, including Base Policy. The Sum Insured and/or the sub-limit for each Benefit under this Section III shall be as specified against that Benefit in the Policy Schedule / Product Benefit Table of this Policy. Payment of the Benefit shall be subject to the availability of the Sum Insured/applicable sub-limit for that Benefit. Our maximum, total and cumulative liability in respect of an Insured Person for any and all claims arising under a Benefit during the Policy Period for that Insured Person shall not exceed the Sum Insured/sub-limit specified against the applicable Benefit in the Policy Schedule / Product Benefit Table of this Policy.

All claims must be made in accordance with the procedure set out in Base Policy/ in this Policy (as applicable).

1) **Future Secure:**

a) **Non-Medical Expense waiver:**
We shall cover cost of Non-Medical Items, listed under Annexure I of this Policy, which are necessarily incurred towards Hospitalization of the Insured Person, arising out of Illness or Injury contracted or sustained during the Policy Period. The Benefit is available subject to claim being admissible under the In-patient Hospitalization Benefit and/ or Day Care Treatment Benefit under the Base Policy and provided that the expenses on Non-Medical Items pertain to the same Illness/injury admitted by Us. The total, cumulative and maximum claim payout under this Benefit shall be limited to applicable Sum Insured under Base Policy as specified in the Policy Schedule/Product Benefit table of the Base Policy.

b) **Sum Insured Inflation Protector:**
We shall provide additional increase in Sum Insured under the Base Policy on the basis of Inflation rate in previous calendar year as an Inflation protector.

The percentage increase will be applicable only on Sum Insured under the Base Policy at the end of each Policy Year on the basis of inflation rate in previous year. The percentage of increase will be applicable on Base Sum Insured under the Policy and not on No Claim Bonus or any other benefit which leads to increase in the Sum Insured.

For the purpose of this Benefit, the inflation rate would be computed as the average CPI of the entire calendar year published by the National Statistical Office (NSO), Ministry of Statistics and Programme Implementation. In case the inflation rate of previous year is not available at Renewal, then the inflation rate available for penultimate calendar year shall be considered.

For information on Consumer price index (CPI) you can visit website – https://www.mospi.nic.in/cpi .

In case the Sum Insured is changed at the time of Renewal, any accumulated in the Sum Insured due to the application of this Benefit will be added to the applicable new Sum Insured opted by Insured Person at the time of Renewal.

Please note that all the accumulated amounts under this Benefit will lapse and the Sum Insured under the Base Policy will roll back to the Sum Insured opted under the Base Policy as specified in the Policy Schedule/Product Benefit table of the Base Policy if this Benefit is not renewed.

c) **No Claim Bonus protector:**
With this Benefit, any No Claim Bonus accrued (if any) under the Base policy will not be impacted or reduced at renewals, if any total claims amount payable in the previous Policy Year under the Base Policy does not exceed the 25% of the Sum Insured under the Base Policy.

However, where the total claim amount payable during the Policy Year is more than 25% of Sum Insured under the Base Policy, this Benefit is not available and accordingly there shall be decrease in the No Claim Bonus amount at same rate at which it has accrued. The increase or decrease in No Claim Bonus amount shall be at a defined rate as mentioned in the Base Policy.

Note:
If the Insured Person has opted for Future Secure Add-on cover and/or any other add-on cover, the increase in the sum insured under Sum Insured Inflation Protector shall be applicable for utilisation for all the other base / add-on covers like Non-medical expenses, Cancer Hospitalization Booster, including Pre-Hospitalization expenses, Post Hospitalization expenses and Day Care Treatment.

2) **Cancer Hospitalization Booster**
We shall provide an additional Sum Insured towards Medical Expenses incurred for Hospitalization in case of "Cancer of Specified Severity" (as defined under this Benefit) during the Policy Period, up to the limit as specified in Policy Schedule / Product Benefit Table of this Policy, for the Insured Person who is Hospitalized for the treatment of "Cancer of Specified Severity", under the In-patient Hospitalization Benefit under the Base Policy during the Policy Year.

