

Health Booster Policy Wording

This detailed document outlines the full terms and conditions of the coverage offered under your health insurance policy, including available coverage, benefits, claim and grievance redressal procedures, exclusions, and other related terms and conditions. It serves as a legal contract between You (Policyholder) and Us (the insurer) which mentions rights, responsibilities, coverage details, and exclusions in clear terms.



Section A. 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

Key Notes: The terms listed in Section B (Definitions) and which have been used elsewhere in the Policy shall have the meaning set out against them in Section B (Definitions), wherever they appear in the Policy. If a word is not specifically defined in the following section, its common meaning will apply.



Section B. Definitions

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

B.1 – Standard Definitions

- 1. Accident:** Sudden, unforeseen and involuntary event caused by external, visible and violent means.
- 2. Break in Policy:** means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.
- 3. Cashless Facility:** 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.
- 4. Condition Precedent:** Policy term or condition upon which the Insurer's liability under the policy is conditional upon.
- 5. 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.
- 6. Emergency care:** 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
- 7. Grace Period:** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received.

The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

- 8. Hospital:** Any institution established for Inpatient 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 Inpatient beds in towns having a population of less than 10,00,000 and at least 15 Inpatient 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.
- 9. Hospitalization:** 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.
- 10. Illness:** 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
- 11. Injury:** 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.
- 12. Inpatient Care:** Treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.
- 13. Maternity Expense** shall include
- i. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);
 - ii. Expenses towards lawful medical termination of pregnancy during the Policy Period.
- 14. Medical Advice:** Any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
- 15. Medical Practitioner:** 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 his licence.
- 16. Medically Necessary Treatment:** 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.
- 17. Migration:** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer
- 18. Network Provider:** Hospital enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an Insured by a Cashless Facility.
- 19. Non-Network Provider:** Any Hospital, Day Care Centre or other provider that is not part of the network
- 20. Portability:** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.
- 21. Pre-existing Disease (PED):** means any condition, ailment, Injury or disease:
- i. that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
 - ii. for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.
- 22. Specific waiting period:** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.
- 23. Surgery or Surgical Procedure:** 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 or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner

B.2 – Specific Definitions

- 1. Aggregate Deductible:** means a cost-sharing requirement that provides that the Company will not be liable for a specified amount of the covered expenses in respect of all admissible claims made under the Policy in aggregate, and which will apply before any benefits are payable by the Company. The Aggregate Deductible does not reduce the Sum Insured.
- 2. Annexure:** A document attached and marked as Annexure to this Policy.
- 3. Add-on covers:** Benefits as specified in Section C of this Policy terms and conditions.
- 4. Base Sum Insured:** means the pre-defined Policy limit applicable for claims made during each Policy Year, as specified against an Insured Person or all Insured Persons in the Policy Schedule and Annexure I - Product Benefit Table.
- 5. Base Policy:** Retail 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
- 6. Benefit** means any benefit shown in the Policy
- 7. Gynaecologist:** A Gynaecologist diagnoses and treats issues with female reproductive organs
- 8. 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.
- 9. 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.

- 10. 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.
- 11. 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.
- 12. Policy Year:** Period of 12 consecutive months commencing from the Start Date
- 13. Pre Natal Expenses:** means medical costs related to pregnancy incurred before childbirth. Expenses will be covered from the date of confirmation of pregnancy
- 14. Post Natal Expenses:** means medical costs related to pregnancy incurred after childbirth. Expenses for a period up to eight (8) weeks from delivery will be covered.
- 15. Sum Insured:**
- 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.
 - 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.
- 16. 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
- 17. We/Our/Us:** means Aditya Birla Health Insurance Co. Limited.
- 18. You/Your/Policyholder:** means the person named in the Policy Schedule as the policyholder and who has concluded this Policy with Us



Section C. Benefits

Benefits under this Section C 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 C 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)

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

C.1 Sub-Limits

On availing this option, if an Insured Person is Hospitalized during the Policy Period for any of the Specified Illnesses or Conditions specified in Policy Schedule/ Product Benefit Table, then it is agreed that our maximum cumulative liability for treatment of all ailments/procedures listed in each section and made under the Policy year will be limited to the amount as per the opted category as specified against the applicable Benefit in the Policy Schedule of this Policy.

