# Activ Health - Prospectus

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## Section I: Basic Covers:

The Benefits listed below are in-built Policy Benefits and shall be available to all Insured Persons as per the opted Plan.

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

Benefits under this Section A.I. are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and / or the Sub-Limit and / or Co-payment as may be applicable for each Benefit under Section A.I. is 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 and the applicable Sub-Limit for that Benefit.

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

**(1) In-patient Hospitalization:**

**What is covered**

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

(i) Reasonable and Customary Charges for Room Rent for accommodation in Hospital room and other boarding charges 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 surgeon, consultants, physicians, 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 the Injury / Illness for which the Insured Person is Hospitalized;
(viii) Anaesthesia, blood, oxygen and blood transfusion charges; Cost of Pacemaker, Diagnostic materials and X rays, Dialysis, Chemotherapy, radiotherapy;
(ix) Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

**Conditions:**

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

**Sub-limits**

For Platinum - Essential Plan, treatment-wise Sub-Limits will apply as below. These Limits are applicable per Policy Year.

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

**(2) Pre – hospitalization Medical Expenses:**

**What is covered**

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 under Section A.I.(1) or Day Care Treatment under Section A.I.(4) or Domiciliary Hospitalization under Section A.I.(5) 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.

**(3) Post – hospitalization Medical Expenses:**

**What is covered**

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.

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**Conditions**

(i) We have accepted a claim for In-patient Hospitalization under Section A.I.(1) or Day Care Treatment under Section A.I.(4) or Domiciliary Hospitalization under Section A.I.(5) for the same Illness / Injury;
(ii) 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.

**(4) Day Care Treatment:**

**What is covered**

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. The list of covered Day Care Treatment is mentioned in Annexure II.

**Conditions**

(i) The Day Care Treatment is Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
(ii) The Medical Expenses are incurred, including for any procedure which requires a period of specialized observation or care after completion of the procedure undertaken by an Insured Person as Day Care Treatment.

**What is not covered**

(i) OPD treatment is not covered under this Benefit.

**(5) Domiciliary Hospitalization:**

**What is covered**

We shall cover the Medical Expenses incurred for the Insured Person's Domiciliary Hospitalization, 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 Domiciliary Hospitalization continues for at least 3 consecutive days in which case We will make payment under this Benefit in respect of Medical Expenses incurred from the First Day of Domiciliary Hospitalization;
(ii) The treating Medical Practitioner confirms in writing that Domiciliary Hospitalization was medically necessary and the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital OR the Insured Person satisfies Us that a Hospital bed was unavailable;
(iii) If a claim is accepted under this Benefit, then We shall pay Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses under Section A.I.(2) and Section A.I.(3) respectively for the same Illness / Injury.

**What is not covered**

We shall not be liable to pay for any claim made under this Benefit in connection with:
(i) Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
(ii) Arthritis, gout and rheumatism;
(iii) Chronic nephritis and nephritic syndrome;
(iv) Diarrhea and all type of dysenteries, including gastroenteritis;
(v) Diabetes mellitus and insipidus;
(vi) Epilepsy;
(vii) Hypertension;
(viii) Psychiatric or psychosomatic disorders of all kinds;
(ix) Pyrexia of unknown origin.

**(6) Road Ambulance Cover:**

**What is covered**

We shall cover the costs incurred up to the Limits as specified in the Policy Schedule / Product Benefit Table of this Policy, towards transportation of the Insured Person by Road Ambulance to a nearest Hospital from the place of occurrence of an Emergency for treatment where such Emergency occurs during the Policy Period.

Coverage shall also be provided under the below circumstances, if the Medical Practitioner certifies in writing that:
(i) It is Medically Necessary to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.
(ii) It is Medically Necessary to transfer the Insured Person to another Hospital during the course of Hospitalization due to lack of super speciality treatment in the existing Hospital.

**Conditions**

(i) The Ambulance / Healthcare Service Provider is duly registered;
(ii) We have accepted a claim for In-patient Hospitalization under Section A.I.(1) above for the same Illness / Injury.

**What is not covered**

Any expenses in relation to transportation of the Insured Person from Hospital to the Insured Person's residence are not payable under this Benefit.

**(7) Organ Donor Expenses:**

**What is covered**

We shall cover the Medical Expenses, up to the Limits as specified in the Policy Schedule / Product Benefit Table of this Policy, incurred by or in respect of the organ donor, for an organ transplant Surgery accepted by Us under Section A.I.(1) solely towards the harvesting of the organ donated.

**Conditions**

(i) The organ donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;
(ii) The Insured Person is the recipient of the organ so donated by the organ donor;
(iii) The organ transplant is medically necessary for the Insured Person as certified by a Medical Practitioner;
(iv) Permanent Exclusion mentioned in Section B.(H).viii.32 does not apply to this Benefit.

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**What is not covered**

(i) Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
(ii) Screening expenses of the organ donor.
(iii) Any other Medical Expenses as a result of harvesting from the organ donor.
(iv) Costs directly or indirectly associated with the acquisition of the donor's organ.
(v) Transplant of any organ / tissue where the transplant is experimental or investigational.
(vi) Expenses related to organ transportation or preservation.
(vii) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

**(8) Reload of Sum Insured:**

**What is covered**

Once in the Policy Year, We shall provide for a reload of the Sum Insured up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy, in case the available Sum Insured which shall be considered to be inclusive of accumulated Cumulative Bonus (if any), is insufficient for covering a claim under the Policy as a result of previous claims in that Policy Year. Reload of Sum Insured shall be available only once during a Policy Year.

**Conditions**

(i) A claim shall be admissible under this Benefit only if the claim is admissible under In-patient Hospitalization under Section A.I.(1) or Day Care Treatment under Section A.I.(4).
(ii) The reload of Sum Insured shall not apply to the First Claim in the Policy Year.
(iii) The reload of Sum Insured shall be available only for subsequent claims and not in relation to any Illness / Injury (including its complications) for which a claim has been admitted for the Insured Person during that Policy Year.
(iv) The reload of Sum Insured shall be available only for Section A.I.(1) Inpatient Hospitalisation and Section A.I.(4) Day care treatment;
(v) The reloaded Sum Insured shall not be considered while calculating the Cumulative Bonus.
(vi) In case of an Individual Policy, reload of the Sum Insured is available to each Insured Person and can be utilised by Insured Persons who are covered under the Policy.
(vii) In case of a Family Floater Policy, the reload of Sum Insured shall be available on a Floater Basis for all Insured Persons in the family that are covered under the Policy.
(viii) If the reload of Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

**(9) Super Reload**

**What is covered**

We shall provide for a Reload of the Sum Insured, unlimited times during the Policy Year up to the Limits as specified in the Policy Schedule / Product Benefit Table of this Policy, in case the available Sum Insured which shall be considered to be inclusive of accumulated Cumulative Bonus (if any), is insufficient for covering a claim under the Policy as a result of previous claims in that Policy Year.

**Conditions**

(i) A claim shall be admissible under this Benefit only if the claim is admissible under In-patient Hospitalization under Section A.I.(1) or Day Care Treatment under Section A.I.(4) or Section A.I.(10) (AYUSH Cover) or Section A.I.(5) (Domiciliary Hospitalization) or Section A.I.(14) (Modern Treatment Methods and Advancement in Technologies) or Section A.I.(7) (Organ Donor Expenses) or Section A.I.(13) (Home Treatment) arising in that Policy Year for any or all Insured Person(s).
(ii) The Super Reload of Sum Insured shall apply to the First Claim in the Policy Year.
(iii) The Super Reload of Sum Insured shall be available for all subsequent claims also and to any Illness / Injury (including its complications) for which a claim has been admitted for the Insured Person during that Policy Year.
(iv) Our total, maximum liability under a single claim under this benefit shall not be more than Base Sum Insured;
(v) The Super Reloaded Sum Insured shall not be considered while calculating the Cumulative Bonus.
(vi) In case of an Individual Policy, Super Reload of the Sum Insured is available to each Insured Person and can be utilised by Insured Persons who are covered under the Policy.
(vii) In case of a Family Floater Policy, the Super Reload of Sum Insured shall be available on a Floater Basis for all Insured Persons in the family that are covered under the Policy.
(viii) If the Super Reload of Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

**(10) Ayush Cover:**

**What is covered**

We shall cover on a reimbursement basis, up to the Limits as specified in the Policy Schedule / Product Benefit Table of this Policy, towards the Medical Expenses for In-patient Hospitalization incurred with respect to the Insured Person's Ayush Treatment undergone in any AYUSH Hospital.

**Conditions**

(i) Treatment taken is within India; and
(ii) Permanent Exclusion mentioned in Section B.(H).viii.13 does not apply to this Benefit.

**What is not covered**

The Pre-hospitalization Medical Expenses and Post- hospitalization Medical Expenses related to Ayush Treatments are not covered in this Benefit.

**(11) Mental Illness Hospitalization:**

**What is covered**

We shall cover the Medical Expenses incurred by the Insured Person upto the limit specified in the Policy Schedule / Product Benefit Table of this Policy, towards Hospitalization of the Insured Person under Section A.I.(1) (In- patient Hospitalization) specifically for any Mental Illnesses. Pre-hospitalization Medical Expenses incurred, immediately preceding the Insured Person's admission to the Hospital and Post-hospitalization Medical Expenses incurred immediately following the Insured Person's discharge, within the Policy Period will also be indemnified under this Benefit in accordance with as per Section A.I.(2) (Pre-hospitalization Medical Expenses) and Section A.I.(3) (Post-hospitalization Medical Expenses) respectively.

**What is not covered:**

(i) Any condition which is not clinically significant or is related to anxiety, bereavement, relationship or academic problems, acculturation difficulties or work pressure;
(ii) Treatment related to intentional self-inflicted Injury or attempted suicide by any means.

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**(12) Obesity Treatment:**

**What is Covered**

We shall cover the related Medical Expenses as specified in the Policy Schedule / Product Benefit Table of this Policy if the Insured Person is hospitalized for a Bariatric Surgery which is Medically Necessary, on the written advice of a Medical Practitioner, subject to the following.

**Conditions:**

(i) The Insured Person undergoing the Surgery is of minimum Age of 18 years.
(ii) Surgery to be conducted is upon the advice of the Medical Practitioner / Bariatric Surgeon.
(iii) The Surgery / Surgical Procedure conducted should be supported by clinical protocols.
(iv) The Medical Practitioner / Bariatric Surgeon confirms in writing that the Insured Person's Body Mass Index (BMI) is:
    I. Greater than or equal to 40 or
    II. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
        i. Obesity-related cardiomyopathy.
        ii. Coronary heart disease.
        iii. Severe sleep apnea.
        iv. uncontrolled type2 diabetes.

**Conditions**

(i) A claim under this Benefit is acceptable only if it is towards any of the below procedures:
    a. Gastric Bypass- The Roux-en-Y Gastric Bypass, Biliopancreatic Diversion with or without Duodenal Switch (BPD/DS) Gastric Bypass.
    b. Sleeve Gastrectomy.
    c. Laparoscopic Gastric Banding.
(ii) Written confirmation from Medical Practitioner / Bariatric Surgeon is provided to Us that the Bariatric Surgery is not for a specific correctable cause for treating obesity. Example: Endocrine disorder.
(iii) A prior approval should be taken from Us before the Bariatric Surgery is performed.
(iv) Permanent Exclusion no. B.(H).viii.7 is not applicable.

**What is not Covered**

(i) Bariatric Surgery for cosmetic / aesthetic reasons.
(ii) For treating Drug-Induced Obesity, for Severe Untreated Hormonal Imbalance, Psychiatric and Eating Disorders-Induced Obesity.

**(13) Home Treatment:**

**What is covered**

We shall cover the treatment expenses up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy for the Insured Person's treatment at his / her home for Illnesses / Injuries such as chemotherapy, dengue, gastroenteritis, hepatitis, peritoneal dialysis on a cashless basis only availed through our Network Provider / Empanelled Service Providers providing such facility, listed on Our website.

**Conditions**

(i) Requisite pre-authorisation is obtained from Us for the said Illness / Injury.
(ii) OPD Treatment is not covered under this Benefit.
(iii) The same Illness is payable as per the conditions specified in Section A.I.(1).
(iv) Insured Person may avail a treatment in a network Hospital under Section A.I.(1) in case that Pre-Authorisation is not received by the Insured Person(s) from Us, as per the terms and conditions of Section A.I.(1).
(v) The amount, frequency and time period of the home treatment services should be reasonable and supported in agreement by the treating Medical Practitioner and the Insured Person availing the service.
(vi) The maximum number of days, of covered services per Insured Person, for each Policy Year, covered under this Benefit shall not exceed 15 days.
(vii) The condition of the Insured Person must be expected to improve in a reasonable and generally predictable period of time.
(viii) Treatment under this Benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the home treatment plan, in accordance with the condition of the Insured Person.
(ix) We do not assume any liability towards, and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner and/or Network Provider / Empanelled Service Provider or in any service under this Benefit or for any consequences of actions taken or not taken in reliance thereon.
(x) The exclusion no. 52 as specified in Annexure I - Non Medical Expenses are waived off to the extent of this Benefit(s) as specified in this Section A.I.(13).
(xi) We do not assume any liability towards any additional or incidental charges / expenses, including but not limited to any charges towards breakage, damage, deposit for equipment, and equipment transportation. All such charges / expenses shall be borne by the Insured Person.
(xii) The foregoing home treatment services are provided through Network Provider / Empanelled Service Provider in select cities for select treatment procedures only. Please contact Us or refer to Our website for updated list of treatment procedures and cities where home treatment service is provided.

**(14) Modern Treatment Methods and Advancement in Technologies:**

**What is covered**

The following procedures in respect of the Insured Person will be covered (wherever medically indicated) either as In-patient Hospitalization (Section A.I.(1)) or as part of Day Care Treatment (Section A.I.(4)) in a Hospital, up to the limit as specified in the Policy Schedule / Product Benefit Table of this Policy, during the Policy Period:

(i) Uterine Artery Embolization and HIFU (High intensity focused ultrasound).
(ii) Balloon Sinuplasty.
(iii) Deep Brain Stimulation.
(iv) Oral Chemotherapy.
(v) Immunotherapy - Monoclonal Antibody to be given as injection.
(vi) Intra Vitreal Injections.
(vii) Robotic Surgeries.
(viii) Stereotactic Radio Surgeries.
(ix) Bronchical Thermoplasty.
(x) Vaporisation of the Prostrate (Green laser treatment or holmium laser treatment).
(xi) IONM - (Intra Operative Neuro Monitoring).
(xii) Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

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**(15) Domestic Emergency Assistance Services (including Air Ambulance):**

**What is covered**

We will provide the Emergency medical assistance as described below when an Insured Person is travelling, within India for 150 (one hundred and fifty) kilometres or more away from his / her residential address as mentioned in the Policy Schedule.

(i) Emergency Medical Evacuation: When an adequate medical facility is not available in the proximity of the Insured Person, as determined by Our Empanelled Service Provider for providing such Emergency Services, the consulting Medical Practitioner and the Medical Practitioner attending to the Insured Person, transportation under appropriate medical supervision will be arranged, through an appropriate mode of transport to the nearest medical facility which is able to provide the required care.

(ii) Medical Repatriation (Transportation): When medically necessary, as determined by Us and the consulting Medical Practitioner, transportation under medical supervision shall be provided in respect of the Insured Person to the residential address as mentioned in the Policy Schedule, provided that the Insured Person is medically cleared for travel via commercial carrier, and provided further that the transportation can be accomplished without compromising the Insured Person's medical condition.

**Conditions**

(i) No claims for reimbursement of expenses incurred for services arranged by Insured Person will be allowed unless agreed by Us or Our authorized representative.

(ii) Please call Our call centre with details on the name of the Insured Person and / or Policyholder and Policy number, on the toll free number specified in the Policy Schedule for availing this Benefit.

**What is not covered**

We will not provide services in the following instances:

(i) Travel undertaken specifically for securing medical treatment.
(ii) Injuries resulting from participation in acts of war or insurrection.
(iii) Commission of an unlawful act(s).
(iv) Attempt at suicide.
(v) Incidents involving the use of drugs unless prescribed by a Medical Practitioner.
(vi) Transfer of the Insured Person from one medical facility to another medical facility of similar capabilities which provides a similar level of care.
(vii) Pandemic / Epidemic.

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

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

**(16) International Emergency Assistance Services (including Air Ambulance):**

**What is covered**

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

(i) Emergency Medical Evacuation: When an adequate medical facility is not available in the proximity of the Insured Person, as determined by Our Empanelled Service Provider for providing such Emergency Services, the consulting Medical Practitioner and the Medical Practitioner attending to the Insured Person, transportation under appropriate medical supervision will be arranged, through an appropriate mode of transport to the nearest medical facility which is able to provide the required care.

(ii) Medical Repatriation (Transportation): When medically necessary, as determined by Us and the consulting Medical Practitioner, transportation under medical supervision shall be provided in respect of the Insured Person to the residential address as mentioned in the Policy Schedule, provided that the Insured Person is medically cleared for travel via commercial carrier, and provided further that the transportation can be accomplished without compromising the Insured Person's medical condition.