We shall cover the following Medical Expenses:
(i) Reasonable and Customary Charges for Room Rent for accommodation in Hospital room up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy;
(ii) ICU Charges;
(iii) Operation theatre expenses;
(iv) Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
(v) Qualified Nurses' charges;
(vi) Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
(vii) Investigative tests or diagnostic procedures directly related to Cancer of Specified Severity for which the Insured Person is Hospitalized and / or treatment of other related illnesses along with cancer treatment where cancer is primary cause of hospitalisation;
(viii) Anaesthesia, blood, oxygen and blood transfusion charges;

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(ix) Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.
(x) When the Insured Person is admitted for any other illnesses other than "Cancer of Specified Severity" and during this course of admission, he is diagnosed with "Cancer of Specified Severity", then the Insured person shall be indemnified under this coverage.

Conditions

(i) This Benefit shall be utilized only after the Sum Insured under the Base Policy has been completely exhausted.
(ii) The total amount payable under this Benefit shall not exceed the sum total of the Sum Insured, No Claim Bonus (if applicable and earned), Super NCB (if applicable under the Base Policy / opted) and Cancer Hospitalization Booster.
(iii) This Benefit shall be available only for such Insured Person for whom claim for Hospitalization following Cancer of Specified Severity has been accepted under the Policy.
(iv) Multiple claims during the Policy year pertaining to cancer treatment under this Add-on cover is payable upto the Sum insured which is available only once during the policy year.
(v) In addition to the foregoing, the conditions stipulated under the In-patient Hospitalization Benefit under the Base Policy shall be applicable.
(vi) This Benefit shall be renewed life long and the Company shall not deny renewal based on claims experience in the previous year.
(vii) Co-payment, if any applicable for Base Policy shall not apply to this add-on cover.

1. **Pre – hospitalization Medical Expenses:**
   We shall cover on a reimbursement basis, up to the Sum Insured for the number of days in accordance with the limits specified in the Policy Schedule / Product Benefit Table of this Policy, the Insured Person's Pre-hospitalization Medical Expenses incurred in respect of an Illness or Injury that occurs during the Policy Period.

   Conditions

   (i) We have accepted a claim for In-patient Hospitalization or Day Care Treatment under Section 2. Cancer Hospitalization Booster for the same Illness/Injury;
   (ii) The date of admission to Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Illness/ Injury.
   (iii) When the Insured Person is admitted for any other illnesses other than "Cancer of Specified Severity" and during this course of admission, he is diagnosed with "Cancer of Specified Severity", then the Insured person shall be indemnified under this coverage.

2. **Post – hospitalization Medical Expenses:**
   We shall cover on a reimbursement basis, up to the Sum Insured for the number of days in accordance with the limits specified in the Policy Schedule / Product Benefit Table of this Policy, the Insured Person's Post-hospitalization Medical Expenses incurred following an Illness or Injury that occurs during the Policy Period.

   Conditions

   a) We have accepted a claim for In-patient Hospitalization under Section 2 (Cancer Hospitalisation Booster) for the same Illness/Injury;
   b) The date of discharge from Hospital for the purpose of this Benefit shall be the date of the Insured Person's discharge from Hospital in relation to the same Illness/ Injury.
   c) When the Insured Person is admitted for any other illnesses other than "Cancer of Specified Severity" and during this course of admission, he is diagnosed with "Cancer of Specified Severity", then the Insured person shall be indemnified under this coverage.

3. **Day Care Treatment:**
   We shall cover the Medical Expenses incurred on the Insured Person's Day Care Treatment, up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy, during the Policy Period following an Illness or Injury that occurs during the Policy Period.

   Conditions

   (i) The Day Care Treatment is Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
   (ii) The treatment(s) covered under this benefit shall be limited to treatment of Cancer on Day care basis only.

   What is not covered

   OPD treatment is not covered under this Benefit.

For the purpose of this Benefit, Cancer of Specified Severity is defined as follows:

CANCER OF SPECIFIED SEVERITY

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

3) Reduction in PED Waiting Period:

If this Add-on cover is opted at the inception of the first policy with Us and We have accepted the same, then We shall reduce the applicable Pre Existing Disease Waiting Period for claims related to Pre-Existing Diseases to the period as opted and specified in the Policy Schedule/Product Benefit Table.

Conditions

(i) The provisions of the Pre-existing Waiting Period Section of Base Policy and as specified in the Definition Section shall continue to be valid in relation to this Benefit, except that the claims will be admissible for any Medical Expenses incurred for Hospitalization under the Base Policy in respect of diagnosis/treatment of any Pre-Existing Disease after such period, as is specified to be applicable in the Policy Schedule of this Policy, provided the Base Policy is renewed with Us without a break.