Table 1. Sub-limits Category

Sub-limits	Category		
	A	B	C (not applicable for Zone 3 - if Base Policy have zonal pricing)
Treatment of Cataract	Up to INR 20,000 per eye	Up to INR 20,000 per eye	Up to INR 30,000 per eye
Treatment of Total Knee Replacement and Treatment of Total Hip Replacement	Up to INR 70,000 per knee/per hip	Up to INR 80,000 per knee/per hip	Up to INR 1,20,000 per knee/per hip
Cumulative liability for treatment of all ailments/procedures listed below:- - Surgery for treatment of all types of Hernia - Hysterectomy - Surgeries for Benign Prostate Hypertrophy (BPH) - Treatment of all Renal Disorders and complications	Up to INR 50,000/Policy year	Up to INR 75,000/Policy year	Up to INR 1,00,000/Policy year
Cumulative liability for treatment of all ailments/procedures listed below:- - Treatment of Cerebrovascular and Cardiovascular disorders - Treatments/Surgeries for Cancer - Treatment for breakage of bones	Up to INR 1,50,000/Policy year	Up to INR 2,25,000/Policy year	Up to INR 3,00,000/Policy year

Conditions:

- i. This cover can be opted at the time of policy inception and subsequent renewals
- ii. Once the Sub-Limits option is availed by the Insured Person, it cannot be opted out of at subsequent renewals.

C.2 Co-Payment

On availing this option, pre-determined percentage of Co-Payment as opted and specified in the Policy Schedule / Product Benefit Table, shall be applied on each and every admissible claim under the Base Policy or this Policy.

Conditions:

- i. This cover can be opted at the time of policy inception and subsequent renewals
- ii. Once the Co-Payment option is availed by the Insured Person, it cannot be opted out of at subsequent renewals.
- iii. This Co-payment will be additive to any other Co-payment in the Base Policy or this Policy, if applicable

C.3 Aggregate Deductible

On availing this option, the Insured Person shall bear an amount equal to the Aggregate Deductible specified on Policy Schedule / Product Benefit Table for all admissible claims made by the Insured Person and assessed by the Company in a Policy Year.

The liability of the Company to pay the admissible claim under that Policy Year will commence only once the specified Aggregate Deductible has been exhausted. This Cover shall be subject to the following conditions:

- i. This Cover is applicable on annual aggregate basis and can be opted only at inception of the Policy or at subsequent renewals. Aggregate Deductible can be increased at the time of renewal
- ii. Once the Aggregate Deductible option is availed by the Insured Person, it can be opted out of at subsequent renewals.
- iii. In case of Individual Policy, the entire amount of Aggregate Deductible must first be exhausted on per Insured Person basis, once in a Policy Year, before the Company pays for claims of that Insured Person in that Policy Year.
- iv. In case of family floater Policy, the entire amount of Aggregate Deductible must first be exhausted by any one or more of the Insured Persons once in a Policy Year before the Company pays for claims of any Family Member covered under the Policy in that Policy Year

C.4 Waiver of Co-Payment

On availing this option, the Mandatory Co-payment applicable in Base Policy shall not apply completely or partially on payable claims under the Base Policy or this Policy as specified in the Policy Schedule / Product Benefit Table.

Conditions:

- i. This cover can be only opted at the time of Policy inception with Us.
- ii. Once the Waiver of Co-Payment option is availed by the Insured Person, it can be opted out of at subsequent renewals.