**Conditions**

(i) No claims for reimbursement of expenses incurred for services arranged by Insured Person will be allowed unless agreed by Us or Our authorized representative.

(ii) Please call Our call centre with details on the name of the Insured Person and / or Policyholder and Policy number, on the toll free number specified in the Policy Schedule for availing this Benefit.

**What is not covered**

We will not provide services in the following instances:

(i) Travel undertaken specifically for securing medical treatment.
(ii) Injuries resulting from participation in acts of war or insurrection.
(iii) Commission of an unlawful act(s).
(iv) Attempt at suicide.
(v) Incidents involving the use of drugs unless prescribed by a Medical Practitioner.
(vi) Transfer of the Insured Person from one medical facility to another medical facility of similar capabilities which provides a similar level of care.
(vii) Trips exceeding 90 days from residential address without prior notification to Us.
(viii) Pandemic / Epidemic.

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

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

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**(17) OPD Cover:**

**What is covered**

We will cover costs incurred for medically necessary consultations, diagnostic tests and pharmacy expenses on an out-patient basis up to the amount specified in the Policy Schedule / Product Benefit Table. You can also call Our contact center toll free number specified in the Policy Schedule for scheduling an appointment.

These services can be also availed at Our Network Providers and Empanelled Service Providers (such as Outpatient clinics or Physicians / Diagnostic centres / Pharmacy Stores) on a Cashless Facility basis. Reimbursement claims can be submitted once in a period of 3 months across a Policy Year.

**Conditions**

(i) This Benefit shall be available on an individual basis to each eligible Insured Person up to the Limit specified in the Policy Schedule for both Individual and Family Floater Policies.
(ii) The Limit for OPD Expenses for each Insured Person(s) covered under this Policy shall remain the same in case of a Family Floater Policy.

**(18) Post-hospitalization Physiotherapy cover:**

**What is covered**

We will cover on a reimbursement basis, in accordance with the limits as specified for Section A.I.(3) (**Post-hospitalization Medical Expenses**) as specified in the Policy Schedule / Product Benefit Table of this Policy, the Insured Person's Post-hospitalization Medical Expenses incurred on physiotherapy provided that such physiotherapy is prescribed in writing by the treating Medical Practitioner as Medically Necessary Treatment following an Illness or Injury that occurs during the Policy Period and is solely and directly related to the same condition that led to Hospitalization under Section A.I.(3).

**Conditions**

(i) We have accepted a claim for In-patient Hospitalization under Section A.I.(1).
(ii) 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.

**(19) Premium Waiver:**

**What is covered:**

If an Insured Person is diagnosed for the first time with or for any of the below listed Critical Illnesses during the Policy Period, the cover under the Policy shall be automatically extended for a tenure of 1 Policy Year starting from the end of that Policy Period.

| List of Critical Illnesses as applicable: | | | |
|---|---|---|---|
| 1 | Cancer of Specified Severity | 11 | Motor Neuron Disease With Permanent Symptoms |
| 2 | Myocardial Infarction (First Heart Attack of specific severity) | 12 | Third Degree Burns |
| 3 | Open Chest CABG | 13 | Deafness |
| 4 | Open Heart Replacement Or Repair Of Heart Valves | 14 | Loss of Speech |
| 5 | Kidney Failure Requiring Regular Dialysis | 15 | Aplastic Anaemia |
| 6 | Stroke Resulting In Permanent Symptoms | 16 | End Stage Liver Failure |
| 7 | Major Organ / Bone Marrow Transplant | 17 | End Stage Lung Failure |
| 8 | Permanent Paralysis Of Limbs | 18 | Bacterial Meningitis |
| 9 | Multiple Sclerosis With Persisting Symptoms | 19 | Fulminant Hepatitis |
| 10 | Coma of Specified Severity | 20 | Muscular Dystrophy |

**Conditions:**

(i) This Benefit is available once in the lifetime in the Policy regardless of the number of years the Policy has served with Us.
(ii) This Benefit is applicable for all the Insured Person Aged 18 years and above.
(iii) The symptoms of the Critical Illness first occur or manifest itself during the Policy Period and after completion of 90 days from the Inception of the First Policy with Us.
(iv) For Platinum Premiere Plan, waiver of premium for 1 year shall be excluding the premium for International Coverage for Major Illnesses, Critical Illness Cover and Personal Accident Cover (AD, PTD).
(v) For Platinum Enhanced Plan, waiver of premium for 1 year shall be excluding the premium of Optional Covers - International Coverage for Major Illness, Critical Illness Cover and Personal Accident Cover (AD, PTD), if opted.

**(20) Co-payment for treatment in a Higher Zone:**

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

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

**(21) Mandatory Co-payment :**

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

**Conditions:**

(i) For persons who have opted for a 'Waiver of Mandatory Co-payment' this Co-payment will not apply.
(ii) Mandatory co-payment is not applicable for optional Benefits - Personal Accident (AD, PTD) and Critical Illness cover.

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## Section II: Additional Benefits

The Benefits listed below are in-built Additional Benefits and shall be available under the Policy with applicable Sub-limits, if any to all Insured Persons in accordance with the applicable Plan as specified in the Policy Schedule / Product Benefit Table of this Policy.

Benefits under this Section A.II are subject to the terms, conditions and exclusions of this Policy.

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

**(22) Cumulative Bonus:**

**What is covered**

We shall apply a Cumulative Bonus in the form of No Claim Bonus at such rates as specified in the Policy Schedule / Product Benefit Table of this Policy on the Sum Insured of the expiring Policy as specified for Section A.I in the Policy Schedule on a cumulative basis, provided that the Insured Person(s) has not made any claim under Section A.I in a Policy Year and has successfully Renewed the Policy with Us continuously and without any break. The accumulated Cumulative Bonus shall not exceed 100% of the Sum Insured on the Renewed Policy as specified in the Policy Schedule / Product Benefit Table of this Policy.

**Conditions**

(i) If the Policy is a Family Floater Policy, then Cumulative Bonus will accrue only if no claims have been made in respect of the Insured Person(s) in the expiring Policy Year. Cumulative Bonus which is accrued during the claim free Policy Year will only be available to those Insured Person(s) who were insured in such claim free Policy Year and continue to be Insured Person(s) in the subsequent Policy Year.
(ii) Cumulative Bonus shall not be accumulated in excess of the percentage applicable under the Plan in force for the Insured Person as stated in the Policy Schedule.
(iii) Cumulative Bonus will not be added if the Policy is not Renewed with Us by the end of the Grace Period.
(iv) If the Policy Period is two or three years, any Cumulative Bonus that has accrued for the first / second Policy Year will be credited at the end of the first / second Policy Year as the case may be and will be available for any claims made in the subsequent Policy Year.
(v) The accumulated Cumulative Bonus can be utilised for Benefits covered under Section A.I.(1) (In-patient Hospitalization), A.I.(2) (Pre-hospitalization Medical Expenses), A.I.(3) (Post-hospitalization Medical Expenses), A.I.(4) (Day Care Treatment), A.I.(5) (Domiciliary Hospitalization), A.I.(6) (Road Ambulance Cover).
(vi) The accumulated Cumulative Bonus can be utilised only when Sum Insured have been completely exhausted.
(vii) The Cumulative Bonus shall not enhance or be deemed to enhance any condition of this Policy or limits as prescribed in the Policy Schedule and Product Benefit Table of this Policy.
(viii) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater Policy basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest accrued amongst all the Insured Persons.
(ix) If the Insured Persons in the expiring Policy are covered on a Family Floater Policy basis and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater Policies / Individual Policies then the Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
(x) If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be reduced in the same proportion to the Sum Insured.
(xi) If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
(xii) The Cumulative Bonus is provisional and is subject to revision if a claim is made in respect of the expiring Policy Year, which is notified after the acceptance of Renewal premium. Such awarded Cumulative Bonus shall be withdrawn only in respect of the expiring year in which the claim was admitted.
(xiii) In case of Family Floater Policies, Dependent Children attaining Age 25 years at the time of Renewal will be moved out of the Family Floater Policy into an Individual Policy. However, all continuity benefits for such Insured Person on the Policy will remain intact. Cumulative Bonus earned on the Policy will stay with the Insured Person(s) covered under the original Policy.
(xiv) In the event of a claim impacting the eligibility of a Cumulative Bonus, the accumulated Cumulative Bonus shall be reduced by the percentage of Sum Insured as accumulated in the previous Policy Year and as mentioned in Policy Schedule / Product Benefit Table of this Policy.

**(23) Dental Consultation & Investigations:**

**What is covered:**

We will provide each the following listed dental services as specified in the Policy Schedule / Product Benefit Table of this Policy, for an Insured Person, once in a Policy Year at Our Network Providers and / or Empanelled Service Providers listed on Our website, on a cashless basis only.

| |
|---|
| One Comprehensive Oral Evaluation (Consultation) |
| One Oral Prophylaxis (Cleaning) |
| One x-ray (IOPA) |

**Conditions**

(i) The services listed in this Benefit shall be arranged by Us only on a cashless basis at Our Network Providers and / or Empanelled Service Providers.
(ii) Requisite pre-authorisation shall be obtained from Us / Our Network Providers and / or Empanelled Service Provider for the services listed in this Benefit.
(iii) Appointments to avail the services listed in this Benefit, may be scheduled by calling at Our toll free call centre number specified in the Policy Schedule.
(iv) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider and/or Empanelled Service Providers in relation to the services availed under this Benefit.
(v) The foregoing services are provided through Network Provider / Empanelled Service Provider in select cities for select treatment procedures only. Please contact Us or refer to Our website for updated list of cities where these services are provided.
(vi) All three services listed under this section Dental Consultation and Investigation, shall be availed on a single appointment scheduled by Us.

**(24) Health Check-up Program:**

**What is covered**

Insured Person(s) Aged 18 years and above on the Start date of the Policy may avail a comprehensive health check-up once in a Policy Year in accordance with the table below and as specified in the Policy Schedule / Product Benefit Table of this Policy:

Medical tests covered in the Health Check-up Program, applicable for Sum Insured up to 75 Lakh rupees for Insured Persons who are Aged 18 years and above on the Start Date are as follows:

| List of Tests - During Annual Health Check up | Sum Insured |
|---|---|
| MER, CBC with ESR, Urine routine, Blood Group, Blood Sugar, Serum Cholesterol, SGPT, Serum Creatinine, ECG | Up to 4 Lacs |
| MER, CBC with ESR, Urine routine, Blood Group, Blood Sugar, Lipid Profile, Kidney Function Test, ECG | 5 Lacs -10 Lacs |
| MER, CBC with ESR, Urine routine, Blood Group, Blood Sugar, Lipid Profile, TMT, Kidney Function Test | 15 Lacs -75 Lacs |

Medical tests covered in the Health Check-up Program, applicable for Sum Insured above 75 Lakh rupees for Insured Persons who are Aged 18 years and above on the Start date are as follows:

| List of Tests - During Annual Health Check up | Sum Insured |
|---|---|
| MER, CBC with ESR, ABO Group & Rh type, Urine routine, Stool routine, S Bilirubin (total / direct), SGOT, SGPT, GGT, Alkaline phosphatase, Total Protein, Albumin: Globulin, Liver Function Test, TMT, ECG, Cholesterol, LDL, HDL, Triglycerides, VLDL, Creatinine, Blood Urea Nitrogen, Uric acid, Hba1C, Chest X-ray, USG Abdomen | Above 75 Lacs |

Reference:
MER - Medical Examiner's Report stamped and signed by a Medical Practitioner who is an MD physician,
BMI - Body Mass Index,
CBC - Complete Blood Count,
ESR - Erythrocyte Sedimentation Rate,
ECG - Electrocardiogram,
TMT - Treadmill Test,
SGPT - Serum Glutamic Pyruvic Transaminase,
SGOT - Serum Glutamic Oxaloacetic Transaminase,
GGT - Gamma-Glutamyl Transferase,
LDL - Low Density Lipoprotein,
HDL - High Density Lipoprotein,
VLDL - Very Low Density Lipoprotein,
Hba1c - Glycated Haemoglobin Test,
USG - Ultrasonography.

**Conditions**

(i) The health check-ups shall be arranged by Us only on cashless basis at Our Network Providers / Empanelled Service Providers (such as Diagnostic centres).
(ii) The Network Provider / Empanelled Service Provider shall be assigned by us post receiving customer's request to avail this Benefit.
(iii) The Insured Person will be eligible to avail a health check-up every Policy Year.
(iv) For calculation of Healthy Heart Score™, tests under Health Assessment™ namely - MER (including BP, BMI, HWR and smoking status), Blood Sugar, Total Cholesterol will have to be carried out at one go (together) and at least once every Policy Year.
(v) Apart from the tests under Health Assessment™ mentioned under point iv) Insured Persons shall be entitled to avail the tests under the Health Check-up Program in one instance or at separate times during the Policy Year provided that the same test cannot be repeated during the same Policy Year.
(vi) If the Insured Person who has a covered chronic condition, has already undergone tests under Chronic Management Program within three months from date of availing this Benefit, then those specific tests shall not be permitted to be repeated under the Health Check-up Program in the same Policy Year.
(vii) Section B.(H).viii.9, is not applicable in respect of coverage under this Benefit.
(viii) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider in relation to the health check-up.

**(25) Second E-Opinion for Major Illness:**

**What is covered**

If an Insured Person is diagnosed with any Major Illness, during the Policy Period, the Insured Person may at his / her sole discretion choose to avail an E-opinion from Our panel of Domestic and International Medical Practitioners, provided that:

(i) The Insured Person on diagnosis of Major Illness should share the following for the e-opinion:
  a) First consultation paper.
  b) Final Diagnosis paper.
  c) Treating doctor certification on final diagnosis.
  d) All investigation reports supporting documents.
  e) Consent Form to collect documents from various source.
  f) Any other relevant documents to ascertain eligibility of claim.
(ii) On the basis of the Insured Person's reported medical condition, We / Our Empanelled Service Provider will identify Medical Practitioners from Our network.
(iii) The Insured Person may choose one of the Medical Practitioners out of the 3 choices given by Us / Our Empanelled Service Provider.
(iv) Medical Reports and all other information pertaining to the Insured Person is shared with the chosen Medical Practitioner.
(v) After receipt of all Medical information, a detailed E-Opinion from the selected Medical Practitioner would be delivered to the Insured Person as soon as it is available.

**Conditions**

(i) It is agreed and understood that the Second E- Opinion will be based only on the information and documentation provided to Us, which will be shared with the Our empanelled Medical Practitioners and is subject to the conditions specified below:
(ii) It is agreed and understood that the Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained, it is the Insured Person's sole and absolute discretion to follow the suggestion for any advice related to his/her health.
(iii) Appointments to avail of this Additional Benefit may be availed through Our Website or Our mobile application or through calling Our call centre on the toll free number specified in the Policy Schedule.
(iv) Under this Additional Benefit, We are only providing the Insured Person with access to an e-opinion and such e-opinion shall not be deemed to substitute the Insured Person's physical visit or consultation to an independent Medical Practitioner.
(v) The e-opinion provided is not valid for any medico legal purposes.
(vi) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner/ Our Empanelled Service Provider.
(vii) This benefit is available on Cashless Facility basis only.

**(26) Recovery Benefit:**

**What is covered**

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

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

## Section III: Value Added Benefits

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

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

**(27) Chronic Management Program (OPD):**

**What is covered**

Under the Chronic Management Program, the Insured Person Aged 18 years and above will be entitled to manage Medical Expenses for Out-Patient treatment of Diabetes, Hypertension, Hyperlipidemia, Asthma, as specified in the Policy Schedule.

(i) Medical Practitioner's consultations.
(ii) Diagnostic test.

These services can be availed at Our Network Providers and / Empanelled Service Providers (such as Outpatient clinics or Physicians / Diagnostic centres) for chronic conditions listed above, on a Cashless basis.

If the Insured Person wishes to undertake the services available under this Benefit, including diagnostic tests at Our Network Providers and / or Empanelled Service Providers and Medical Practitioner's consultation, for the Chronic conditions listed above on a reimbursement basis, then We will reimburse costs as specified in the Policy Schedule / Product Benefit Table of this Policy, up to the limits specified therein for each service, against original invoices for management of the medical condition(s). Original invoices of such consultations along with prescription from the Medical Practitioner can be submitted each month. We will settle such claims accepted by Us, on a monthly basis.