(ii) This Benefit will be available only at the time of inception of the first policy with Us and only for the Sum Insured opted at such inception.
Not applicable to opt at the time of renewal or for portability cases.

Note-

If the Insured Person has opted for Reduction in PED waiting period add-on along with other Add-on cover, then the Reduction in PED waiting period shall be applicable for Future Secure and cancer hospitalization booster wherever opted and pre-existing claim shall be payable after completion of reduced PED waiting period.

4) Vaccine cover:

We shall cover the Medical Expenses incurred towards the vaccination of the Insured Person upto the limit as specified in the Policy Schedule / Product Benefit Table of this Policy for protection against any disease (s), which has been declared as pandemic or epidemic by World Health Organisation(WHO) or Central Government or State Government

Claim Documents:

- Duly filled & signed claim form along with Original Invoice for Vaccination / OPD consultation and payment receipt.
- Original Prescription from treating Medical Practitioner.

5) Tele-OPD Consultation

(a) Doctor Consultation:
We shall indemnify charges incurred towards the medically necessary e- consultation and/or tele consultation from Medical Practitioners on cashless basis within Our Network Provider's network on out-patient basis only pertaining to an Illness, Injury contracted or sustained by an Insured Person during the Policy Period.

(b) There is no limit on number of consultation.

(c) Once this Add-on is purchased, we shall be sending the login details of You / Insured Person through which this benefit can be availed and Insured person will select the doctor for tele/ E consultation.

(d) The cost of e- consultation and/or tele consultation shall be borne by Us.

The Insured Person is free to choose whether or not to obtain any e-consultation or tele-consultation from Our Network Provider's network, and if obtained, it is the Insured Person's sole and absolute discretion to follow the suggestion for any advice related to his/her health. It is understood and agreed that any information and documentation provided to Us for the purpose of seeking a consultation shall be shared with our Network Provider's network. In no event shall We be liable for any direct, indirect, punitive, incidental, special, or consequential damages or any other damages whatsoever caused to You/Insured Person while receiving the services from any Medical Practitioners in Our Network Provider's network or arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by such Medical Practitioner.

6) Personal Accident:

Benefits under this Section are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and/or the sub-limit for each Benefit under this Add-on cover is specified against that Benefit in the Policy Schedule /the Product Benefit Table. Payment of the Benefit shall be subject to the availability of the Sum Insured/applicable sub-limit for that Benefit.

1. Accidental Death Cover (AD):
We shall pay the benefit equal to 100% of Sum Insured, specified in the policy schedule, on death of the insured person, due to an Injury sustained in an Accident during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of the Accident. Where claim payment has been made owing to disappearance of insured person following an accident, if after the payment of accidental death claim, it is found that the insured person has survived the accident, then the policyholder has to refund the payment back to the Us in consideration of the obligatory guarantee as provided during the claim.

2. Permanent Total Disablement (PTD):
We shall pay the benefit equal to 100% of Sum Insured, specified in the policy schedule, if an insured Person suffers Permanent Total Disablement of the nature specified below, solely and directly due to an Accident during the Policy Period, provided that the Permanent Total Disablement occurs within 12 months from the date of the Accident:

a) Total and irrecoverable loss of sight of both eyes or
b) Physical separation or loss of use of both hands or feet or
c) Physical separation or loss of use of one hand and one foot or
d) loss of sight of one eye and Physical separation or loss of use of hand or foot

If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever.

3. Permanent Partial Disablement (PPD)
We shall pay the following percentage of Sum Insured, specified in the policy schedule, if the Insured Person suffers Permanent Partial Disablement of the nature specified below solely and directly due to an Accident during the Policy Period provided that the Permanent Partial Disablement shall occur within 12 months of the date of the Accident.

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

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2	Loss of Use of both ears	50%
3	Loss of Use of one ear	20%
4	Loss of four fingers and thumb of one hand	40%
5	Loss of four fingers	35%
6	Loss of thumb - both phalanges - one phalanx	 25% 10%
7	Loss of Index finger - three phalanges two phalanges one phalanx	 10% 8% 4%
8	Loss of middle finger – three phalanges two phalanges one phalanx	 6% 4% 2%
9	Loss of ring finger - three phalanges two phalanges one phalanx	 5% 4% 2%
10	Loss of little finger – three phalanges two phalanges one phalanx	 4% 3% 2%
11	Loss of metacarpus - first or second (additional) third, fourth or fifth (additional)	 3% 2%
12	Any other permanent partial disablement	Percentage as assessed by the independent Medical Practitioner

Maximum amount payable in respect of multiple nature of disablements shall be restricted to sum insured chosen by the Insured Person.