C.5 Sum Insured Multiplier

Even when a policy is purchased for longer than a 1-year tenure, the Sum Insured operates on an annual basis. For instance, if the policy is for INR 10 lakhs, this amount can be utilized each policy year, regardless of whether the policy's tenure extends over 2 or 3 years.

On availing this option, Base Sum Insured of the policy is combined for the entire tenure opted. This combined Sum Insured will be available for the entire policy tenure as a combination of Base Sum Insured and Sum Insured Multiplier Sum Insured.

In the sequence of utilization of the Base product the Sum Insured Multiplier, if opted, shall apply immediately after Base Sum Insured utilization and rest all benefits will follow after Sum Insured Multiplier is utilized completely.

Illustration – Activ One NXT: The modified sequence of utilization of Sum Insured of the Base Policy after opting for this cover will be as below:

1. Base Sum Insured followed by;
2. Sum Insured Multiplier (if opted) followed by;
3. Super Credit (if opted and applicable)
4. Super Reload/ Modification of Super Reload followed by;
5. Cancer Booster (if opted and applicable)

Example:

Base Plan opted for INR 10 Lakh Base Sum Insured.

Base plan of multiple years' tenure opted is combined and is available for the entire policy tenure. The policy tenure thus is the entire duration of the policy which could be 2 or 3 years as opted.

Without Sum Insured Multiplier Add-on, the Sum Insured is always Annual i.e. available on policy year basis despite the policy tenure being 2 or 3 years.

Sum Insured:

Policy Year	Policy tenure 1 year	Policy tenure 2 years without Sum Insured Multiplier	Policy tenure 3 years without Sum Insured Multiplier	Policy tenure 2 years with Sum Insured Multiplier	Policy tenure 3 years with Sum Insured Multiplier
1	INR 10 Lakhs	INR 10 Lakhs	INR 10 Lakhs	INR 20 Lakhs	INR 30 Lakhs
2	INR 10 Lakhs	INR 10 Lakhs	INR 10 Lakhs		
3	INR 10 Lakhs	INR 10 Lakhs	INR 10 Lakhs	INR 20 Lakhs	
4	INR 10 Lakhs	INR 10 Lakhs	INR 10 Lakhs		
5	INR 10 Lakhs	INR 10 Lakhs	INR 10 Lakhs	INR 20 Lakhs	
6	INR 10 Lakhs	INR 10 Lakhs	INR 10 Lakhs		

Conditions:

- i. The Add-on is available on your Base Sum Insured only.
- ii. This cover can only be opted at the time of Policy inception with Us.
- iii. Once the Sum Insured Multiplier option is availed by the Insured Person, it can be opted out of at subsequent renewals.
- iv. All waiting periods, co-payments, permanent exclusions, definitions, claims procedure and general terms & conditions applicable to the Base Policy or this Policy will apply to this Add-on as well.
- v. This Add-on cannot be opted with single tenure policies.

C.6 Removal of Super Credit

On availing this option, the Insured Person will not receive the additional percentage of Base Sum Insured under Super Credit benefit (if applicable) that is available under the Base Policy.

Conditions:

- i. This cover can be opted at the time of policy inception and subsequent renewals
- ii. Once the Removal of Super Credit option is availed by the Insured Person, it cannot be opted out of at subsequent renewals.

C.7 Modification of Super Reload

On availing this option and if the Base Sum Insured along with accumulated Super Credit (if applicable) for the Policy Year in respect of the Insured Person, is completely exhausted or is insufficient for covering a claim, the Super Reload Benefit in the Base Policy will be available only once during the policy year as specified in the Policy Schedule/Product Benefit Table of this Policy.

Conditions:

- i. This cover can be opted at the time of policy inception and subsequent renewals
- ii. Once the Modification of Super Reload option is availed by the Insured Person, it cannot be opted out of at subsequent renewals.
- iii. Rest all terms and conditions of Super Reload in the Base Policy shall be applicable including the sequence of utilization.