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

For ease of understanding broad definitions of covered Chronic conditions are as below:

(i) **Asthma** is a Chronic condition that affects the airways (bronchi) of the lungs, causing them to constrict (become narrow) when exposed to certain triggers which results in the symptoms of wheezing, coughing, tight chest and shortness of breath.
(ii) **Hypertension** is the term used to describe a persistent elevated blood pressure, commonly referred to as high blood pressure, and if this chronic disease is not treated appropriately, is a major risk factor for heart disease, stroke, kidney disease and even eye diseases.
(iii) **Hyperlipidaemia** is a chronic disease that refers to an elevated level of lipids (fats), including cholesterol and triglycerides, in the blood and if not treated appropriately, it is a major risk factor for increased risks of heart disease, heart attacks, strokes and other incidents of disease.
(iv) **Diabetes** mellitus is a chronic, progressive disease in which impaired insulin production leads to high blood glucose (sugar) levels, and without good self-management and proper treatment, the increased glucose (sugar) in the blood affects and damages every organ in the body, which causes serious health consequences

**Eligibility to avail Benefit under the Chronic Management Program**

If either of one out of two conditions mentioned below is fulfilled, the Insured Person shall be eligible to avail the services under this Benefit:

1. <u>If the Insured Person has undergone a Pre-Policy Medical Examination carried out before the Start Date of the Policy:</u>
   (i) Based on the declarations and reports of the Pre-Policy Medical Examination, if the Insured Person is found to be suffering from one or more chronic conditions, then We will manage such conditions from day 1 under the Chronic Management Program. In-patient Hospitalization for such conditions will be covered after 30 days from the Start of the Policy.
   (ii) In case the results of the Pre-Policy Medical Examination indicates that the Insured Person does not have any such chronic conditions, then the Insured Person will be covered under the Chronic Management Program from subsequent Policy Anniversary post detection of any of the 4 listed Chronic conditions above, if the Insured Person develops such conditions anytime during the Policy Period or post subsequent Renewals, if the Policy has been Renewed with Us continuously and without any break.
   (iii) In case after the Pre-Policy Medical Examination, the Insured Person is not detected with one or more aforementioned chronic conditions, but gets detected with other medical conditions, then coverage shall follow the general underwriting guidelines as specified in the Board approved underwriting Policy.

2. <u>If the Insured Person chooses to undergo a Health Assessment™ or Health Check-up Program / Comprehensive Health Check-up with Dental Investigation, to be carried out post the Start Date of this Policy:</u>
   (i) If the Insured Person did not undergo a Pre-Policy Medical Examination, then to avail the benefit under Chronic Management Program, the Insured Person Aged 18 years and above must undergo a Health Assessment™ within 3 months from the Start Date of the Policy. Health Assessment™ is a simple health exam that measures the Insured Person on the parameters of MER (including BP, BMI, HWR and smoking status), Blood Sugar and Total Cholesterol.
   (ii) If the results of the Health Assessment™ indicate that the Insured Person does not have any of the aforementioned Chronic conditions, then the Insured Person will be entitled to avail the benefits under Chronic Management Program, from subsequent Policy Anniversary post detection of any of the 4 listed Chronic conditions above, In the event that the Insured Person develops any such Chronic condition(s) anytime during the Policy Period or post subsequent Renewals, if the Policy has been Renewed with Us continuously and without any break.
   (iii) If the results of this Health Assessment™ indicate that the Insured Person suffers from any of the aforementioned Chronic conditions, then the Insured Person shall be entitled to avail the Benefits under the Chronic Management Program, after 24 months of Waiting Period from the Start Date of the Policy, provided that the detected chronic condition was not a Pre-Existing Disease, no additional premium shall be required to activate the benefits under the Chronic Management Program.

The foregoing eligibility conditions shall also be applicable in case of Portability cases, where the Insured Person has not undergone Pre-Policy Medical Examination.

**<u>Chronic Offering in case an Insured Person suffers from a combination of Chronic Conditions:</u>**
If the Insured Person is suffering from more than one of above Chronic Conditions at the Inception of the Policy, then the Insured Person will be charged as per applicable premium grid depending on the number of Chronic Conditions such Insured Person is suffering from.

The Benefits available to the Insured Person under the Chronic Management Program during the Policy Period would be as eligible at the Start Date of the Policy. Any enhancement in the coverage due to further co-morbid conditions acquired by the Insured Person and covered under Chronic Management Program during the Policy Period would be effected only on subsequent Policy Anniversary after charging additional premium.

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Note: When an Insured Person purchases a Policy where he / she is suffering from an existing Chronic condition, then he / she mandatorily will have to buy the Policy as per applicable Premium grid and loading (as applicable) for such condition. Deletion of coverage under Chronic Management Program for such condition shall not be allowed on subsequent Renewals of the Policy. If an Insured Person progresses from a Non-Chronic to Chronic condition any time after the first inception of the Policy, then subject to eligibility, the Insured Person will be covered under Chronic Management Program without being charged any additional premium. Chronic Management Program will be available for all acquired Chronic conditions covered in the Policy.

**Conditions**

(i) In order to avail Cashless Facilities benefits under this Program, the Insured Person is required to carry the health identification card issued by Us along with valid identity proof.
(ii) We shall retain the Insured Person's medical reports generated under this Program, subject to receipt of Your consent at the time of enrolment into the program, and a copy of the medical check-up reports shall be sent to You upon Your request.
(iii) Commencement of Chronic Management Program, in case of any new Chronic condition covered under the Policy suffered by the Insured Person(s), shall be effective only at the subsequent Policy Anniversary, only if the Policy has been Renewed continuously with Us without any break.

**(28) Health Assessment™:**

**What is covered**

Health Assessment™ measures MER including BP, BMI, HWR and smoking status, Blood Sugar and Total Cholesterol. Charges for the same shall be borne by Us once in a Policy Year. All tests mentioned as a part of Health Assessment™ shall be conducted together.

**Conditions**

(i) If the Insured Person who has undergone tests under Health Check-up Program / Comprehensive Health Check-up with Dental Investigation, then those specific tests shall not be permitted to be repeated under the Health Assessment™ in the same Policy Year.
(ii) Health Assessment™ can be undertaken at Our Network Providers / Empanelled Service Providers on a cashless basis. An appointment for the medical examination can be scheduled at a time convenient to the Insured Person by calling Our call centre.

**(29) HealthReturns™:**

An Insured Person can earn HealthReturns™ by looking after his / her health and being physically active on a regular basis.

**How to Earn HealthReturns™**

**Earned by way of a percentage of Premium through Healthy Heart Score™ and Active Dayz™**

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

(i) Complete the online health questionnaire through Our website or mobile application. If requested, We would assist the Insured Person in completing the questionnaire over a call. The result of this questionnaire would help the Insured Person understand his / her current health status.
(ii) Undergo a Health Assessment™

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

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

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

Charges for Health Assessment™ shall be borne by Us once a Policy Year. In case the Insured Person wants to undergo another Health Assessment™ at Our Network Providers / Empanelled Service Providers, he / she can do so by payment of requisite charges at the Network Providers / Empanelled Service Providers.

**Conditions**

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

Step 2 - Comply with Chronic Management program

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

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

(i) Active Dayz™ encourages and recognises all types of exercise / fitness activities by making use of activity tracking apps, devices and visits to the Fitness centre or yoga centres to track and record the activities members engage in.
(ii) One Active Dayz™ can be earned by:
  (1) Completing a Fitness centre or yoga centre activity for a minimum of 30 minutes at Our panel of Fitness or yoga centre, OR;
  (2) Recording 10,000 steps or more in a day for all Insured Persons Aged less than 60 years and 7,500 steps or more for all Insured Persons Aged 60 years above (tracked through Our mobile application or a wearable device linked to the Policy number) OR;
  (3) Burning 300 calories or more in one exercise session per day OR;
  (4) Participation in a recognized marathon / walkathon / cyclothon or a similar activity which offers a completion certificate with timing
(iii) In order to make it easier for the Insured Person to earn HealthReturns™, We provide two fitness assessments per Policy Year. These fitness assessments will measure the Insured Person's cardiovascular endurance, flexibility, strength, height to weight ratio and waist to hip ratio. The Insured Person will receive fitness assessment results based on his / her measurements.
(iv) The fitness assessment results will be valid for six months and the best of the fitness assessment result and number of Active Dayz™ will be used in a given month to calculate HealthReturns™.

Active Dayz™, can be earned by undertaking any one of the three activities under point (ii) or 'Fitness Assessment' under point (iii).

The Insured Person will earn HealthReturns™ based on the Healthy Heart Score™, the fitness assessment result and the number of Active Dayz™ recorded. HealthReturns™ is accrued on a monthly basis according to the following grid.

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

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

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

In addition to the above monthly earning slabs, the Insured Person will earn additional HealthReturns™ based on the Healthy Heart Score™ and the number of Active Dayz™ recorded based on the below grid which shall be calculated basis the number of Active Dayz™ achieved on yearly basis. Fitness Assessment Results shall not be considered for earning the following annual slabs

The below mentioned slabs are in addition to the monthly slabs, and are independent of the monthly slabs. e.g. Insured Person with Healthy Heart Score™ who on a monthly basis has accomplished 13 days or more every month in a Policy Year, and has achieved at least 325 Active Dayz™ in the same Policy Year shall be rewarded with 100% HealthReturns™ (30% accumulated every month + 20% on achieving 275 Active Dayz™ + 50% on achieving 325 Active Dayz™):

| | Healthy Heart Score™ | | |
|---|---|---|---|
| No of Active Dayz™ in a year | Red | Amber | Green |
| 275 | 4% | 8% | 20% |
| 325 | 10% | 20% | 50% |

The sum total earning under this benefit shall not exceed:
a. In case of Platinum Essential Plan - 50 % of the premium excluding premium for optional benefit(s).
b. In case of Platinum Enhanced Plan - 100% of the premium excluding premium for optional benefit(s).
c. In case of Platinum Premiere Plan - 100% of the premium excluding premium for International Coverage for Major Illnesses, Personal Accident Cover (AD, PTD), Critical Illness Cover.

How it works for an Individual Policy
In case of an Individual Policy, each Insured Person would be tracked separately and shall earn HealthReturns™ based on individual performance as per grid of Healthy Heart Score™ and Active Dayz™. The following relations upto Age of 25 years shall not be eligible for earning HealthReturns™ namely son, daughter, brother, sister, grandson, granddaughter, brother in-law, sister in-law, nephew, niece.

How it works for a Family Floater Policy
In case of a Family Floater Policy, each Insured Person would be tracked separately and shall earn HealthReturns™ based on individual performance as per grid of Healthy Heart Score™ and Active Dayz™. For the purpose of calculating HealthReturns™, We will allocate the overall premium to the adults in the Policy. The allocation ratio shall be 2:1 for Parents and Other Adults under the Policy. Weightages for allowed family combinations are as described in the table below.

Dependent Children upto 25 years of Age are not eligible for HealthReturns™.

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

**Earned HealthReturns™ can be utilized by any covered member under a Policy.**
**How can one spend HealthReturns™:**
Funds under HealthReturns™ may be utilized towards the following expenses:
i. In-patient Medical Expenses and Day Care Treatment, provided that the Sum Insured, accumulated Cumulative Bonus (if any) / Reloaded Sum Insured (if any), Super Reload Sum Insured (if any) are exhausted during the Policy Year.
ii. Payment of Co-payment (wherever applicable).
iii. For non-payable claims, in case of an In-patient Hospitalization or Day Care Treatment.
iv. Non-Medical expenses under listed in Annexure I 'Non Medical Expenses' that would not otherwise be payable under the Policy.
v. Out-patient expenses up to the value of accrued funds.
vi. Ayush Treatments in excess of the limits as specified in Policy Schedule / Product Benefit Table of this Policy.
vii. For expenses towards buying health wearable device which can be used to track steps and Active Dayz™.

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

Alternatively funds can also be utilized towards the payment of Renewal Premium or payment of premium for any retail Policy with Us. Funds earned as HealthReturns™, once earned can be carried forward each month as long as the Policy is Renewed with Us in accordance with the Renewal Terms under the Policy.

If HealthReturns™ earned is not utilized during the Policy Year, by default it will be automatically adjusted to pay Renewal Premium prior to the due date for payment for Renewal Premium.

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Permanent Exclusions and Waiting Periods do not apply under this Benefit.

The claim for accumulated HealthReturns™ can be made a maximum 4 times in a Policy Year. If You / Insured Person wish to know the present value of the funds earned as HealthReturns™, then You may contact Us at our toll free number or through Our website or through Our mobile application.

**(30) Expert Health Coach:**

**1) Health Coach:**
Insured Person(s), are eligible for a health coaching session with Our Health Coach. Our Health Coach shall be coaching the Insured Person on Medical Counselling and General Wellness and lifestyle.

**2) Nutrition Coach:**
Insured Person(s), are eligible for a nutrition coaching session with our Nutrition Coach, provided the same is specified in the Policy Schedule / Product Benefit Table of this Policy. Our Nutrition Coach shall be coaching the Insured Person on General nutritional and diet counselling.

**3) Mental Health Coach:**
Insured Person(s), are eligible for Activ Mind Assessment followed by support. We shall support the Insured Person(s) for the following:

1. **Guidance on knowing your mental health status**
   The Insured Person will be guided to take an online mental health assessment tool. The result of this assessment will be given on a scale of healthy to extremely severe risk for anxiety, depression and stress.
   - Healthy: Needs sustenance support
   - Mild: Needs Needs Self care support
   - Moderate: Needs intervention and support
   - Severe: Needs intervention and support
   - Extremely Severe: Needs intervention and support

2. **Guidance on Improving your mental health** (Available only for Platinum - Enhanced and Platinum Premiere plan)

   Based on the result of the mental health assessment under point 1 above, the Insured Person(s) will be eligible for a screening for mental health status and consultation sessions as mentioned below.

| Know your mental health status | Eligibility |
|---|---|
| Moderate | 1 screening for mental health status followed by 2 consultation sessions |
| Severe to Extremely Severe | 1 screening for mental health status followed by 4 consultation sessions |

3. **Tele / Online Support:**
   Insured Person(s) will be given access to telephonic / online support helpline during the Policy Period for discussion on general mental health issues with a mental health expert; this helpline shall not prescribe medication or provide access to psychiatric consultation.

**4) Tele Consultation with Homeopathy Doctor (Available only for Platinum - Enhanced and Platinum Premiere plan):**
Upon the Insured Person's request, We shall also provide access to a homeopathy Medical Practitioner(s), for consultation via tele-medicine, followed up with a prescription as may be applicable.

**Conditions applicable to Health Coach, Nutrition Coach, Mental Health Coaching, Tele Consultation with Homeopathy Doctor.**

(i) These coaches shall be available over a telephonic discussion as a call back service / feasible mode of communication. The request for call back may be placed through Digital self-servicing mediums of mobile APP / website.
(ii) It is agreed and understood that Our coaches are not providing and shall not be deemed to be providing any Medical Advice. They shall only provide a suggestion for the Insured Person's consideration and it is the Insured Person's sole and absolute choice to follow the suggestion for any health-related advice.
(iii) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this Benefit.
(iv) Mental health coaching services will render general support for issues concerning stress, anxiety and depression. This will not include support for clinically established mental health conditions like bipolar disorder, schizophrenia, dementia, Alzheimer's disease and / or any other Pre-Diagnosed Condition. Our support includes grief / bereavement counselling, support on mental health issues arising from rape / gender based violence, HIV, parenting and inter personal relationships. We do not offer any medical or legal / financial advice.

## Section IV: Inbuilt Premiere Benefit (Applicable only to Platinum – Premiere Plan)

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

**Sum Insured under this cover is available on Individual Basis only for both Individual and Family Floater Policy. The Sum Insured under these Benefits are independent and over and above the base Sum Insured.**

**(31) International Coverage for Major Illnesses**

Benefits under this Section A.IV.(31) are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and / or the Sub-Limit for each Benefit under Section is 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 and the 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.

We will indemnify the Reasonable and Customary Charges incurred towards medical treatment taken by the Insured Person during the Policy Period for an Illness, Injury or conditions described in the Benefits below if it is contracted or sustained by an Insured Person during the Policy Period. This Policy covers only treatment which is planned and scheduled in advance and taken outside India and does not cover any Emergencies occurring or Emergency Care required while the Insured Person is overseas or in India.

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All claims paid under this Section will impact the Sum Insured available under the Policy, and must be made in accordance with the procedure set out in Section B.(O). Coverage under section A.I.(16) International Emergency Assistance Services (including Air Ambulance) is not applicable for this Section. A.IV.(31).

**(31). (a) In-patient Hospitalization (outside India)**
**What is covered**
We will cover the Medical Expenses incurred towards the Insured Person for one or more of the following arising out of an Insured Person's Inpatient Care outside India during the Policy Period caused solely and directly due to a Major Illness that occurs or manifests itself during the Policy Period:
(i) Reasonable and Customary Charges incurred towards the Room Rent of a Hospital room and other boarding charges, up to the Sub-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 the Major Illness for which the Insured Person is Hospitalized;
(viii) Anaesthesia, blood, oxygen and blood transfusion charges;
(ix) Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.
(x) Medication applied as per the medical prescription issued by the treating Medical Practitioner while the Insured Person is Hospitalized for treatment of a Major Illness.
(xi) Medication prescribed for post-operative treatment is covered for up to 30 days from the date the Insured Person has completed the stage of the treatment received out of India and only when this medication is purchased prior to the Insured Person returning to India.