4. Cumulative bonus for Personal Accident:
Sum insured (excluding cumulative bonus) shall be increased by 5% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 50% of the sum insured. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it has accrued.

Notes:
(i) The cumulative bonus is applicable only in respect of base covers referred at Section 6.(1), 6.(2) and 6.(3) Addition or reduction of cumulative bonus will be done only if claim made under these benefits
(ii) The CB shall be added and available individually to the insured persons under the policy, if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
(iii) CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
(iv) If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn

Note:
The base sum insured chosen and cumulative bonus, if any, is applicable cumulatively for all the three covers specified under 6.(1), 6.(2) and 6.(3) above i.e, there is a single sum insured for all the three covers namely, Accidental death, Permanent total disability and Permanent Partial Disability.

If the accident occurs during the policy period, benefits covered under 6.(1), 6.(2) and 6.(3) above are payable, even if death or Permanent Total Disablement or Permanent Partial Disablement or any combination thereof occurs after the completion of policy period, but within 12 months from the date of accident.

Specific terms and conditions applicable to this Add-on Cover

1. Permanent Exclusions applicable to this Add-on cover
We shall not be liable to make any payments under this policy in respect of:

(i) Any claim for death or disablement (whether of a permanent nature or of a temporary nature), directly or indirectly due to War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
(ii) Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person
a) from intentional self-injury unless in self-defense or to save life, suicide or attempted suicide;
b) whilst under the influence of intoxicating liquor or drugs or other intoxicants except where the insured is not directly responsible for the injury / accident though under influence of intoxication.
c) whilst engaging in aviation or ballooning, or whilst mounting into, or dismounting from or travelling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any Scheduled Airlines in the world.
[Standard type of aircraft means any aircraft duly licensed to carry passengers (for hire or otherwise) by appropriate authority irrespective of whether such an aircraft is privately owned or chartered or operated by a regular airline or whether such an aircraft has a single engine or multiengine;]
d) arising or resulting from the Insured Person committing any breach of law with criminal intent.

(iii) Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

(iv) Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from:
A. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self-sustaining process of nuclear fission) of nuclear fuel.
B. Nuclear weapons material
C. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
D. Nuclear, chemical and biological terrorism

(v) Any loss arising out of the Insured Person's actual or attempted commission of or willful participation in an illegal act or any violation or attempted violation of the law.

2. Claims Procedure for Personal Accident:

a. Intimation of Claim

You or anyone on behalf of the Insured Person(s) shall intimate a claim to Us within 30 days from the date of the Accident or admission in the Hospital (as the case may be) by any of the following means
- Call centre : 1800 270 7000
- Email : care.healthinsurance@adityabirlacapital.com
- Writing to Our office address : Aditya Birla Health Insurance Co. Limited 9th Floor, Tower 1, One World Centre, Jupiter Mills Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai 400013

The following minimum details are required to be provided at the time of intimation of claim:
1. The Policy number;
2. Name of the Policyholder;
3. Name and address of the Insured Person in respect of whom the request is being made.

b. Claim Documents:

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

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

1. Personal Accident Cover

Documents required for all Benefits under Personal Accident Cover

(1) Claim Form (in original) duly completed and signed as prescribed by Us
(2) Photo ID and Age proof of Insured Person / Nominee (if Insured Person is not alive)
(3) Claim intimation or claim reference number (if any)
(4) Attested copy of medico legal certificate copy / first information report copy / Panchnama (spot / inquest)
(5) Copies of consultation letters detailing the treatment taken immediately after Accident
(6) Radiological investigation reports like X ray, CT scan, MRI etc with films supporting the diagnosis of Injury
(7) Cancelled cheque for NEFT

Accidental Death Cover (AD)

(1) Attested copy of the death certificate issued by government / municipal authorities
(2) Attested copy of cause of death certificate issued by treating Medical Practitioner/ Hospital
(3) Copy of burial certificate (wherever applicable)
(4) Attested copy of post-mortem report, if applicable
(5) Attested copy of viscera report and chemical analysis report
(6) Attested copy of witness statement (if available)
(7) Copy of death summary if the Insured Person was Hospitalized
(8) Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details and patient's progress (where the death summary is not detailed) (if available)
(9) Translation of all vernacular documents in English duly notarized.(wherever applicable)
(10) Salary slips for last 3 months with seal and signature of authorized signatory of the organization (if employed)
(11) Last 3 years financial years income tax return for self-employed persons
(12) Legal heir certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized (If Nominee name is not mentioned on Policy Schedule or Nominee is a minor, then legal guardian.)