C.8 Unlimited Care

On availing this option, Insured person will get coverage for the Medical Expenses incurred in respect of Hospitalization under In-Patient Treatment / AYUSH Treatment for any one claim during the lifetime of the Policy without any limits on the Base Sum Insured subject to the following conditions:

- i. The time period to opt for this Add-on cover shall be limited to 2 Policy Years (irrespective of the Policy Tenure). Such that:
 - a. If the Policy Tenure is of single year and is continuously renewed as single year, the Insured Person has to opt for this cover either at the time of Policy Inception or the first renewal. The Add-on cover shall not be applicable in case the Insured Person wishes to opt for this cover at the time of second renewal or subsequent renewals.
 - b. If the Policy Tenure is of 2 or 3 years, the cover has to be opted at the time of Policy inception itself to avail the benefit.
- ii. This cover is applicable only for one claim in the lifetime of the Policy, irrespective of Policy Tenure or Policy Type (Individual or Floater), and should be admissible under Inpatient Treatment/ AYUSH Treatment. All the conditions applicable to the Base Policy Covers shall be applicable to this Add-on cover
- iii. Once opted, the Add-on cover has to be opted continuously by the Insured Person until any one claim is made under this cover. If the Insured Person opts out of this Add-on cover during any renewal, the same cannot be opted again.
- iv. Once a claim has been made under this Add-on cover, the cover will cease to exist and cannot be opted again upon subsequent renewals.
- v. The Total Sum Insured means Base Sum Insured + Sum Insured Multiplier (if opted) + Super Credit (if accrued) + Super Reload/Modification of Super Reload + Cancer Booster (if opted) and shall be utilized as per following sequence:
 1. Base Sum Insured followed by;
 2. Sum Insured Multiplier (if opted) followed by;
 3. Super Credit
 4. Super Reload/ Modification of Super Reload followed by;
 5. Cancer Booster (if opted and applicable)
- vi. After utilization of the Unlimited Care cover, all the above mentioned Total Sum Insured shall be reduced to zero for that Policy Year following the payment of claim under this benefit.
- vii. Add-on cover Section C.1 (Sub-limits) or Add-on cover Section C.2 (Co-payment) or Add-on cover Section C.3 (Aggregate Deductible) cannot be bought with this Add-on cover
- viii. This cover will not be available for any of the International covers of the VIP and VIP+ Plans when opted with Base product Activ One, namely Section Global Cover (Emergency Only), Section Specified Illness Cover (if applicable), Section Maternity Cover and Section Global Enhanced Cover (if applicable).

C.9 Air Ambulance (Domestic)

On availing this option, if an Insured Person requires emergency care that necessitates immediate and rapid transportation via airplane or helicopter, which ground transportation cannot provide, the Company shall cover expenses incurred for ambulance transportation from the site of the first occurrence of the illness or accident to the nearest hospital during the policy year. The claim is subject to a maximum of limit as specified in the Policy Schedule / Product Benefit Table against this Cover, and subject to the following conditions:

- i. The Air Ambulance transportation is advised in writing by a Medical Practitioner.
- ii. Medically Necessary Treatment is not available at the location where the Insured Person is residing at the time of emergency.
- iii. The Air Ambulance provider is a registered entity.
- iv. The cover is available for both cashless and reimbursement
- v. No return transportation to the Insured Person's residing location or elsewhere by the Air Ambulance will be covered under this Cover.
- vi. This cover can be opted at the time of policy inception and subsequent renewals
- vii. Once the Air Ambulance option is availed by the Insured Person, it can be opted out of at subsequent renewals.

Note:

This will be paid only if claim for hospitalization is paid by us under the Base policy.

C.10 Maternity Cover

On availing this option, Insured Person will get a lump-sum amount as Maternity Expenses as specified in the Policy Schedule / Product Benefit Table.