**Conditions**
(i) The Hospitalization is towards Medically Necessary Treatment, and follows the written advice of a Medical Practitioner.
(ii) For the purpose of this Benefit, the treatment should be taken in a registered Hospital or clinic as per law, rules and / or regulations applicable to the country where the treatment is taken, and which is a listed Network Provider / Empanelled Service Provider. For the list of Network Providers, You may please visit Our / Our Empanelled Service Provider's website or contact Us at Our call centre on the toll free number specified in the Policy Schedule.
(iii) Any payment shall be made only on a Cashless Facility basis.
(iv) Requisite pre-authorisation shall be obtained from Us / Our Empanelled Service Provider for the said Illness / Injury in accordance with the Claims Procedure set out in Section B.(O).
(v) The symptoms of the Major Illness first occur or manifest itself during the Policy Period and after completion of the initial Waiting Period of 30 days, subject to applicability of any Waiting Periods specified in the Policy Schedule.
(vi) The rate of exchange as published by the Reserve Bank of India (RBI) as on the date of payment to the Hospital shall be used for conversion of amounts not settled in Indian rupee into Indian rupees for calculation of claim payments under this Benefit. If the RBI rates are not published on the date of the Insured Person's discharge from the Hospital, the exchange rate next published by the RBI shall be considered for conversion of any amounts not settled in Indian rupee.
(vii) The Medical Expenses are incurred outside India.
(viii) Permanent Exclusion No.B.(H).viii.39.
(ix) Permanent Exclusion No.B.(H).viii.46 (Treatment taken outside India) is not applicable in respect of this Benefit.
(x) No Pre-hospitalization Medical Expenses are covered under this Benefit.

**For the purpose of this section, Major Illness shall mean the Illnesses, Medical Events or Surgical Procedures as specifically defined below:**

| S.l. No. | Major Illnesses | Definition |
|---|---|---|
| 1 | Cancer Treatment | I. We will be covering Primary Treatment of a malignant tumour 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 including but not limited to leukemia, lymphoma and sarcoma (except cutaneous lymphoma).<br>II. Any In-situ Cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues.<br>III. Any pre-cancerous change in the cells that are cytologically or histologically classified as high grade dysplasia or severe dysplasia.<br>IV. The following are excluded – All tumours in the presence of HIV infection. |
| 2 | Coronary Artery By-Pass surgery | I. We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a Cardiologist.<br>II. The following are excluded: Angioplasty and / or any other intra-arterial procedures. |
| 3 | Heart Valve Replacement | I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a Specialist Medical Practitioner.<br>II. The following are excluded: Catheter based techniques including but not limited to, balloon valvotomy / valvuloplasty are excluded. |

| | | |
|---|---|---|
| 4 | Major Organ Transplantation | I. We will be covering the actual undergoing of a transplant of one of the following human organs: lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ. The undergoing of a transplant has to be confirmed by a Specialist Medical Practitioner.<br><br>II. The following are excluded:<br>a) Any transplant when the need for a transplant arises as a consequence of alcoholic liver disease.<br>b) Any transplant when the transplant is conducted as a self-transplant.<br>c) Any transplant when the Insured is a donor for a third-party.<br>d) Any transplants from a dead donor.<br>e) Any organ transplant that involves Stem Cells treatment.<br>f) Where only islets of langerhans are transplanted.<br>g) The transplant made possible by the purchase of donor organs.<br>h) Any disease which has been caused by an organ transplant save where the disease in question is qualified as a Major Illnesses covered under the product. |
| 5 | Bone Marrow Transplant | We will be covering Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured originating from:<br>a. The Insured (Autologous bone marrow transplant); or<br>b. From a living compatible donor (allogeneic bone marrow transplant). |
| 6 | Neurosurgery | We will be covering any<br>I. Surgical intervention of the brain or any other intracranial structures.<br>II. Surgical Treatment of benign solid tumours located in the spinal cord. |
| 7 | Pulmonary artery graft surgery | I. We will be covering the undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft. |
| 8 | Aorta Graft Surgery | I. We will be covering the actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of “Aorta” shall mean the thoracic and abdominal aorta but not its branches.<br><br>II. The following are excluded:<br>a. Surgery performed using only minimally invasive or intra-arterial techniques.<br>b. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures. |
| 9 | Coronary Artery By-Pass surgery post occurrence of Myocardial Infraction | I. We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures, post the occurrence of myocardial infraction. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a Cardiologist.<br><br>II. The following are excluded: Angioplasty and/or any other intra-arterial procedures. |
| 10 | Surgical treatment for Stroke | I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a Specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.<br><br>II. We will be covering surgical treatment of Stroke limited to;<br>a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy.<br>b. Stenting of Intra cranial blood vessels, needed for the treatment of Stroke.<br><br>III. The following are excluded:<br>a. Transient ischemic attacks (TIA).<br>b. Traumatic injury of the brain.<br>c. Vascular disease affecting only the eye or optic nerve or vestibular functions. |

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| | | |
|---|---|---|
| 11 | Surgical treatment for benign Brain tumour | I. We will be covering surgical treatment of Benign solid brain tumour limited to;<br>a. Surgical Removal of solid brain tumour through Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy.<br>b. Embolization of Intra cranial blood vessels, needed for the treatment of solid brain Tumour.<br><br>II. Benign solid brain tumour is defined as a life threatening, non-cancerous tumour in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI.<br><br>III. This brain tumour must result in at least one of the following and must be confirmed by the relevant Medical Specialist.<br>a. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or;<br>b. Undergone surgical resection or radiation therapy to treat the brain tumour. |
| 12 | Lung Transplant Surgery in case of End Stage Lung Disease | I. We will be covering Lung Transplant Surgery due to following cases.<br><br>a. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:<br>i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and<br>ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and<br>iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and<br>iv. Dyspnea at rest. |
| 13 | Kidney Transplant Surgery in case of End Stage Renal Failure | We will be covering Kidney Transplant Surgery due to following cases.<br><br>I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a Specialist Medical Practitioner. |
| 14 | Skin grafting surgery for Major Burns | I. We will be covering the undergoing of skin transplantation due to accidental major burns where major burns is as defined below.<br><br>a. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.<br><br>II. Skin grafting surgery for Major Burns should be medically required and not aesthetic / cosmetic in nature. |
| 15 | Surgical treatment of Coma | I. We will be covering surgical treatment of Coma limited to;<br>a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy.<br><br>II. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:<br>a. no response to external stimuli continuously for at least 96 hours.<br>b. life support measures are necessary to sustain life; and<br>c. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.<br>d. The condition has to be confirmed by a specialist medical practitioner.<br><br>III. The following are excluded:<br>Coma resulting directly from alcohol or drug abuse is excluded. |
| 16 | Surgery for Pheochromocytoma | I. We will be covering the actual undergoing of surgery to remove the tumour.<br><br>II. Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines and the Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who is an Endocrinologist. |

**(31). (b) Post – hospitalization Medical Expenses:**

**What is covered**

We will cover the Insured Person's Post-hospitalization Medical Expenses incurred following a Major Illness as specified under Section A.IV.(31).(a) that occurs or manifests during the Policy Period, on a reimbursement basis, for upto 30 days from the date of discharge from Hospitals and up to the Limits specified against Benefit A.IV.(31) in the Policy Schedule / Product Benefit Table of this Policy.

**Conditions**

(i) We have accepted a claim for In-patient Hospitalization under Section A.IV.(31).(a) for the same Major Illness.
(ii) 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 Major Illness.
(iii) Treatment taken inside India is not applicable.

**(31). (c) Organ Donor Expenses:**

**What is covered**

We shall cover the Medical Expenses, up to the Limit specified against Section A.IV.(31) in the Policy Schedule / Product Benefit Table, incurred by or in respect of the Insured Person's organ donor solely towards the harvesting of the organ donated, for any organ transplant Surgery accepted by Us under Section A.IV.(31).(a).

**Conditions**

(i) The organ donation conforms to the Transplantation of Human Organs Act 1994 as amended from time to time.
(ii) The Insured Person is the recipient of the organ so donated by the organ donor.
(iii) The Insured Person has been advised to undergo an organ transplant based on the Medical Advice of the treating Medical Practitioner.
(iv) Permanent Exclusion No.B.(H).viii.32 does not apply to this Benefit.

**What is not covered**

(i) Pre-hospitalization Medical Expenses or Post-Hospitalization Medical Expenses of the organ donor.
(ii) Any costs incurred towards donor screening expenses.
(iii) Any other Medical Expenses or treatment incurred by the organ donor incidental to the harvesting from the organ donor.
(iv) Costs directly or indirectly associated with the acquisition of the donor's organ.
(v) Transplant of any organ/tissue where the transplant is experimental or investigational.
(vi) Expenses related to organ transportation or preservation.
(vii) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

**(31). (d) Travel Expenses:**

**What is covered**

If We have admitted a claim under Section A.IV.(31).(a) in respect of the Insured Person and Our pre-authorization has been obtained, then We / Our Empanelled Service Provider shall arrange the following travel expenses up to the limit specified against Benefit A.IV.(31) in the Policy Schedule / Product Benefit Table of this Policy, for the Insured Person, one accompanying attendant from the Country of Residence and the living donor (only in the case of any organ transplant Surgery accepted by Us) for the same Major Illness:

(i) Transportation from the Insured Person's place of residence to the designated airport.
(ii) One-time economy class air fare by direct route to the city of treatment and onwards transportation to the designated place of accommodation in the city of treatment or the Hospital.
(iii) Transportation from the airport to the Hospital or place of accommodation in the city of treatment.
(iv) Transportation from the place of accommodation in the city of treatment or the Hospital to the nearest airport in the city of treatment.
(v) One-time economy class air fare by direct route to the city of the Insured Person's permanent address, and onwards transportation to his / her place of residence.

**Conditions:**

(i) We shall be liable to pay an amount only up to the costs of direct route economy class fare (business class, air ambulance or medical stretcher may be provided subject to availability in the international carrier, but only for the Insured Person under written advice of the attending Medical Practitioner due to the severity of his/her medical conditions) as available on the date of the journey.
(ii) The costs for the accompanying attendant's and / or living donor's airfare shall be indemnified by Us only if the treating Medical Practitioner has certified in writing that an accompanying attendant and / or living donor must accompany the Insured Person.
(iii) Treatment taken inside India is not applicable in respect of this Benefit.
(iv) Permanent Exclusion No.B.(H).viii.46 (Treatment taken outside India) is not applicable in respect of this Benefit.
(v) We / Our Empanelled Service Provider will provide an onward travel date based on the agreement reached with the treating Medical Practitioner and Hospital.
(vi) We / Our Empanelled Service Provider will arrange the onward travel subject to a ready to fly certificate from the attending Medical Practitioner in the Insured Person's Country of Residence.
(vii) We / Our Empanelled Service Provider will arrange the return travel based on the completion of the Medically Necessary Treatment and the agreement with the treating Medical Practitioner that the Insured Person is fit to travel.
(viii) In the event that the Insured Person changes the dates of travel from those booked and communicated by Us / Our Empanelled Service Provider, You will be liable to compensate Us for all the associated costs of organizing and providing new arrangements, unless the changes are proven to be necessary from a medical standpoint and Our prior approval is obtained in writing.
(ix) This Benefit is available on Cashless Facility basis only, unless a prior approval in writing has been taken from Us before making such travel booking.

**Documents to be submitted for any Claim under this Benefit**

It is a Condition Precedent to Our liability under this Benefit that the following information and documentation shall be submitted to Us or Our Empanelled Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

(i) A certificate from the Medical Practitioner specifying the period of Hospitalization.
(ii) Discharge summary of the Hospital furnishing details including the date of admission and date of discharge.
(iii) Original bill and receipt from the carrier indicating the amount paid for the travel.
(iv) Payment receipt of any change in the travel booking with the documentation, if Cashless Facility for the same is not provided.
(v) Pre Authorization form and Claim form duly filed and signed by the Insured Person for Cashless Facility.

**(31). (e) Accommodation Expenses:**

**What is covered**

If We have admitted a Claim under Section A.IV.(31).(a) and Our pre-authorization has been obtained, then We / Our Empanelled Service Provider shall arrange a reasonable accommodation for the Insured Person and / or accompanying attendant and / or living donor (only in the case of any organ transplant Surgery accepted by Us) in the city of treatment which is not the Insured Person's permanent address as specified in the Policy Schedule, up to the limit specified in A.IV.(31) in the Policy Schedule / Product Benefit Table of this Policy.

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**Conditions:**
(i) We / Our Empanelled Service Provider will arrange the accommodation booking dates based on the approved treatment schedule. These dates will be communicated to the Insured Person to allow for sufficient time for the Insured Person to make all the necessary personal arrangements.
(ii) We / Our Empanelled Service Provider will arrange a checking-out date for the place of accommodation based on the completion of the treatment and the agreement with the treating Medical Practitioner that the Insured Person is fit to travel.
(iii) In the event that the Insured Person changes the dates of travel from those booked and communicated by Us / Our Empanelled Service Provider, You will be liable to compensate Us for all the associated costs of organizing and providing new accommodation arrangements, unless the changes are proven to be necessary from a medical standpoint and Our prior approval is obtained in writing.
(iv) The accommodation arrangements will include bookings for a double room or twin bed room in a three or four-star hotel or accommodation category. (The choice of accommodation will always be subject to availability and the proximity to the Hospital or treating Medical Practitioner.)
(v) The accommodation arrangements exclude any expenses towards breakfast, meals and incidental costs (not limited to minibar, laundry, personal expenses) at the place of accommodation, and any upgrades to the room.
(vi) This Benefit is available on Cashless Facility basis only, unless a prior approval in writing has been taken from Us before making such accommodation booking.

**Documents to be submitted for any Claim under this Benefit**
It is a Condition Precedent to Our liability under this Benefit that the following information and documentation shall be submitted to Us or Our Empanelled Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:
(i) A certificate from the Medical Practitioner specifying the period of Hospitalization.
(ii) Discharge summary of the Hospital furnishing details including the date of admission and date of discharge.
(iii) Original bill and receipt or letter obtained from the hotel indicating the amount paid for the accommodation.
(iv) Payment receipt of extension of hotel booking with the documentation, if Cashless Facility for the same is not provided.
(v) Pre Authorization form and Claim form duly filed and signed by the Insured Person for Cashless Facility.

**(31). (f) Repatriation of Mortal Remains:**
**What is covered**
If the Insured Person dies whilst undergoing treatment which has been pre-authorised by Us / Our Empanelled Service Provider under Section A.IV.(31).(a) in the Policy Period for any of the Major Illnesses, We shall reimburse the costs of Repatriation of the Mortal Remains of the Insured Person up to the Limit specified against Benefit A.IV.(31) in the Policy Schedule / Product Benefit Table, to the city of his / her permanent address in the Country of Residence, up to an equivalent amount, for a local burial (excluding costs incurred towards buying / procuring a grave) or cremation at the country where death has occurred.

**Conditions**
(i) This Benefit may also be provided on a Cashless Facility basis, provided that the costs are authorized by Us or Our Empanelled Service Provider in advance.

**Documents to be submitted for any Claim under this Benefit:**
It is a Condition Precedent to Our liability under this Benefit that the following necessary information and documentation shall be submitted to Us or Our Empanelled Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:
(i) Copy of the Death Certificate providing details of the place, date, time, and the circumstances and cause of death.
(ii) Copy of the Post-Mortem Report / Certificate.
(iii) Documentary proof for expenses incurred towards disposal of the Mortal Remains.
(iv) In case of transportation of the body of the deceased to the city of his / her permanent address in the Country of Residence, the receipt for expenses incurred towards preparation and packing of the Mortal Remains of the deceased and also for the transportation of the Mortal Remains of the deceased.
(v) Copy of Embalming Certificate.

**(31). (g) International Second E-opinion for Major Illness:**
**What is covered**
If an Insured Person is diagnosed with any listed Major Illnesses as specified under Section A.IV.(31) during the Policy Period, the Insured Person may at his / her sole discretion choose to avail an E-Opinion from Our panel of internationally available Medical Practitioners, provided that.
(i) The Insured Person on diagnosis of Major Illness should share the following for the e-opinion:
  (a) First consultation paper.
  (b) Final Diagnosis paper.
  (c) Treating doctor certification on final diagnosis.
  (d) All investigation reports supporting documents.
  (e) Consent Form to collect documents from various source.
  (f) Any other relevant documents to ascertain eligibility of claim.
(ii) On the basis of the Insured Person's reported medical condition, We / Our Empaneled Service Provider will identify Medical Practitioners from Our network.
(iii) The Insured Person may choose one of the Medical Practitioners out of the 3 choices given by Us / Our Empaneled Service Provider.
(iv) Medical reports and all other information pertaining to the Insured Person is shared with the chosen Medical Practitioner.
(v) After receipt of all medical information, a detailed e-opinion from the selected Medical Practitioner would be delivered to the Insured Person as soon as it is available.

**Conditions:**
It is agreed and understood that the Second E-Opinion will be based only on the information and documentation provided to Us, which will be shared with the Our empanelled Medical Practitioners and is subject to the conditions specified below:
(i) It is agreed and understood that the Insured Person is free to choose whether or not to obtain the expert opinion, 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.
(ii) Appointments to avail of this Additional Benefit may be availed through Our Website or Our mobile application or through calling Our call centre on the toll free number specified in the Policy Schedule.
(iii) Under this Additional Benefit, We are only providing the Insured Person with access to an e-opinion and such e-opinion shall not be deemed to substitute the Insured Person's physical visit or consultation to an independent Medical Practitioner.
(iv) The E-Opinion provided under this Additional Benefit shall be limited to the covered listed Major Illnesses under A.IV.(31).(a) and not be valid for any medico legal purposes.
(v) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner / Our Empanelled Service Provider.
(vi) This Benefit is available on Cashless Facility basis only.