Permanent Total Disablement (PTD) / Permanent Partial Disablement (PPD)

(1) Attested copy of disability certificate issued by civil surgeon of district Hospital mentioning the type and percentage of disability.
(2) Original photograph of the Insured Person reflecting the disablement or injured part for which the claim is made
(3) Leave records with seal and signature of authorized signatory of the organization (if employed)
(4) Salary slips for last 3 months with seal and signature of authorized signatory of the organization (if employed)
(5) Last 3 years financial years income tax return for self-employed persons
(6) Copies of medical documents towards treatment taken during disability period, including discharge summary of the Hospital
(7) Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details and patient's progress (where the discharge summary is not detailed) (if available)

Additional documents required for Specific Benefits

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

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IV. EXCLUSIONS

Waiting Period:
There is no waiting period for the above mentioned Add-on covers. However, this Policy shall follow waiting periods applicable in Base Policy unless otherwise stated and covered in Section III of this policy terms and conditions

Permanent Exclusions:
The add-on covers under this Policy shall follow exclusions mentioned in the Base Policy unless otherwise stated and covered in Section III of this policy terms and conditions.

V. GENERAL TERMS & CONDITIONS

Conditions under this section are same as Base Policy unless otherwise stated under this section specifically.

1. Standard General terms & Conditions

1. Disclosure of information
The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any Material Facts by the Policyholder.

2. Condition Precedent to Admission of Liability
The terms and conditions of the policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

3. Claim Settlement (Provision for Penal Interest)
(a) The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
(b) In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
(c) However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
(d) In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

4. Complete Discharge
Any payment to the Policyholder, Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

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

6. Fraud
If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, all benefits under this Policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/Policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Company.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the Company or to induce the Company to issue an insurance policy:
(a) The suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
(b) The active concealment of a fact by the Insured Person having knowledge or belief of the fact;
(c) Any other act fitted to deceive; and
(d) Any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the Policy benefits on the ground of fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Company.

7. Cancellation
1. Cancellation by You
The Policyholder may cancel this Policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired Policy Period as detailed in below grid

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the Policy.

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

2. Automatic Cancellation:
   a. Individual Policy:
      The Policy shall automatically terminate on the death of all Insured Persons.
   b. Family Policy
      The Policy shall automatically terminate in the event of the death of all the Insured Persons.
   c. Refund:
      A refund in accordance with the grid above shall be payable if there is an automatic cancellation of the Policy provided that no claim has been filed under the Policy by or on behalf of any Insured Person.
3. Cancellation by Us:
   The Company may cancel the Policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the Insured Person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

If the Base policy is cancelled, any add-on cover opted shall stand cancelled.

8. Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company by applying for migration of the Policy atleast 30 days before the Policy Renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration.

For Detailed Guidelines on Migration, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987&flag=1]

9. Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the Policy Renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987&flag=1]

10. Renewal of Policy

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

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

11. Withdrawal of Policy

(i) In the likelihood of this product being withdrawn in future, the Company will intimate the Policy holder about the same 90 days prior to expiry of the Policy.
(ii) Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as Cumulative Bonus, waiver of waiting period. as per IRDAI guidelines, provided the Policy has been maintained without a break.

12. Moratorium Period

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

13. Premium Payment in instalments

If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

(i) Grace Period of 15 days would be given to pay the instalment premium due for the Policy.
(ii) During such Grace Period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
(iii) The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period.

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(iv) No interest will be charged If the instalment premium is not paid on the due date
(v) In case of instalment premium due not received within the Grace Period, the Policy will get cancelled.
(vi) In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

The Company has the right to recover and deduct all the pending instalments from the claim amount due under the Policy.

14. Possibility of Revision of Terms of the Policy including Premium rates

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

15. Free Look Period

The free look period shall be applicable on new individual health insurance policies and not on Renewals or at the time of porting/migrating the Policy

The Insured Person shall be allowed free look period of fifteen days (30 days in case of contracts with a term of 3 years, offered over distance marketing mode) from date of receipt of the Policy document to review the terms and conditions of the Policy, and to return the same if not acceptable.