Conditions:

- i. The female Insured Person of Age 18 years or above is covered under the Policy
- ii. Both the Insured Person and his / her legally married spouse or Live-in partner are covered under the Base Policy.
- iii. The Maternity Cover may be claimed under the Policy in respect of eligible Insured Person(s) only once during the lifetime of the Policy thereafter for the delivery of a child or Medically Necessary and lawful termination of pregnancy up to maximum 1 pregnancy or termination after the completion of Waiting Period as specified in the Policy Schedule.
- iv. This cover can only be bought with a 3-year tenure Base Policy
- v. This cover can only be opted at the time of policy inception with Us and can be opted out of at subsequent Renewal.
- vi. Once a claim has been made under this Add-on cover, the cover will cease to exist and cannot be opted again upon subsequent renewals.
- vii. Maximum liability during the lifetime of the Insured Person: 100% of the Sum Insured.

Expenses listed below are excluded from this Cover:

- a. Expenses incurred in respect of the harvesting and storage of stem cells for any purposes whatsoever
- b. Medical Expenses for ectopic pregnancy will be considered under Base cover and not Section C.10 (Maternity Cover)
- c. Maternity Expenses incurred in connection with the voluntary medical termination of pregnancy during the first 12 weeks from the date of conception

C.11 Maternity Care

On availing this option, the Insured Person may avail wellness services as mentioned in the Policy Schedule / Product Benefit Table. The services will include wellness services as specified in the Policy Schedule.

The Insured on availing this Add-on cover can utilize the below services (as applicable as per Policy Schedule) during the policy period:

Table 2: Wellness Services

Services	Advanced	Premium
Tenure	12 Months	12 Months
Tele-Consultation with OB & GYN	4	Unlimited
Personalized Diet Consultation with Diet Plan	2	4
Live Pre-natal or Postnatal Group Yoga Sessions	2 Months Unlimited	4 Months Unlimited
Self Help - Curated content (Yoga & Meditation Videos, Recipes, Blogs etc.)	Complimentary	Complimentary
Unlimited access to Health Trackers and Ovulation Tracker to Track & Manage various parameters (Fertile Window, Weight, Hormones, Stress Level, Sleep, Cramps etc.)	Complimentary	Complimentary
Discount on other online consultations (Sexual Wellness Coach, Fertility Expert, Financial Assessment & Advisory Expert, Mental Wellness Coach, Dermatologist, Career Coach, Physiotherapists, Paediatrician etc.)	As mentioned in Policy Schedule	As mentioned in Policy Schedule
Discount on Packages/Consultations - Pregnancy Care, Yoga/Fitness, Childbirth, Natural Birthing, Lactation, Holistic Wellness, Diet/Weight Management, Mental Wellness, Couple Therapies etc.	As mentioned in Policy Schedule	As mentioned in Policy Schedule
Discount on Pathology (5,000+ tests covering 400+ cities)	As mentioned in Policy Schedule	As mentioned in Policy Schedule
Discount on Radiology (5,000+ tests covering 400+ cities)	As mentioned in Policy Schedule	As mentioned in Policy Schedule
Discount on Genetic Testing & Super Specialized Testing	As mentioned in Policy Schedule	As mentioned in Policy Schedule
Discount on Self Testing Kits (at home) like Omega Score for Pregnant or Breastfeeding, GenePass or InferGenes, Perimenopause, Fertility, HPV, STD, Chlamydia and Gonorrhoea etc.	As mentioned in Policy Schedule	As mentioned in Policy Schedule
Discount on Medicines	As mentioned in Policy Schedule	As mentioned in Policy Schedule
Discount on Stem Cell Banking (Exclusive Offers)	As mentioned in Policy Schedule	As mentioned in Policy Schedule
Discount on Fertility Packages / Treatments	As mentioned in Policy Schedule	As mentioned in Policy Schedule
Pre and Post Natal Dance Movement Therapy Sessions	As mentioned in Policy Schedule	As mentioned in Policy Schedule
Diastasis Recti - Mommy Belly Post Recovery Sessions	As mentioned in Policy Schedule	As mentioned in Policy Schedule
Discount on Products to Shop for Mother & Baby - Clothes, Hygiene, Skin & Hair Care, Innovative Products, Nutrition, Supplements, Accessories, Baby Products etc. throughout the year	As mentioned in Policy Schedule	As mentioned in Policy Schedule
Discount on Care Kits at home (Pregnancy, UTI, Wellness, Kidney)	As mentioned in Policy Schedule	As mentioned in Policy Schedule