**(31). (h) Visa Documentation Guidance:**

**What is covered**

We / Our Empanelled Service Provider shall provide information concerning visa documentation and guidance for overseas travel for the purpose of any Medically Necessary Treatment pre-authorized by Us / Our Empanelled Service Provider under Section A.IV.(31).(a). This assistance shall be provided to the Insured Person at any time, whether or not the Insured Person is travelling or an emergency has occurred. We / Our Empanelled Service Provider shall inform the Insured Person requesting such information that We / Our Empanelled Service Provider is simply communicating the information set forth as per applicable procedure and We / Our Empanelled Service Provider shall specify the source of such information.

We / Our Empanelled Service Provider shall also provide the address, telephone number and hours of opening of the appropriate consulate and embassy worldwide, nearest to the Insured Person.

**Conditions**

(i) We do not assume any liability towards any loss or damage arising out of or in relation to any rejection of visa by the foreign country.
(ii) We do not assume any liability towards any actual or alleged errors in the information provided by us, including any consequence of the Insured Person's actions taken or not taken in reliance thereon.
(iii) Under this Additional Benefit, We are only providing the Insured Person with information concerning visa documentation and this shall not be construed to be a provision of visa or facilitation of the visa process itself, on Our part.

**(32) Personal Accident Cover (AD, PTD):**

Benefits under this Section A.IV.(32) are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and / or the Sub-Limit for each Benefit under Section A.IV.(32) 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.

All claims under Section must be made in accordance with the procedure set out in Section B.(O).

**1. Accidental Death Cover (AD):**

**What is covered**

If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and that Injury results in the death of the Insured Person within 365 days from the date of the Accident, We shall pay the Sum Insured as specified in the Policy Schedule / the Product Benefit Table of this Policy.

In the event of the disappearance of the Insured Person, following a forced landing, stranding, sinking or wrecking of a conveyance in which such Insured Person was known to have been travelling as an occupant, it shall be deemed after 365 days, subject to all other terms and conditions of this Policy, that such Insured Person shall have died as a result of an Accident. If, at any time, after the payment of the Sum Insured payable under this Benefit, it is discovered that the Insured Person is still alive, all payments shall be reimbursed in full to Us

**Condition**

(i) Once a claim has been accepted and paid under this Benefit then cover (Personal Accident Cover (AD, PTD)) under this Policy shall immediately and automatically cease in respect of that Insured Person.

**2. Permanent Total Disablement (PTD):**

**What is covered**

If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and that Injury results in the permanent total disablement of the Insured Person of the nature as specified in the table below within 365 days from the date of the Accident, We shall pay the Sum Insured as specified in the Policy Schedule / the Product Benefit Table of this Policy, as applicable.

| **Table of Benefits** |
|---|
| Type of Permanent Total Disablement |
| i) Total and irrecoverable loss of sight of both eyes |
| ii) Loss by physical separation or total and permanent loss of use of both hands or both feet |
| iii) Loss by physical separation or total and permanent loss of use of one hand and one foot |
| iv) Total and irrecoverable loss of sight of one eye and loss of a Limb |
| v) Total and irrecoverable loss of hearing of both ears and loss of one Limb / loss of sight of one eye |
| vi) Total and irrecoverable loss of hearing of both ears and loss of speech |
| vii) Total and irrecoverable loss of speech and loss of one Limb / loss of sight of one eye |
| viii) Permanent total and absolute disablement (not falling under the above) disabling the Insured Person from engaging in any employment or occupation or business for remuneration or profit, of any description whatsoever which results in Loss of Independent Living. |

**Conditions**

(i) For the purpose of this Benefit:
- Limb means a hand at or above the wrist or a foot above the ankle;
- Physical separation of one hand or foot means separation at or above wrist and / or at or above ankle, respectively.
  In this benefit, Loss means the physical separation of a body part, or the total loss of functional use of a body part or organ provided this has continued for at least 365 days from the onset of such disablement and provided further that We are satisfied based on a written confirmation by a Medical Practitioner at the expiry of the 365 days that there is no reasonable medical hope of improvement.

(ii) Once a claim has been accepted and paid under this Benefit then cover under ( Personal Accident Cover (AD, PTD)) of this Policy shall immediately and automatically cease in respect of that Insured Person.

**What is not covered**

(i) Loss caused directly or indirectly due to the following shall not be covered:
   a. Due to infections (except pyogenic infections which occur through an Accidental cut or wound) or any other kind of disease; or
   b. Any Surgical Procedure except as may be necessary solely as a result of the Injury.

**(33) Critical Illness Cover**

**What is covered**

If the Insured Person suffers from a Critical Illness of the nature as specified in this Section during the Policy Period and while the Policy is in force, then We shall pay the Sum Insured as set out in the Policy Schedule / Product Benefit Table for that Critical Illness provided that the Critical Illness is first diagnosed or first manifests itself during the Policy Period as a first incidence.

| | **List of Critical Illnesses as applicable:** |
|---|---|
| 1 | Cancer of Specified Severity |
| 2 | Myocardial Infarction (First Heart Attack of specific severity) |
| 3 | Open Chest CABG |
| 4 | Open Heart Replacement Or Repair Of Heart Valves |
| 5 | Kidney Failure Requiring Regular Dialysis |
| 6 | Stroke Resulting In Permanent Symptoms |
| 7 | Major Organ / Bone Marrow Transplant |
| 8 | Permanent Paralysis Of Limbs |
| 9 | Multiple Sclerosis With Persisting Symptoms |
| 10 | Coma of Specified Severity |
| 11 | Motor Neuron Disease With Permanent Symptoms |
| 12 | Third Degree Burns |
| 13 | Deafness |
| 14 | Loss of Speech |
| 15 | Aplastic Anaemia |
| 16 | End Stage Liver Failure |
| 17 | End Stage Lung Failure |
| 18 | Bacterial Meningitis |
| 19 | Fulminant Hepatitis |
| 20 | Muscular Dystrophy |

**Conditions**

(i) Our total, cumulative, maximum liability during the lifetime of the Insured Person is upto 100% of the Sum Insured.
(ii) Once a claim for a listed condition is admissible in respect of an Insured Person, no further Renewals shall be allowed for that Insured Person under this Benefit.

**Survival Period:**

The payment of a Benefit under Section shall be subject to survival of the Insured Person for 15 days following the first diagnosis of the Critical Illness / undergoing the Surgical Procedure for the first time.

## Section V: Optional Covers

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

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

In case of Individual Policy, each individual Insured Person can opt for any of the below optional covers as per their requirements. In case of Family Floater Policy, once selected, the optional covers shall apply to all Insured Persons (on individual basis) without any individual selection except for in case of Personal Accident cover, Critical Illness Cover, International coverage for Major Illnesses.

**The Sum Insured under these benefits are independent and over and above the base Sum Insured.**

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

**(34) Personal Accident Cover:**

Benefits under this Section A.V.(34) are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and / or the Sub-Limit for each Benefit under Section A.V.(34) 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.

All claims under Section must be made in accordance with the procedure set out in Section B.(O).

**1. Accidental Death Cover (AD):**

**What is covered**

If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and that Injury results in the death of the Insured Person within 365 days from the date of the Accident, We shall pay the Sum Insured as specified in the Policy Schedule / the Product Benefit Table of this Policy.

In the event of the disappearance of the Insured Person, following a forced landing, stranding, sinking or wrecking of a conveyance in which such Insured Person was known to have been travelling as an occupant, it shall be deemed after 365 days, subject to all other terms and conditions of this Policy, that such Insured Person shall have died as a result of an Accident. If, at any time, after the payment of the Sum Insured payable under this Benefit, it is discovered that the Insured Person is still alive, all payments shall be reimbursed in full to Us.

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**Condition**

(i) Once a claim has been accepted and paid under this Benefit then cover under this Policy shall immediately and automatically cease in respect of that Insured Person.

**2. Permanent Total Disablement (PTD):**

**What is covered**

If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and that Injury results in the permanent total disablement of the Insured Person of the nature as specified in the table below within 365 days from the date of the Accident, We shall pay the Sum Insured as specified in the Policy Schedule / the Product Benefit Table of this Policy, as applicable.

| **Table of Benefits** | |
|---|---|
| Type of Permanent Total Disablement | |
| i) | Total and irrecoverable loss of sight of both eyes |
| ii) | Loss by physical separation or total and permanent loss of use of both hands or both feet |
| iii) | Loss by physical separation or total and permanent loss of use of one hand and one foot |
| iv) | Total and irrecoverable loss of sight of one eye and loss of a Limb |
| v) | Total and irrecoverable loss of hearing of both ears and loss of one Limb/loss of sight of one eye |
| vi) | Total and irrecoverable loss of hearing of both ears and loss of speech |
| vii) | Total and irrecoverable loss of speech and loss of one Limb/loss of sight of one eye |
| viii) | Permanent total and absolute disablement (not falling under the above) disabling the Insured Person from engaging in any employment or occupation or business for remuneration or profit, of any description whatsoever which results in Loss of Independent Living. |

**Conditions**

(i) For the purpose of this Benefit:
- Limb means a hand at or above the wrist or a foot above the ankle;
- Physical separation of one hand or foot means separation at or above wrist and/or at or above ankle, respectively.
  In this benefit, Loss means the physical separation of a body part, or the total loss of functional use of a body part or organ provided this has continued for at least 365 days from the onset of such disablement and provided further that We are satisfied based on a written confirmation by a Medical Practitioner at the expiry of the 365 days that there is no reasonable medical hope of improvement.

(ii) Once a claim has been accepted and paid under this Benefit then cover under Section 34 (Personal Accident Cover (AD, PTD)) of this Policy shall immediately and automatically cease in respect of that Insured Person.

**What is not covered**

(I) Loss caused directly or indirectly due to the following shall not be covered:
   a. Due to infections (except pyogenic infections which occur through an Accidental cut or wound) or any other kind of disease; or
   b. Any Surgical Procedure except as may be necessary solely as a result of the Injury.

**(35) Critical Illness Cover:**

**What is covered**

If the Insured Person suffers from a Critical Illness of the nature as specified in this Section during the Policy Period and while the Policy is in force, then We shall pay the Sum Insured as set out in the Policy Schedule / Product Benefit Table for that Critical Illness provided that the Critical Illness is first diagnosed or first manifests itself during the Policy Period as a first incidence.

| | **List of Critical Illnesses as applicable:** |
|---|---|
| 1 | Cancer of Specified Severity |
| 2 | Myocardial Infarction (First Heart Attack of specific severity) |
| 3 | Open Chest CABG |
| 4 | Open Heart Replacement Or Repair Of Heart Valves |
| 5 | Kidney Failure Requiring Regular Dialysis |
| 6 | Stroke Resulting In Permanent Symptoms |
| 7 | Major Organ / Bone Marrow Transplant |
| 8 | Permanent Paralysis Of Limbs |
| 9 | Multiple Sclerosis With Persisting Symptoms |
| 10 | Coma of Specified Severity |
| 11 | Motor Neuron Disease With Permanent Symptoms |
| 12 | Third Degree Burns |
| 13 | Deafness |
| 14 | Loss of Speech |
| 15 | Aplastic Anaemia |
| 16 | End Stage Liver Failure |
| 17 | End Stage Lung Failure |
| 18 | Bacterial Meningitis |
| 19 | Fulminant Hepatitis |
| 20 | Muscular Dystrophy |

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**Conditions**
(i) Our total, cumulative, maximum liability during the lifetime of the Insured Person is upto 100% of the Sum Insured.
(ii) Once a claim for a listed condition is admissible in respect of an Insured Person, no further Renewals shall be allowed for that Insured Person under this Benefit.

**Survival Period:**
The payment of a Benefit under Section shall be subject to survival of the Insured Person for 15 days as specified in Policy Schedule / the Product Benefit Table of this Policy following the first diagnosis of the Critical Illness / undergoing the Surgical Procedure for the first time.

**(36) International Coverage for Major Illnesses:**
Benefits under this Section A.V.(36) are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and / or the Sub-Limit for each Benefit under Section is 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 and the 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.

We will indemnify the Reasonable and Customary Charges incurred towards medical treatment taken by the Insured Person during the Policy Period for an Illness, Injury or conditions described in the Benefits below if it is contracted or sustained by an Insured Person during the Policy Period. This Policy covers only treatment which is planned and scheduled in advance and taken outside India and does not cover any Emergencies occurring or Emergency Care required while the Insured Person is overseas or in India.

All claims paid under this Section will impact the Sum Insured available under the Policy, and must be made in accordance with the procedure set out in Section B.(O). Coverage under section (16) International Emergency Assistance Services (including Air Ambulance) is not applicable for this Section. A.V.(36).

**(36). (a) In-patient Hospitalization (outside India):**
**What is covered**
We will cover the Medical Expenses incurred towards the Insured Person for one or more of the following arising out of an Insured Person's Inpatient Care outside India during the Policy Period caused solely and directly due to a Major Illness that occurs or manifests itself during the Policy Period:
(i) Reasonable and Customary Charges incurred towards the Room Rent of a Hospital room and other boarding charges, up to the sub-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 the Major Illness for which the Insured Person is Hospitalized;
(viii) Anaesthesia, blood, oxygen and blood transfusion charges;
(ix) Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure;
(x) Medication applied as per the medical prescription issued by the treating Medical Practitioner while the Insured Person is Hospitalized for treatment of a Major Illness;
(xi) Medication prescribed for post-operative treatment is covered for up to 30 days from the date the Insured Person has completed the stage of the treatment received out of India and only when this medication is purchased prior to the Insured Person returning to India.

**Conditions**
(i) The Hospitalization is towards Medically Necessary Treatment, and follows the written advice of a Medical Practitioner.
(ii) For the purpose of this Benefit, the treatment should be taken in a registered Hospital or clinic as per law, rules and / or regulations applicable to the country where the treatment is taken, and which is a listed Network Provider / Empanelled Service Provider. For the list of Network Providers, You may please visit Our / Our Empanelled Service Provider's website or contact Us at Our call centre on the toll free number specified in the Policy Schedule.
(iii) Any payment shall be made only on a Cashless Facility basis.
(iv) Requisite pre-authorisation shall be obtained from Us / Our Empanelled Service Provider for the said Illness / Injury in accordance with the Claims Procedure set out in Section B.(O).
(v) The symptoms of the Major Illness first occur or manifest itself during the Policy Period and after completion of the initial Waiting Period of 30 days, subject to applicability of any Waiting Periods specified in the Policy Schedule.
(vi) The rate of exchange as published by the Reserve Bank of India (RBI) as on the date of payment to the Hospital shall be used for conversion of amounts not settled in Indian rupee into Indian rupees for calculation of claim payments under this Benefit. If the RBI rates are not published on the date of the Insured Person's discharge from the Hospital, the exchange rate next published by the RBI shall be considered for conversion of any amounts not settled in Indian rupee.
(vii) The Medical Expenses are incurred outside India.
(viii) Permanent Exclusion No.B.(H).viii.39 is not applicable in respect of this Benefit.
(ix) Permanent Exclusion No.B.(H).viii.46 (Treatment taken outside India) is not applicable in respect of this Benefit.
(x) No Pre-hospitalization Medical Expenses are covered under this Benefit.