If the Insured Person has not made any claim during the free look period, the Insured Person shall be entitled to

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

16. Redressal Procedure

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

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

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

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

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

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

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

17. Nomination

The Policyholder is required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Policyholder, the Company will pay the Nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting Nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of the Company's liability under the Policy.

2. Specific General terms & Conditions

18. Material Change

Material information to be disclosed includes every matter that You are aware of, or could reasonably be expected to know, that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk of insurance and if so on what terms. You must exercise the same duty to disclose those matters to Us before the Renewal, extension, or endorsement of the contract and communicate the same to Us in the Change Request form. The Policy terms and conditions will not be altered.

19. Records to be maintained

You or the Insured Person, as the case may be shall keep an accurate record containing all relevant medical records and shall allow Us or Our representative(s) to inspect such records. You or the Insured Person as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Period and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy.

20. No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder/ Insured Person which is in Our possession and not specifically informed by the Policyholder / Insured Person shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

21. Policy Dispute

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

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22. Communications & Notices

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

(i) The Policyholder's, at the address/e-mail ID as specified in the Policy Schedule /Proposal Form or provided to Us by the Policyholder/Insured Person

(ii) To Us , at the address specified in the Policy Schedule.

(iii) No insurance agents, brokers, other person or entity is authorised to receive any notice on the behalf of Us unless explicitly stated in writing by Us.

23. Endorsements

The Policy will allow the following endorsements during the Policy Period. Any request for endorsement must be made by You in writing along with the mandatory documents. Any endorsement would be effective from the date of the request as received from You, or the date of receipt of premium, whichever is later except in the case of date of birth and gender correction in which the endorsement effective date will be the Policy inception or Renewal Start Date.

(i) Non-Financial Endorsements – which do not affect the premium.

(1) Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)
(2) Rectification in gender of the Proposer/ Insured Person*
(3) Rectification in relationship of the Insured Person with the Proposer
(4) Rectification of date of birth of the Insured Person (if this does not impact the premium)*
(5) Change in the correspondence address of the Proposer
(6) Change/Updation in the contact details viz., Phone No., E-mail Id, alternate contact address of the Proposer etc.
(7) Change in Nominee Details
(8) Updation of PAN/Aadhaar/passport/EIA/CKYC No.
(9) Change in Height, weight, marital status (if this does not impact the premium) *
(10) Change in bank details
(11) Change in educational qualification
(12) Change in occupation
(13) Change in Nationality
(14) Others

* These endorsements, if impact the premium, and if accepted, shall be effective from the Start Date of the Policy.

(ii) Financial Endorsements – which result in alteration in premium

(1) Addition of Insured Person (New Born Baby or newly wedded spouse)
(2) Deletion of Insured Person on Death* or Separation or Policyholder/Insured Person leaving India
(3) Change in Age/Date of Birth*
(4) Change in Height, weight*
(5) Others

* These endorsements, if impact the premium, and if accepted, shall be effective from the Start Date of the Policy.

^ The Policyholder should provide a fresh application in a proposal form along with birth certificate / marriage certificate as the case may be for addition of Insured person.

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

24. Grace Period

The Policy may be renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable to pay for any claim arising out of an Illness/ Injury/ Accident/ Condition that occurred during the Grace Period. The provisions of Section 64VB of the Insurance Act shall be applicable. All policies Renewed within the Grace Period shall be eligible for continuity of cover. If the Policy is not Renewed within the Grace Period then We may agree to issue a fresh Policy subject to Our underwriting guidelines and no continuity of benefits shall be available from the expired Policy

25. Electronic Transactions

You agree to comply with all the terms and conditions of electronic transactions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as the internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, in respect of this Policy and/or claim related details, shall constitute legally binding when done in compliance with Our terms for such facilities.

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to You. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated / confirmed by You.

26. Territorial Jurisdiction

All benefits are available in India only and all claims shall be payable in India in Indian Rupees only.

IV. CLAIMS PROCESS

All claims must be made in accordance with the procedure set out in Base Policy unless otherwise stated and covered in Section III of these policy terms and conditions.

Health Add-ons - Policy Wordings - Annexure - I - List of Non-medical expenses waived off

Sr. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL/ INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR

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43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY
69	SURGICAL PLATE

Product Name: Health Add-ons; Product UIN : ADIHLIA22177V012122.