Conditions:

- i. The services will be provided through an empanelled Service Provider. It is entirely for the Insured Person to decide whether to obtain these services.
- ii. We shall not be responsible for any disputes arising between the Insured Person and the Service Provider.
- iii. The services provided under this benefit, does not constitute Medical Advice of any kind and it is not intended to be, and should not be, used to diagnose or identify treatment for a medical or mental health condition.
- iv. This cover can be opted at the time of policy inception and subsequent renewals.
- v. Once the Maternity Care option is availed by the Insured Person, it can be opted out of at subsequent renewals.

C.12 NRI Discount

On availing this option, if the Insured Person qualifies as an NRI (Non-Resident Indian) as per below mentioned condition (i) then the Insured Person will be entitled for a pre-defined discount as specified in the Policy Schedule / Product Benefit Table.

Conditions:

- i. An NRI or Non-Resident Indian is an Indian Citizen living outside India for a minimum of 183 days in 1 financial year for the purpose of employment, business, or vocation (occupation for which an individual is trained).
- ii. Insured will have to make a declaration at the time of opting this Add-on cover every year to avail the discount.
- iii. For Insured who have been offered NRI discount in a particular policy year and at policy renewal makes further declaration of his stay abroad for the forthcoming year the applicable NRI discount would be offered on the renewal premium. If the Insured would be based in India then no discount would be applicable upon renewal.
- iv. This discount will be applicable on member level in both Floater and Individual policies.
- v. This cover can be opted at the time of policy inception and subsequent renewals.
- vi. Once the NRI Discount option is availed by the Insured Person, it can be opted out of at subsequent renewals.

**Section D. Waiting Period and Permanent Exclusions**

Waiting Period: There's no waiting period for the above mentioned Add-on covers except for Section C.10 – Maternity Cover (applicable option) as mentioned in the Policy Schedule.

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

**Section E. General Terms and Conditions**

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

E.1 Standard General Terms and Clauses**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 fact by the policyholder. (Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

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)

- i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- ii. In case, the claim is repudiated or disallowed partially, details shall be conveyed to the claimant along with full details giving reference to the specific terms and conditions of the policy document.
- iii. In 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.
- iv. 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.
- v. 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

- i. In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his / her policies. In all such cases the insurer chosen by the Insured Person, shall be treated as the primary Insurer and shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
- ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this Policy.
- iii. In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the policyholder.
- iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

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 shall be forfeited. Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a insurance Policy:

- i. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
- ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
- iii. any other act fitted to deceive; and
- iv. any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy 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 mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries

7. Cancellation

i. Cancellation by You for benefits other than Maternity Cover

The Insured may cancel his/her policy at any time during the term, by giving 7 days' notice in writing.

The Insurer shall

- a. refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period.
- b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

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.

ii. Cancellation by You for Maternity Cover

In case there is no claim in the entire policy year under the Section C.10- Maternity Cover, the Company shall refund premium as detailed in below grid:

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

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 under Section C.10 (Maternity Cover) by the Insured Person under the Policy

iii. 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 Section 7.i. (a) or (b) 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.

iv. Cancellation by Us:

The Company may cancel this 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.

No refund will be processed for cancellation of policies with Premium Payment Mode as Half-yearly, Quarterly or Monthly.

8. Migration

The Insured Person (including all members under family cover and group insurance policies) will have the option to migrate the Policy to an alternative health insurance product/ plans, offered by the Company policy, to the extent of the sum insured and the benefits available in the previous policy by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product / plan offered by the Company, the Insured Person can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.