**For the purpose of this section, Major Illness shall mean the Illnesses, Medical Events or Surgical Procedures as specifically defined below:**

| S.l. No. | Major Illnesses | Definition |
|---|---|---|
| 1 | Cancer Treatment | I. We will be covering Primary Treatment of a malignant tumour 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 including but not limited to leukemia, lymphoma and sarcoma (except cutaneous lymphoma).<br>II. Any In-situ Cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues.<br>III. Any pre-cancerous change in the cells that are cytologically or histologically classified as high grade dysplasia or severe dysplasia.<br>IV. The following are excluded – All tumours in the presence of HIV infection. |

| | | |
|---|---|---|
| 2 | Coronary Artery By-Pass surgery | I. We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a Cardiologist.<br>II. The following are excluded: Angioplasty and / or any other intra-arterial procedures. |
| 3 | Heart Valve Replacement | I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a Specialist Medical Practitioner.<br>II. The following are excluded: Catheter based techniques including but not limited to, balloon valvotomy / valvuloplasty are excluded. |
| 4 | Major Organ Transplantation | I. We will be covering the actual undergoing of a transplant of one of the following human organs: lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ. The undergoing of a transplant has to be confirmed by a Specialist Medical Practitioner.<br><br>II. The following are excluded:<br>a) Any transplant when the need for a transplant arises as a consequence of alcoholic liver disease.<br>b) Any transplant when the transplant is conducted as a self-transplant.<br>c) Any transplant when the Insured is a donor for a third-party.<br>d) Any transplants from a dead donor.<br>e) Any organ transplant that involves Stem Cells treatment.<br>f) Where only islets of langerhans are transplanted.<br>g) The transplant made possible by the purchase of donor organs.<br>h) Any disease which has been caused by an organ transplant save where the disease in question is qualified as a Major Illnesses covered under the product. |
| 5 | Bone Marrow Transplant | We will be covering Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured originating from:<br>a. The Insured (Autologous bone marrow transplant); or<br>b. From a living compatible donor (allogeneic bone marrow transplant). |
| 6 | Neurosurgery | We will be covering any<br>I. Surgical intervention of the brain or any other intracranial structures.<br>II. Surgical Treatment of benign solid tumours located in the spinal cord. |
| 7 | Pulmonary artery graft surgery | I. We will be covering the undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft. |
| 8 | Aorta Graft Surgery | I. We will be covering the actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of “Aorta” shall mean the thoracic and abdominal aorta but not its branches.<br><br>II. The following are excluded:<br>a. Surgery performed using only minimally invasive or intra-arterial techniques.<br>b. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures. |
| 9 | Coronary Artery By-Pass surgery post occurrence of Myocardial Infraction | I. We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures, post the occurrence of myocardial infraction. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a Cardiologist.<br><br>II. The following are excluded: Angioplasty and / or any other intra-arterial procedures. |
| 10 | Surgical treatment for Stroke | I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a Specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.<br><br>II. We will be covering surgical treatment of Stroke limited to;<br>a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy.<br>b. Stenting of Intra cranial blood vessels, needed for the treatment of Stroke. |

| | | |
|---|---|---|
| | | III. The following are excluded:<br>a. Transient ischemic attacks (TIA).<br>b. Traumatic injury of the brain.<br>c. Vascular disease affecting only the eye or optic nerve or vestibular functions. |
| 11 | Surgical treatment for benign Brain tumour | I. We will be covering surgical treatment of Benign solid brain tumour limited to;<br>a. Surgical Removal of solid brain tumour through Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy.<br>b. Embolization of Intra cranial blood vessels, needed for the treatment of solid brain Tumour.<br><br>II. Benign solid brain tumour is defined as a life threatening, non-cancerous tumour in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI.<br><br>III. This brain tumour must result in at least one of the following and must be confirmed by the relevant Medical Specialist.<br>a. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or;<br>b. Undergone surgical resection or radiation therapy to treat the brain tumour. |
| 12 | Lung Transplant Surgery in case of End Stage Lung Disease | I. We will be covering Lung Transplant Surgery due to following cases.<br><br>a. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:<br>i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and<br>ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and<br>iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and<br>iv. Dyspnea at rest. |
| 13 | Kidney Transplant Surgery in case of End Stage Renal Failure | We will be covering Kidney Transplant Surgery due to following cases<br><br>I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a Specialist Medical Practitioner. |
| 14 | Skin grafting surgery for Major Burns | I. We will be covering the undergoing of skin transplantation due to accidental major burns where major burns is as defined below.<br><br>a. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.<br><br>II. Skin grafting surgery for Major Burns should be medically required and not aesthetic / cosmetic in nature. |
| 15 | Surgical treatment of Coma | I. We will be covering surgical treatment of Coma limited to;<br>a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy.<br><br>II. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following.<br>a. no response to external stimuli continuously for at least 96 hours.<br>b. life support measures are necessary to sustain life; and<br>c. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.<br>d. The condition has to be confirmed by a specialist medical practitioner.<br><br>III. The following are excluded:<br>Coma resulting directly from alcohol or drug abuse is excluded. |
| 16 | Surgery for Pheochromocytoma | I. We will be covering the actual undergoing of surgery to remove the tumour.<br><br>II. Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines and the Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who is an Endocrinologist. |

**(36). (b) Post – hospitalization Medical Expenses:**

**What is covered**

We will cover the Insured Person's Post-hospitalization Medical Expenses incurred following a Major Illness as specified under Section A.V.(36).(a) that occurs or manifests during the Policy Period, on a reimbursement basis, for upto 30 days from the date of discharge from Hospitals and up to the Limits specified against Benefit A.V.(36) in the Policy Schedule / Product Benefit Table of this Policy.

**Conditions**

(i) We have accepted a claim for In-patient Hospitalization under Section A.V.(36).(a) for the same Major Illness.
(ii) 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 Major Illness.
(iii) Treatment taken inside India is not applicable.

**(36). (c) Organ Donor Expenses:**

**What is covered**

We shall cover the Medical Expenses, up to the Limit specified against Section A.V.(36) in the Policy Schedule / Product Benefit Table, incurred by or in respect of the Insured Person's organ donor solely towards the harvesting of the organ donated, for any organ transplant Surgery accepted by Us under Section A.V.(36).(a).

**Conditions**

(i) The organ donation conforms to the Transplantation of Human Organs Act 1994 as amended from time to time.
(ii) The Insured Person is the recipient of the organ so donated by the organ donor.
(iii) The Insured Person has been advised to undergo an organ transplant based on the Medical Advice of the treating Medical Practitioner.
(iv) Permanent Exclusion No.B.(H).viii.32 does not apply to this Benefit.

**What is not covered**

(i) Pre-hospitalization Medical Expenses or Post-Hospitalization Medical Expenses of the organ donor.
(ii) Any costs incurred towards donor screening expenses.
(iii) Any other Medical Expenses or treatment incurred by the organ donor incidental to the harvesting from the organ donor.
(iv) Costs directly or indirectly associated with the acquisition of the donor's organ.
(v) Transplant of any organ/tissue where the transplant is experimental or investigational.
(vi) Expenses related to organ transportation or preservation.
(vii) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

**(36). (d) Travel Expenses:**

**What is covered**

If We have admitted a claim under Section A.V.(36).(a) in respect of the Insured Person and Our pre-authorization has been obtained, then We / Our Empanelled Service Provider shall arrange the following travel expenses up to the limit specified against Benefit A. V.(36) in the Policy Schedule / Product Benefit Table of this Policy, for the Insured Person, one accompanying attendant from the Country of Residence and the living donor (only in the case of any organ transplant Surgery accepted by Us) for the same Major Illness:

(i) Transportation from the Insured Person's place of residence to the designated airport.
(ii) One-time economy class air fare by direct route to the city of treatment and onwards transportation to the designated place of accommodation in the city of treatment or the Hospital.
(iii) Transportation from the airport to the Hospital or place of accommodation in the city of treatment.
(iv) Transportation from the place of accommodation in the city of treatment or the Hospital to the nearest airport in the city of treatment.
(v) One-time economy class air fare by direct route to the city of the Insured Person's permanent address, and onwards transportation to his / her place of residence.

**Conditions:**

(i) We shall be liable to pay an amount only up to the costs of direct route economy class fare (business class, air ambulance or medical stretcher may be provided subject to availability in the international carrier, but only for the Insured Person under written advice of the attending Medical Practitioner due to the severity of his / her medical conditions) as available on the date of the journey.
(ii) The costs for the accompanying attendant's and / or living donor's airfare shall be indemnified by Us only if the treating Medical Practitioner has certified in writing that an accompanying attendant and / or living donor must accompany the Insured Person.
(iii) Treatment taken inside India is not applicable in respect of this Benefit.
(iv) Permanent Exclusion No.B.(H).viii.46 (Treatment taken outside India) is not applicable in respect of this Benefit.
(v) We / Our Empanelled Service Provider will provide an onward travel date based on the agreement reached with the treating Medical Practitioner and Hospital.
(vi) We / Our Empanelled Service Provider will arrange the onward travel subject to a ready to fly certificate from the attending Medical Practitioner in the Insured Person's Country of Residence.
(vii) We / Our Empanelled Service Provider will arrange the return travel based on the completion of the Medically Necessary Treatment and the agreement with the treating Medical Practitioner that the Insured Person is fit to travel.
(viii) In the event that the Insured Person changes the dates of travel from those booked and communicated by Us / Our Empanelled Service Provider, You will be liable to compensate Us for all the associated costs of organizing and providing new arrangements, unless the changes are proven to be necessary from a medical standpoint and Our prior approval is obtained in writing.
(ix) This Benefit is available on Cashless Facility basis only, unless a prior approval in writing has been taken from Us before making such travel booking.

**Documents to be submitted for any Claim under this Benefit**

It is a Condition Precedent to Our liability under this Benefit that the following information and documentation shall be submitted to Us or Our Empanelled Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

(i) A certificate from the Medical Practitioner specifying the period of Hospitalization.
(ii) Discharge summary of the Hospital furnishing details including the date of admission and date of discharge.
(iii) Original bill and receipt from the carrier indicating the amount paid for the travel.
(iv) Payment receipt of any change in the travel booking with the documentation, if Cashless Facility for the same is not provided.
(v) Pre Authorization form and Claim form duly filed and signed by the Insured Person for Cashless Facility.

**(36). (e) Accommodation Expenses:**

**What is covered**

If We have admitted a Claim under Section A.V.(36).(a) and Our pre-authorization has been obtained, then We / Our Empanelled Service Provider shall arrange a reasonable accommodation for the Insured Person and / or accompanying attendant and / or living donor (only in the case of any organ transplant Surgery accepted by Us) in the city of treatment which is not the Insured Person's permanent address as specified in the Policy Schedule, up to the limit specified in A.V.(36) in the Policy Schedule / Product Benefit Table of this Policy.

**Conditions:**
(i) We / Our Empanelled Service Provider will arrange the accommodation booking dates based on the approved treatment schedule. These dates will be communicated to the Insured Person to allow for sufficient time for the Insured Person to make all the necessary personal arrangements.
(ii) We / Our Empanelled Service Provider will arrange a checking-out date for the place of accommodation based on the completion of the treatment and the agreement with the treating Medical Practitioner that the Insured Person is fit to travel.
(iii) In the event that the Insured Person changes the dates of travel from those booked and communicated by Us / Our Empanelled Service Provider, You will be liable to compensate Us for all the associated costs of organizing and providing new accommodation arrangements, unless the changes are proven to be necessary from a medical standpoint and Our prior approval is obtained in writing.
(iv) The accommodation arrangements will include bookings for a double room or twin bed room in a three or four-star hotel or accommodation category. (The choice of accommodation will always be subject to availability and the proximity to the Hospital or treating Medical Practitioner.)
(v) The accommodation arrangements exclude any expenses towards breakfast, meals and incidental costs (not limited to minibar, laundry, personal expenses) at the place of accommodation, and any upgrades to the room.
(vi) This Benefit is available on Cashless Facility basis only, unless a prior approval in writing has been taken from Us before making such accommodation booking.

**Documents to be submitted for any Claim under this Benefit**
It is a Condition Precedent to Our liability under this Benefit that the following information and documentation shall be submitted to Us or Our Empanelled Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:
(i) A certificate from the Medical Practitioner specifying the period of Hospitalization.
(ii) Discharge summary of the Hospital furnishing details including the date of admission and date of discharge.
(iii) Original bill and receipt or letter obtained from the hotel indicating the amount paid for the accommodation.
(iv) Payment receipt of extension of hotel booking with the documentation, if Cashless Facility for the same is not provided.
(v) Pre Authorization form and Claim form duly filed and signed by the Insured Person for Cashless Facility.

**(36). (f) Repatriation of Mortal Remains:**
**What is covered**
If the Insured Person dies whilst undergoing treatment which has been pre-authorised by Us / Our Empanelled Service Provider under Section A.V.(36).(a) in the Policy Period for any of the Major Illnesses, We shall reimburse the costs of Repatriation of the Mortal Remains of the Insured Person up to the Limit specified against Benefit A.V.(36) in the Policy Schedule / Product Benefit Table, to the city of his / her permanent address in the Country of Residence, up to an equivalent amount, for a local burial (excluding costs incurred towards buying / procuring a grave) or cremation at the country where death has occurred.

**Conditions**
(i) This Benefit may also be provided on a Cashless Facility basis, provided that the costs are authorized by Us or Our Empanelled Service Provider in advance.

**Documents to be submitted for any Claim under this Benefit:**
It is a Condition Precedent to Our liability under this Benefit that the following necessary information and documentation shall be submitted to Us or Our Empanelled Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:
(i) Copy of the Death Certificate providing details of the place, date, time, and the circumstances and cause of death.
(ii) Copy of the Post-Mortem Report / Certificate.
(iii) Documentary proof for expenses incurred towards disposal of the Mortal Remains.
(iv) In case of transportation of the body of the deceased to the city of his / her permanent address in the Country of Residence, the receipt for expenses incurred towards preparation and packing of the Mortal Remains of the deceased and also for the transportation of the Mortal Remains of the deceased.
(v) Copy of Embalming Certificate.

**(36). (g) International Second E-opinion for Major Illness:**
**What is covered**
If an Insured Person is diagnosed with any listed Major Illnesses as specified under Section A. V.(36) during the Policy Period, the Insured Person may at his / her sole discretion choose to avail an E-Opinion from Our panel of internationally available Medical Practitioners, provided that.
(i) The Insured Person on diagnosis of Major Illness should share the following for the e-opinion:
  (a) First consultation paper.
  (b) Final Diagnosis paper.
  (c) Treating doctor certification on final diagnosis.
  (d) All investigation reports supporting documents.
  (e) Consent Form to collect documents from various source.
  (f) Any other relevant documents to ascertain eligibility of claim.
(ii) On the basis of the Insured Person's reported medical condition, We / Our Empaneled Service Provider will identify Medical Practitioners from Our network.
(iii) The Insured Person may choose one of the Medical Practitioners out of the 3 choices given by Us / Our Empaneled Service Provider.
(iv) Medical reports and all other information pertaining to the Insured Person is shared with the chosen Medical Practitioner.
(v) After receipt of all medical information, a detailed e-opinion from the selected Medical Practitioner would be delivered to the Insured Person as soon as it is available.

**Conditions:**
It is agreed and understood that the Second E-Opinion will be based only on the information and documentation provided to Us, which will be shared with the Our empanelled Medical Practitioners and is subject to the conditions specified below:
(i) It is agreed and understood that the Insured Person is free to choose whether or not to obtain the expert opinion, 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.
(ii) Appointments to avail of this Additional Benefit may be availed through Our Website or Our mobile application or through calling Our call centre on the toll free number specified in the Policy Schedule.
(iii) Under this Additional Benefit, We are only providing the Insured Person with access to an e-opinion and such e-opinion shall not be deemed to substitute the Insured Person's physical visit or consultation to an independent Medical Practitioner.
(iv) The E-Opinion provided under this Additional Benefit shall be limited to the covered listed Major Illnesses under A.V.(36).(a) and not be valid for any medico legal purposes.
(v) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner / Our Empanelled Service Provider.
(vi) This Benefit is available on Cashless Facility basis only.

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**(36). (h) Visa Documentation Guidance:**

**What is covered**

We / Our Empanelled Service Provider shall provide information concerning visa documentation and guidance for overseas travel for the purpose of any Medically Necessary Treatment pre-authorized by Us / Our Empanelled Service Provider under Section A.V.(36).(a). This assistance shall be provided to the Insured Person at any time, whether or not the Insured Person is travelling or an emergency has occurred. We / Our Empanelled Service Provider shall inform the Insured Person requesting such information that We / Our Empanelled Service Provider is simply communicating the information set forth as per applicable procedure and We / Our Empanelled Service Provider shall specify the source of such information.

We / Our Empanelled Service Provider shall also provide the address, telephone number and hours of opening of the appropriate consulate and embassy worldwide, nearest to the Insured Person.

**Conditions**

(i) We do not assume any liability towards any loss or damage arising out of or in relation to any rejection of visa by the foreign country.
(ii) We do not assume any liability towards any actual or alleged errors in the information provided by us, including any consequence of the Insured Person's actions taken or not taken in reliance thereon.
(iii) Under this Additional Benefit, We are only providing the Insured Person with information concerning visa documentation and this shall not be construed to be a provision of visa or facilitation of the visa process itself, on Our part.

**(37) Preferred Provider Network (PPN) Discount:**

**What is covered**

If this option is chosen by the Policyholder on the basis of the conditions provided below, then the Policyholder is entitled for a discount of 10% on the premium payable.

**Conditions**

(i) If the Insured Person takes In-patient Hospitalization Treatment as applicable under section A.I.(1) in a Hospital other than those listed as "Preferred Provider Network", then the Policyholder / Insured Person shall bear a Co-Payment of 10% on each and every claim arising in such regard, which will be in addition to any other Co-Payment applicable under the Policy.
(ii) The updated list of Hospitals listed as "Preferred Provider Network" can be referred to on Our website.
(iii) PPN discount in Premiere plan is not applicable for below benefits:
  a. Personal Accident.
  b. Critical Illness.
  c. International Coverage for Major Illnesses.
(iv) PPN discount is not applicable on optional covers for below plans:
  a. Platinum Enhanced.
  b. Gold Enhanced.
(v) Under Platinum Essential Plan, PPN discount Optional Cover is applicable on 'Waiver of Mandatory Co-payment' when opted. For other optional covers under this plan, PPN discount is not applicable.

**(38) Waiver of Mandatory Co-payment:**

**What is covered**

If this Benefit is in force, the applicable Mandatory Co-payment specified in Section (21) shall not apply on payable claims under the Policy as specified in the Policy Schedule/ Product Benefit Table.

**(39) Maternity Expenses:**

**i. Maternity Expenses:**

**What is covered**

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

**Coverage under this Benefit shall include:**

(i) Medical Expenses for a delivery of a child (including caesarean section) or lawful medical termination of pregnancy;
(ii) Pre or post natal Maternity Expenses;
(iii) Any claim under this benefit shall not impact the Opted Sum Insured or Cumulative Bonus.

**Conditions:**

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

**What is not covered:**

(i) Medical expenses for ectopic pregnancy. However, these expenses will be covered under In-patient Treatment under Section A.I.(1);
(ii) Any Pre-hospitalization Medical Expenses or Post – hospitalization Medical Expenses under Section A.I.(2) and A.I.(3), above will not be covered under this Benefit,
(iii) Any Reloaded Sum Insured will not be available for coverage under this Benefit.

**Note:** Section B.H.viii (Permanent Exclusion 30), is not applicable if this Benefit is in force.

**ii. New Born Baby Expenses:**

**What is covered**

We cover Medical Expenses towards the treatment of the New Born Baby as an In-patient, up to the limit of the Maternity Sum Insured, while the Insured Person is Hospitalised as an in-patient for delivery, subject to a valid claim being accepted under Maternity Expenses.
(i) This would include in-patient hospitalisation expenses incurred on the New Born Baby while the Insured Person is Hospitalised as an in-patient for delivery.
(ii) Charges incurred on the New Born Baby during and post birth up to 90 days from the date of delivery, within the limits of Maternity Expenses.
(iii) A New Born Baby beyond 90 days can be covered under the Policy by way of an endorsement or at the next Renewal whichever is earlier, on payment of requisite premium.

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

**iii. Vaccination Expenses**
**What is covered**
We will cover vaccination expenses listed below of a New Born Baby from birth to until the New Born Baby completes two years.

| S.l. No. | Name of Vaccine | Time to be given |
|---|---|---|
| 1 | Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed | 6wks, 10wks, 14wks; 16-18months; |
| 2 | Varicella Vaccine, live attenuated | 15months; |
| 3 | Human Rotavirus Vaccine, Live Attenuated | 6wks, 10wks, 14wks; |
| 4 | Combined Measles, Mumps, and Rubella Vaccine (live attenuated) | 9months, 15months; |
| 5 | BCG Vaccines | At Birth; |
| 6 | OPV | At Birth, 6months, 9months; |
| 7 | Hepatitis B | At Birth, 6wks, 6months; |
| 8 | Haemophilus influenzae type b Vaccine (Hib) | 6wks, 10wks, 14wks; 16-18months; |
| 9 | Inactivated Hepatitis A virus Vaccine | 12months, 18months; |
| 10 | Pneumococcal Polysaccharide and Non-Typeable Haemophilus influenzae (NTHi) Protein D Conjugate Vaccine, Adsorbed | 14wks, 15months; |
| 11 | Typhoid | 9-12months, 18-2yrs; |
| 12 | IPV | 6wks, 10wks, 14wks; |

**Conditions**
(i) Coverage will be subject to claims admitted under Maternity Expenses cover and will be up to the limits of Maternity Sum Insured.
(ii) Vaccination expenses will be covered only if the Insured Person whose maternity claim has been accepted by Us continues to Renew the Policy with Us during the period. Reimbursement claims for vaccination expenses can be submitted quarterly in a Policy Year.
(iii) Section B.H.viii (Permanent Exclusion 20), is not applicable if this Benefit is in force.
(iv) Benefits under this Section shall be available separately and on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule for an Individual Policy and shall be available on a floater basis for all eligible Insured Persons up to the limits specified in the Policy Schedule for Family Floater Policies.

**Note:**
(i) Our total liability under Maternity Expenses inclusive of New born baby expenses and vaccination expenses will be ₹75,000 per event subject to maximum of 2 events, if the insured person has a normal delivery.

(ii) Our total liability under Maternity Expenses inclusive of New born baby expenses and vaccination expenses will be ₹1,00,000 per event subject to maximum of 2 events, if the insured person has a C-Section delivery.

**iv. Stem cell preservation:**
**What is covered**
We will cover onetime Medical Expenses up to the limit specified in the Policy Schedule towards the harvesting and storage of stem cells of the New Born Baby.

**Conditions**
i. The harvesting and storage of the stem cells of the New Born Baby is carried out as a preventive measure against possible future Illnesses.
ii. The stem cells of the New Born Baby are preserved in an India based Stem Cell Bank only.
iii. The payment under this Benefit is subject to a valid claim being accepted by Us under Maternity Expenses under section A.V.(39).(I).
iv. The coverage under this Benefit will be over and above the Maternity Expenses limit and up to the limits specified in the Policy Schedule and Product Benefit Table.
v. We shall be covering stem cell preservation for a maximum upto 2 New Born Baby(s) during the lifetime of an Insured Person.

**(40) OPD Expenses**
**What is covered**
We will cover costs incurred for medically necessary consultations, diagnostic tests and pharmacy expenses on an out-patient basis upto the amount specified in the Product Benefit Table and Policy Schedule. Appointments can be scheduled through Our website or the mobile application; You can also call Our contact center toll free number specified in the Policy Schedule for scheduling an appointment.

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

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

If in a Policy Year an Insured Person does not utilize the complete limit under OPD Expenses, then the unutilized amount will be carried

forward to the subsequent Policy Year, if the Policy has been Renewed with Us continuously without any break and shall be available for utilization within 12 months of such carry forward only. However, such carry forward is not applicable for unutilized limit for Road Traffic Accident Diagnostic as specified in the Product Benefit Table and Policy Schedule.

**OPD Bonus on Unutilized OPD Expenses:**
We will add a OPD Bonus of 5% to the unutilized OPD Expenses at the end of the Policy Year, if OPD Expenses have not been utilized completely by the Insured Person in the expiring Policy Year, provided that:
(i) This OPD Bonus will apply even if claims under other Benefits have been made under the Policy;
(ii) This OPD Bonus will be calculated based on the unutilised OPD Expenses, irrespective of any change in the Sum Insured or OPD Expenses opted in.
(iii) This OPD Bonus on the unutilized OPD Expenses limit shall not apply in case the Policy is not renewed within the Grace Period.
(iv) This OPD Bonus is not applicable on unutilized limit for Road Traffic Accident Diagnostic.
Unutilized OPD Expenses along with earned OPD Bonus shall be carried forward to the subsequent Policy Year, if the Policy has been Renewed with Us continuously without any break and shall be available for utilization within 12 months of such carry forward only. Unutilized OPD Expenses along with earned OPD Bonus shall not be carried forward, if the Policy has not been Renewed with Us continuously without any break. Permanent Exclusions and Waiting Periods do not apply in respect of this Benefit.

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

**(41) Hospital Cash Benefit**
**What is covered**
We will pay the Hospital Cash Benefit specified in the Policy Schedule, for each continuous and completed period of 24 hours of Hospitalisation, during the Policy Period for treatment of an Illness or Injury.
This Benefit shall be payable for a maximum limit of 30 days in a Policy Year and 10 days for each claim.

**Conditions**
(i) A deductible of 24 hours shall apply under this Benefit, thus the benefits shall become payable only after the completion of the first 24 hours of Hospitalization of the Insured Person.
(ii) Benefits under this Section shall be available on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule irrespective of the type of Policy.
(iii) Claim under this Benefit shall be payable only if in-patient claim has been settled by Us under this Policy under Section A.I.(1).

## Section B. Terms and Conditions:

**A. Eligibility and Coverage:**

**a) Minimum Age at Entry:**
i. Family Floater Policy:
- 91 days (for dependent child) and 18 years (for adults).
- Dependent Children from Age - 91 days to 5 years will be covered only if one adult is covered under Family Floater Policy.

ii. Individual Policy:
- In case of an Individual Policy, minimum age at entry is 5 years.

**b) Maximum Age at Entry:**
- Gold - Enhanced, Platinum - Essential and Enhanced - No Maximum age at entry
- Platinum - Premiere Plan - 65 years

**Note:**
1. Children up to 25 years can be covered under the floater as dependents.
2. Age is calculated as no. of years completed as on last birthday.
3. Individual Policy: Children beyond 25 years if dependent on the parents can be covered under an individual policy
4. Family Floater Policy: Dependent child in a family floater policy is not eligible for the benefits under Chronic Management Program, even when his condition progresses to any of the specified chronic conditions but is eligible to avail Inpatient Hospitalization for the said condition.

**B. 1. Policy Type:**
The policy can be purchased on an Individual basis or a Family floater basis.
a) In case of an Individual policy, each Insured Person under the policy will have a separate Sum Insured.
b) In case of a floater Policy, one family will share a single Opted Sum Insured.

**Relationships covered:**

**a) Family Floater Policy:**
- New Business: Self & legally wedded spouse, dependent children upto 3 (i.e. natural or legally adopted) between the age 3 months to 25 years.
- Renewal only: All relationships issued a policy under UIN: IRDAI/HLT/ABHI/P-H/V.1/32/16-17 to be continued as renewal only.

**b) Individual Policy:**
- Self, legally married spouse as long as they continue to be married, son, daughter, mother, father, brother, sister, mother in-law, father in-law, grandfather, grandmother, grandson, granddaughter, son in-law, daughter in-law, brother in-law, sister in-law, nephew, niece.

**Note:** Son/Daughter/Child will include legally adopted Child and Step Child.

2. Optional covers under family floater policies, if chosen, will be applicable to all members in the Policy except in case of Personal Accident Cover (AD, PTD), Critical Illness Cover, International coverage for Major Illnesses.

3. Critical illness Cover - Minimum entry age 18 years and maximum entry age is 65 years.

4. Personal Accident Cover (AD, PTD) - Minimum entry age 5 years and maximum entry age is 65 years. The Limits for plan other than Platinum - Premiere.
- Adult member - To select among the available options (SI- 5L,10L,15L,20L,30L) on Individual Basis.
- For Child - For child applicable Sum Insured 5 Lacs Only.

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5. International Coverage for Major Illnesses - Minimum entry age 91 days and maximum entry age is 65 years.

6. Chronic Management Program where it is applicable, shall be covered for adult members of the age 18 years and above.

7. International Coverage for Major Illnesses benefit is applicable only for Insured Person(s) who are Indian Citizens residing in India.

8. **Inbuilt Premiere Benefit (Applicable only to Platinum - Premiere Plan)**
   1. For Platinum - Premiere Plan, International Coverage for Major Illnesses, Personal Accident, Critical Illness Cover are inbuilt benefits and shall be available at individual / multi individual basis only for both Individual and Family Floater Policy.

   2. Minimum and Maximum Age at Entry
      - International Coverage for Major Illnesses - Minimum age is 91 days and maximum age is 65 years.
      - Personal Accident Cover (AD, PTD) - Minimum age is 5 years and maximum age is 65 years.
      - Critical Illness Cover - Minimum age is 18 years and maximum age is 65 years.

   3. Availability of cover:
      a. International Coverage for Major Illnesses - All member on individual basis.
      b. Personal Accident Cover (AD, PTD) - All member on individual basis.
      c. Critical Illness Cover - All member on individual basis.

   4. Sum Insured Eligibility for:
      1. International Coverage for Major Illness
         (I) To select from S.I.- 3Cr / 6Cr by all members on Individual basis.
      2. Personal Accident Cover (AD, PTD)
         (ii) For Earning Member(s) - To select among options Sum Insured - 50L / 100L.
         (iii) Non-earning Spouse - 30 Lacs.
         (iv) Children - 10 Lacs.
      3. Critical Illness Cover
         (v) To select from S.I. - 5L / 10L / 15L / 20L / 25L.

9. International Coverage for Major Illnesses Benefit (Inbuilt Premiere Benefit / Optional Benefit) - Cap on the Sum Insured claimable under this Policy in the Insured Person's lifetime, shall be limited to twice the Sum Insured specified for that Insured Person in the Policy Year during which the Major Illness was first diagnosed for the Insured Person.

10. HealthReturns™
    - Plan Platinum - Essential / Enhanced - HealthReturns™ is calculated as percentage of premium available for base cover and not optional cover.
    - Plan Platinum - Premiere - HealthReturns™ is calculated as percentage of premium available for base cover (except International Coverage for Major Illness, Critical Illness and Personal Accident) and not optional cover.

11. Mandatory co-payment is not applicable for optional Benefits - Personal Accident (AD, PTD) and Critical Illness cover.

12. Waiver of co-payment is applicable for base benefit and not optional covers except PPN discount, if opted.

**C. Sum Insured**

**Gold - Enhanced:**
2 Lac, 3 Lac, 4 Lac, 5 Lac, 6 Lac, 7 Lac, 8 Lac, 9 Lac, 10 Lac, 15 Lac, 20 Lac, 25 Lac, 30 Lac, 40 Lac, 50 Lac, 100 Lac, 150 Lac, 200 Lacs.

**Platinum - Essential:**
50,000, 75,000, 1 Lac, 2 Lac, 3 Lac, 4 Lac, 5 Lac, 6 Lac, 7 Lac, 8 Lac, 9 Lac, 10 Lacs, 15 Lac, 20 Lac, 25 Lac, 30 Lac, 40 Lac, 50 Lac, 100 Lac.

**Platimum - Enhanced:**
2 Lac, 3 Lac, 4 Lac, 5 Lac, 6 Lac, 7 Lac, 8 Lac, 9 Lac, 10 Lac, 15 Lac, 20 Lac, 25 Lac, 30 Lac, 40 Lac, 50 Lac, 100 Lac, 150 Lac, 200 Lacs.

**Platinum - Premiere:**
10 Lac, 15 Lac, 20 Lac, 25 Lac, 30 Lac, 40 Lac, 50 Lac, 100 Lac, 150 Lac, 200 Lacs.

**D. Policy Period option**

You can buy the Policy for one, two or three continuous years at the option of the Insured. 'One Policy Year' shall mean a period of one year from the Start Date of the Policy.

**E. Discounts under the Policy**

You can avail of the following discounts on the premium on Your Policy.

**a. Family Discount on Multi Individual Policy:**
- 2 members in a Policy – 5% discount on applicable premium.
- 3 or more members in a Policy – 10% discount on applicable premium.

**b. Long Term Discount:**
- A long term discount of 7.5% and 10% on selecting a 2 and 3 years Policy respectively. Long term discount will apply only in case of Single Premium Policies.

**c. Employee Discount:**
- A 10% discount is applicable for employees of Aditya Birla Health Insurance Company Limited upon purchase of this product.

**d. Affiliate Employee Discount:**
- A 10% discount is applicable for employees of intermediaries of Aditya Birla Health Insurance Company Limited upon purchase of this product.

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**e. Loyalty Discount:**

- A loyalty Discount of 5% maximum up to Rs.2500 on the applicable Premium of the subsequent Policy for Customers buying a subsequent Retail Policy in the same Policy Year from Aditya Birla Health Insurance Company Limited.

**F. Pre-Policy Medical Examination**

Pre-Policy medical check-up may be required based on cover(s) chosen, Sum Insured, Age and / or any health declaration. Medical tests will be facilitated by Us and conducted at Our network of diagnostic centres. Full cost of all such tests will be borne by Us for all accepted proposals. In case of rejected proposals or where a counter offer is not accepted by the customer We will bear only 50% of the cost for such tests.

**G. Underwriting and Loadings**

i. We may apply a risk loading (additional premium) on the premium payable (excluding statutory levies and taxes) based on the details of the Insured Person, including the health status, habits and lifestyle, past medical records, declarations on the Proposal Form and the results of the Pre-Policy medical examination.
ii. The maximum risk loading applicable for an individual shall not exceed above 100% per Insured Person. Loadings will be applied from the Inception Date of the first Policy including subsequent Renewal. There will be no loadings based on individual claims experience on Renewals for the Policies Renewed with Us continuously without any break.
iii. We will inform You about the applicable risk loading through a counter offer letter and We will only issue the Policy once We receive your consent and applicable additional premium. In case, You neither accept the counter offer nor revert to Us within 10 working days, We shall cancel Your application and refund the premium paid.
iv. Your Policy shall not be issued unless We receive Your consent.

**H. Waiting Periods and Permanent Exclusions**

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

**i. 30-day Waiting Period (Code- Excl03)**
**(Not applicable for Section A.IV.32 and Section A.V.34 - (Personal Accident Cover - AD, PTD), Section A.IV.33 and Section A.V.35 (Critical Illness Cover)).**

(i) Expenses related to the treatment of any Illness within 30 days from the First Policy Commencement Date shall be excluded except claims arising due to an accident, provided the same are covered.
(ii) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
(iii) The within referred Waiting Period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

**ii. Initial Waiting Period (Applicable for Section A.IV.32 and Section A.V.34 (Personal Accident Cover – AD,PTD) and Section A.IV.33 and Section A.V.35 Critical Illness cover)**

(i) For Section A.IV.32 and Section A.V.34 - Personal Accident, no initial Waiting Period applicable.
(ii) For Section A.IV.33 and Section A.V.35 Critical Illness Cover, We shall not be liable to make any payment in respect of any Critical Illness whose signs or symptoms first occur within 90 days from the Start Date of cover.