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 (individual or group policy) with an Indian General/Health insurer, the proposed Insured Person is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy.

10. Renewal of the Policy

- i. The Policy shall ordinarily be renewable provided the product is not withdrawn, except on grounds of established fraud or non-disclosure or misrepresentation by the Insured Person.
- ii. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- iii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding Policy Years.
- iv. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
- v. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of fifteen days where premium payment mode is monthly and thirty days in all other cases to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- vi. No loading shall apply on renewals based on individual claims experience
- vii. An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.

11. Withdrawal of Policy

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.
- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as 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 sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.

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, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

- i. Grace Period of 15 days for monthly and 30 days for quarterly, Half-yearly and Annual mode premium policies, would be given to pay the instalment premium due for the policy.
- ii. The Policy will be in force during such grace period and any claim arising during the grace period will be subject to policy terms and conditions
- iii. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
- iv. No interest will be charged if the instalment premium is not paid on due date.
- v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
- vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

14. Possibility of Revision of Terms of the Policy including the Premium Rates:

The Company may revise or modify the terms of the Policy including the premium rates with prior approval of the Product Management Committee, of the Company. 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, except for those policies with tenure of less than a year. Free-look is not applicable on renewals or at the time of porting / migrating the policy.

The Insured Person shall be allowed free look period of thirty days from date of receipt of the policy document, whether received electronically or otherwise, to review the terms and conditions of the policy, and to return the same if not acceptable.

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

- i. Refund of the premium paid, less any expenses incurred by the Company on medical examination of the Insured Person, if any and 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, any expenses incurred by the Company on medical examination of the Insured Person, if any and stamp duty charges or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period, any expenses incurred by the Company on medical examination of the Insured Person, if any and stamp duty charges.
- iv. A request received by insurer for cancellation of the policy during free look period shall be processed and premium shall be refunded within 7 days of receipt of such request

16. Redressal of Grievances

In case of any grievance the Insured Person / Policyholder may contact the

Website: <https://www.adityabirlacapital.com/healthinsurance/faqs>

Toll - Free: 1800 270 7000

E-Mail: care.healthinsurance@adityabirlacapital.com (Senior citizens may write to us at: seniorcitizen.healthinsurance@adityabirlacapital.com)

In case you are not satisfied with the resolution you may write to Head – Customer Care: carehead.healthinsurance@adityabirlacapital.com

Courier:

Write to our HO at below address
Unit no 1101 & 1104 11th floor,
Unit no 1501& 1502 15th floor,
G Corp Tech Park, Kasarwadavali, Ghodbunder Road, Thane West-400601

Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance. If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at:

gro.healthinsurance@adityabirlacapital.com

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

Grievance may also be lodged at IRDAI Integrated Grievance Management System - <https://bimabharosa.irdai.gov.in/>

17. Nomination:

The insured person is required at the inception of the policy and at the time of renewal, to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Nomination can be changed any time during the term of the policy. 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 its liability under the policy.

E.2 Specific Terms and Clauses**1. Material Change**

Material information to be disclosed includes eve' matter that You are aware of, or could reasonably be expected to know, that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk of insurance. You must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, or endorsement of the contract. The Policy terms and conditions shall not be altered.

2. Records to be Maintained

You or the Insured Person, as the case may be shall keep an accurate record containing all relevant medical records relevant to the Injury in respect of which a claim has been made under this Policy and shall allow Us or our representative(s) to inspect such records. Such information shall be furnished to Us as may be required by Us under this Policy at any time during the Policy Period and up to the later of three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy.

3. No Constructive Notice

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

4. Dispute Resolution

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 without reference to any principle which would result in the application of the law of any other jurisdiction.

5. 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; No insurance agents, brokers, other person or entity is authorised to receive any notice on behalf of Us unless explicitly stated in writing by Us;
- iii. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

6. 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/Updation in the contact details viz., Phone No., E-mail Id, alternate contact address of the Proposer etc.
 - (6) Change in Nominee Details
 - (7) Updation of PAN/Aadhaar/passport/EIA/CKYC No.
 - (8) Change in Height, weight, marital status (if this does not impact the premium)*
 - (9) Change in bank details
 - (10) Change in educational qualification
 - (11) Change in occupation
 - (12) Change in Nationality
 - (13) 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) Change in the correspondence address of the Proposer
 - (6) 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.

7. Grace Period

The Policy may be Renewed by mutual consent for life subject to application of renewal and realization of renewal premium 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 (for Quarterly, Half yearly and annual instalments) & 15 days for Monthly policies from the date of expiry of the Policy. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected. Insurance coverage may be made available during the Grace Period as per the product design

8. Electronic Transactions

The Policyholder and the Insured agree to adhere and comply with all such terms and conditions of electronic transactions as We may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of Us, for and in respect of the Policy or its terms, or Our other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with Our terms and conditions for such facilities, as may be prescribed from time to time. Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Policyholder. A voice recording in case of tele-sales or other evidence for sales through the Internet shall be maintained and such consent shall be subsequently validated / confirmed by the Policyholder.

9. Territorial Jurisdiction

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

Section F. Claims Process

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

Annexure I- Product Benefit Table

S.No.	Benefits	Limits/Details		
1	Sub-Limits	Choice from Category A/B/C (Table 1. Sub-Limits Category)		
2	Co-Payment	Options- 10%/20%/ 30%/40%/50%		
3	Aggregate Deductible	INR 20,000/30,000/50,000/1,00,000/2,00,000/3,00,000/ 5,00,000		
4	Waiver of Co-Payment (Removal of Mandatory co-payment from Base Product)	The following Waiver of Co-payment option is available:		
		Product Name	Plan Name	Waiver of Co-payment Options*
		Activ Health	Platinum Essential	20%
		Activ Assure	Diamond	
		Activ Care	Standard	
		Activ Care	Classic	
		Activ Care	Premier	10%
		Arogya Sanjeevani		5%
		*The customer will have an option to opt for partial waiver of co-payment		
5	Sum Insured Multiplier Allowed for: A: Zone 1 - Base Sum Insured from INR 10 Lacs to INR 1 Crore B: Zone 2 & 3 - Base Sum Insured from INR 7 Lacs to INR 1 Crore	Combine multi tenure Base sum insured to be used anytime. Applicable for Base Sum insured only.		

6	Removal of Super Credit	Super Credit will not be available as a Base Benefit
7	Modification of Super Reload	Available (Up to 100% of Base Sum Insured)
8	Unlimited Care	One-time Unlimited Sum Insured for any one selected admissible claim in Policy life
9	Air Ambulance (Domestic)	Up to Base Sum Insured
10	Maternity Cover	Maternity SI: INR 50,000 Waiting Period Options-1: Zero Days Options-2: 3 months Options-3: 6 months Options-4: 9 months
11	Maternity Care	Wellness Services Option:1 Advanced Option:2 Premium
12	NRI Discount	Base Sum Insured INR 10Lacs - INR 15Lacs: 15% Base Sum Insured INR 15Lacs- INR 25Lacs: 20% Base Sum Insured INR 25Lacs and above: 25%

Aditya Birla Health Insurance Co. Limited

Product Name: Health Booster, Product UIN: ADIHLIA25035V012425.
1800 270 7000 | care.healthinsurance@adityabirlacapital.com | www.adityabirlahealthinsurance.com
Trademark/Logo Aditya Birla Capital is owned by Aditya Birla Management Corporation Private Limited and
Trademark/Logo HealthReturns, Healthy Heart Score and Active Day are owned by Momentum Metropolitan Life Limited
(Formerly known as MMI Group Limited). These trademark/Logos are being used by Aditya Birla Health Insurance Co. Limited
under licensed user agreement(s).

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