**iii. Specified Disease / Procedure Waiting Period: (Code- Excl02)**
**(Not applicable for Section A.IV.32 and Section A.V.34 - (Personal Accident) , Section A.IV.33 and Section A.V.35 (Critical Illness cover)**

(i) Expenses related to the treatment of the listed Conditions, Surgeries / Treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with Us. This exclusion shall not be applicable for claims arising due to an accident.
(ii) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
(iii) If any of the Specified Disease / Procedure falls under the Waiting Period specified for Pre-Existing Diseases, then the longer of the two Waiting Periods shall apply.
(iv) The Waiting Period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
(v) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then Waiting Period for the same would be reduced to the extent of prior coverage.
(vi) List of Specific Diseases/ Procedures:

| | Body System | Illness | Treatment/ Surgery |
|---|---|---|---|
| 1 | Eye | Cataract | Cataract Surgery |
| | | Glaucoma | Glaucoma Surgery |
| | | Refractive Error Correction | Correction Surgery |
| 2 | Ear Nose Throat | Sinusitis | Medical & Surgical Treatment |
| | | Rhinitis | Medical & Surgical Treatment |
| | | Tonsillitis & Adenitis | Medical & Surgical Treatment |
| | | Tympanitis & Non Traumatic Perforation | Medical & Surgical Treatment |
| | | Deviated Nasal Septum | Medical & Surgical Treatment |
| | | Otitis Media | Medical & Surgical Treatment |
| | | Adenoiditis | Medical & Surgical Treatment |
| | | Mastoiditis | Medical & Surgical Treatment |
| | | Cholesteatoma | Medical & Surgical Treatment |

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| | | | |
|---|---|---|---|
| 3 | Gynecology | All Cysts, Mass, Swelling, Lump, Granulomas, Polyps, Fibroids & Benign Tumour of the female genito urinary system | Medical & Surgical treatment |
| | | Polycystic Ovarian Disease | Medical & Surgical treatment |
| | | Uterine Prolapse | Medical & Surgical treatment |
| | | Fibroids (Fibromyoma) | Medical & Surgical treatment |
| | | Breast lumps (excluding Malignant) | Medical & Surgical treatment |
| | | Dysfunctional Uterine Bleeding (DUB) | Medical & Surgical treatment |
| | | Endometriosis | Medical & Surgical treatment |
| | | Menorrhagia | Medical & Surgical treatment |
| | | Pelvic Inflammatory Disease | Medical & Surgical treatment |
| 4 | Orthopedic / Rheumatological | Gout | Medical & Surgical treatment |
| | | Rheumatism, Rheumatoid Arthritis | Medical & Surgical treatment |
| | | Non infective arthritis | Medical & Surgical treatment |
| | | Osteoarthritis | Medical & Surgical treatment |
| | | Osteoporosis | Medical & Surgical treatment |
| | | Prolapse of the intervertebral disc | Medical & Surgical treatment |
| | | Spondilosis, Spondioarthritis, Spondylopathies | Medical & Surgical treatment |
| | | Ankylosing Spondilitis / Spondylopathies | Medical & Surgical treatment |
| | | Psoriatic Arthritis / Arthropathy | Medical & Surgical treatment |
| | | Internal Derangement of Knee / Ligament or Tendon or Meniscus Tear | Medical & Surgical treatment |
| | | Joint Replacement Surgery | Medical & Surgical treatment |
| | | Non Specific Arthritis | Medical & Surgical treatment |
| 5 | Gastroenterology (Alimentary Canal and related Organs) | Stone in Gall Bladder, Bile duct & other parts of Biliary System | Medical & Surgical treatment |
| | | Cholecystitis | Surgical treatment |
| | | Pancreatitis | Surgical treatment |
| | | Fissure, Fistula in ano, hemorrhoids (piles), Pilonidal Sinus, Ano-rectal & Perianal Abscess | Medical & Surgical treatment |
| | | Rectal Prolapse | Medical & Surgical treatment |
| | | Gastric or Duodenal Erosions or Ulcers, Gastritis, Duodenitis & Colitis | Medical & Surgical treatment |
| | | Gastro Esophageal Reflux Disease (GERD) | Medical & Surgical treatment |
| | | Cirrhosis | Medical & Surgical treatment |
| | | Chronic Appendicitis | Surgical treatment |
| | | Appendicular lump, Appendicular abscess | Medical & Surgical treatment |
| 6 | Urogenital (Urinary and Reproductive system | Stones in Urinary system (Stone in the Kidney, Ureter, Urinary Bladder) | Medical & Surgical treatment |
| | | Benign Hypertrophy / Enlargement of Prostate (BHP / BEP) | Medical & Surgical treatment |
| | | Hernia, Hydrocele | Medical & Surgical treatment |
| | | Varicocoele / Spermatocoele | Medical & Surgical treatment |
| 7 | Skin | Skin tumour (unless malignant) | Medical & Surgical treatment |
| | | All skin diseases | Medical & Surgical treatment |
| 8 | General Surgery | Any Swelling, Tumour, Cyst, Nodule, Ulcer, Polyp, Mass, Swelling, Lump, Granulomas, Benign Tumour anywhere in the body (unless malignant) | Medical & Surgical treatment |
| | | Varicose veins, Varicose ulcers | Medical & Surgical treatment |
| | | Internal Congenital Anomaly or internal congenital diseases | Medical & Surgical treatment |

If any of the Illness / Conditions listed above are Pre-Existing Diseases, then they will be covered only after the completion of the Pre-Existing Disease Waiting Period described below in section B.(H).vi.

**iv. Specified Disease / Procedure Waiting Period: (Code- Excl02)**
**(Not applicable for Section A.IV.32 and Section A.V.34 - (Personal Accident Cover (AD, PTD)), Section A.IV.33 and Section A.V.35 (Critical Illness Cover))**

(i) Expenses related to the treatment of the listed Conditions, Surgeries / Treatments shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first Policy with Us. This exclusion shall not be applicable for claims arising due to an accident.
(ii) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
(iii) If any of the Specified Disease / Procedure falls under the Waiting Period specified for Pre-Existing Diseases, then the longer of the two Waiting Periods shall apply.
(iv) The Waiting Period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
(v) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then Waiting Period for the same would be reduced to the extent of prior coverage.
(vi) List of Specific Diseases / Procedures:
1. Genetic disease and Disorders.

**v. Chronic Management Program Waiting Period**

(i) Where the Insured Person has under gone a Health Assessment™ and the results of the Health Assessment™ indicate that the Insured Person is suffering from a chronic condition, then a Waiting Period of 24 months shall be applicable from the Start Date of the Policy in respect of the Insured Person for Chronic Management Program. However, Hospitalization related to these conditions will be covered after a Waiting Period as specified in section B.(H).(i).
(ii) If the results of the Health Assessment™ indicate that the Insured Person does not have any of the aforementioned conditions, then the Insured Person will be entitled to avail the benefits under Chronic Management Program, if the Insured Person develops any such conditions later in life, without any applicability of the Waiting Period. However, Hospitalization related to these conditions will be covered after a Waiting Period as specified in section B.(H).(i).
(iii) Where the Insured Person has undergone a Pre-Policy medical examination and is found to be suffering from a covered chronic condition under the Policy, Chronic Management Program shall be available from day 1 for such condition(s). However, Hospitalization related to these conditions will be covered after a Waiting Period of 30 days.

**vi. Pre-Existing Diseases (Code- Excl01)**
**(Not applicable for Section A.IV.32 and Section A.V.34 - Personal Accident Cover (AD, PTD))**

(i) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of the number of months of continuous coverage after the date of inception of the first Policy with Us, as specified in the Policy Schedule / Product Benefit Table of this Policy.
(ii) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
(iii) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then Waiting Period for the same would be reduced to the extent of prior coverage.
(iv) Coverage under the Policy after the expiry of months specified in Policy schedule / Product Benefit Table of this Policy for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

**vii. Maternity Waiting Period**

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

**viii. Permanent Exclusions:**
**(Not applicable for Section A.IV.(32) and Section A.V.(34) - (Personal Accident Cover (AD, PTD)) , Section A.IV.(33) and Section A.V.(35) (Critical Illness Cover)**

1. Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, uprising, revolution, insurrection, military or usurped acts, nuclear weapons / materials, chemical and biological weapons, ionizing radiation, contamination by radioactive material or radiation of any kind, nuclear fuel, nuclear waste.
2. Breach of law: (Code- Excl10) - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
3. Willful or deliberate exposure to danger, intentional self Injury, participation or involvement in naval, military or air force operation.
4. Hazardous or Adventure sports: (Code- Excl09) - Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
5. Any Illness / Injury / Accident due to abuse of intoxicants, smoking cessation programs and the treatment of nicotine addiction, unless prescribed by a Medical Practitioner.
6. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code- Excl12)
7. Obesity / Weight Control (Code- Excl06)
   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   1) Surgery to be conducted is upon the advice of the Doctor.
   2) The surgery / Procedure conducted should be supported by clinical protocols.
   3) The member has to be 18 years of age or older and.
   4) Body Mass Index (BMI);
      a) Greater than or equal to 40 or;
      b) Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         i. Obesity-related cardiomyopathy.
         ii. Coronary heart disease.
         iii. Severe Sleep Apnea.
         iv. Uncontrolled Type2 Diabetes.
8. Refractive Error: (Code- Excl15) - Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
9. All routine examinations and preventive health check-ups.
10. Cosmetic or plastic Surgery: (Code- Excl08)
    Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of Medically Necessary Treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
11. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment).
12. Change-of-Gender treatments: (Code- Excl07)
    Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

13. Non allopathic treatment.
14. Conditions for which treatment could have been done on an outpatient basis without any Hospitalization.
15. Experimental, investigational or devices and pharmacological regimens.
16. Unproven Treatments: (Code- Excl16)
    Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
17. Investigation & Evaluation (Code- Excl04)
    a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
    b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
18. Rest Cure, rehabilitation and respite care (Code- Excl05)
    a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
        i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
        ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
19. Convalescence, cure, , sanatorium treatment, private duty nursing, , long-term nursing care or custodial care.
20. Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing.
21. Admission for nutritional and electrolyte supplements unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
22. Hearing aids, spectacles or contact lenses including optometric therapy, multifocal lens.
23. Treatment for alopecia, baldness, wigs, or toupees, and all treatment related to the same.
24. Medical supplies including elastic stockings, diabetic test strips, and similar products.
25. Any expenses incurred on prosthesis, corrective devices external durable medical equipment of any kind, like wheelchairs crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident. Cost of artificial limbs, crutches or any other external appliance and / or device used for diagnosis or treatment.
26. Parkinson and Alzheimer's disease, general debility or exhaustion ("rundown condition"), sleep-apnea, stress.
27. External Congenital Anamolies or diseases or defects.
28. Stem cell therapy (except Hematopoietic stem cells for bone marrow transplant for haematological conditions) or related Surgery, or growth hormone therapy.
29. Venereal disease, all sexually transmitted disease or Illness including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
30. Maternity Expenses (Code- Excl18):
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy.
    ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy period.
31. Sterility and Infertility: (Code- Excl17)
    Expenses related to sterility and infertility. This includes:
    i. Any type of contraception, sterilization.
    ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI.
    iii. Gestational Surrogacy.
    iv. Reversal of sterilization.
32. Expenses for organ donor screening, or save as and to the extent provided for in the treatment of the donor (including Surgery to remove organs from a donor in the case of transplant Surgery).
33. Admission for Organ Transplant but not compliant under the Transplantation of Human Organs Act, 1994 (amended).
34. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.
35. Dentures and artificial teeth, Dental Treatment and Surgery of any kind, unless requiring Hospitalization due to an Accident.
36. Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose.
37. Treatment for Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy, KTP Laser Surgeries, cyber knife treatment, Femto laser surgeries, bioabsorbable stents, bioabsorbable valves, bioabsorbable implants, use of Infliximab, rituximab, avastin, lucentis.
38. Expenses which are medically not necessary such as items of personal comfort and convenience including but not limited to television (if specifically charged), charges for access to telephone and telephone calls (if specifically charged), food stuffs (save for patient's diet), cosmetics, hygiene articles, body care products and bath additives, barber expenses, beauty service, guest service as well as similar incidental services and supplies, vitamins and tonics unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
39. Treatment taken from a person not falling within the scope of definition of Medical Practitioner with any state medical council / medical council of India.
40. Treatment charges or fees charged by any Medical Practitioner acting outside the scope of license or registration granted to him by any medical council.
41. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, except if pre-approved by Us.
42. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.
43. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure (Code- Excl14).
44. Administrative Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing, including MRD charges (medical records department charges).
45. Non-Medical Expenses including but not limited to RMO charges, surcharges, night charges, service charges levied by the Hospital under any head and as specified in the Annexure I for Non-Medical Expenses.
46. Treatment taken outside India except for the Benefit B.IV.(31) and B.V.(36).
47. Use of Radio Frequency (RF) probe for ablation or other procedure unless specifically approved by Us in writing in advance.
48. Excluded Providers: (Code- Excl11)
    Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer as disclosed in website (https://www.adityabirlacapital.com/healthinsurance) / notified to the Policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
49. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons (Code- Excl13).

50. In respect of the Existing Diseases, disclosed by the Insured Person and mentioned in the Policy Schedule (based on Insured Person's consent), Policyholder is not entitled to get the coverage for specified ICD codes.

Additional exclusion for Section A.IV.(31) and A.V.(36) (International Coverage for Major Illnesses)

1. Any treatment taken inside India.

**ix. Permanent Exclusions specific to Section A.IV.(32) & Section A.V.(34) (Personal Accident Cover (AD, PTD)**

We shall not be liable to make any payment for any claim under any Benefit under Section Section B.IV.(32) & Section B.V.(34) in respect of any Insured Person, directly or indirectly for, caused by or arising from or in any way attributable to any of the following or as specified in the Policy Schedule:

1. Any Pre-Existing Disease or Injury or disability arising out of a Pre-Existing Disease or any complication arising therefrom.
2. Any payment in case of more than one claim under the Policy during any one Policy Period by which Our total, cumulative and maximum liability in that period would exceed the Sum Insured.
3. Suicide or attempted suicide, intentional self-inflicted Injury, acts of self-destruction whether the Insured Person is medically sane or insane.
4. Mental Illness or sickness or disease including a psychiatric condition, mental disorders of or disturbances of consciousness, strokes, fits or convulsions which affect the entire body and pathological disturbances caused by mental reaction to the same.
5. Certification by a Medical Practitioner who shares the same residence as the Insured Person or who is a member of the Insured Person's family.
6. Any event arising out of or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), participation in any naval, military or air-force operation, civil war, public defence, rebellion, revolution, insurrection, military or usurped power.
7. Any event directly or indirectly caused by or associated with any venereal disease or sexually transmitted disease.
8. External Congenital Anomaly, diseases, defects in consequence thereof.
9. Bacterial infections (except pyogenic infection which occurs through a cut or wound due to Accident).
10. Medical or Surgical Procedure except as necessarily required, solely and directly as a result of an Accident.
11. Any event directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) and its variants or mutants,.
12. Any change of profession after Start Date which results in the enhancement of Our risk under the Policy, if not accepted and endorsed by Us on the Policy Schedule.
13. Any event arising out of or resulting from the Insured Person committing any breach of law or participating in an actual or attempted felony, riot, crime, misdemeanour or civil commotion with criminal intent.
14. Any event arising from or caused due to use, abuse or a consequence or influence of abuse of any substance, intoxicant, drug, alcohol or hallucinogen.
15. Any event resulting directly or indirectly, contributed or aggravated or prolonged by childbirth or from pregnancy or a consequence thereof including ectopic pregnancy unless specifically arising due to an Accident.
16. Any event caused by participation of the Insured Person in any flying activity, except as a bona fide, fare-paying passenger of a recognized civil airline on regular routes and on a scheduled timetable.
17. Engaging in a speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports in so far as they involve the training for or participation in competitions or professional sports.
18. Involvement in naval, military or air force operations.
19. Working in underground mines, tunnelling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in Hazardous Activities.
20. Any event arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack:
    a) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
    b) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) microorganisms and / or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.
21. Any condition arising from Hernia.
22. Any Injury and / or accidental death due to insect bite.
23. Any expenses (other than as mentioned therein) specified in List of Non-Medical Expenses as set out in Annexure I and as also provided on Our website adityabirlahealth.com/healthinsurance.

**x. Permanent Exclusions - Specific to Critical Illness Cover Section A.IV.(33) and Section A.V.(35), if opted.**

We shall not be liable to make any payment under Section B.IV.(33) and Section B.V.(35), of this Policy towards a covered Critical Illness, directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following or as specified in the Policy Schedule:

1. Any Illness, sickness or disease other than those specified as Critical Illnesses under this Policy.
2. Any condition directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) and its variants or mutants.
3. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilus, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
4. Any Illness / Injury / Accident due to the abuse of intoxicant.
5. Narcotics used by the Insured Person unless taken as prescribed by a Medical Practitioner.
6. Any condition directly or indirectly caused due to intentional self-Injury, suicide or attempted suicide; whether the Insured Person is medically sane or insane.
7. Any condition directly or indirectly, caused by or arising from or attributable to a foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
8. Any condition caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.
9. Working in underground mines, tunneling or involving electrical installations with high tension supply, or as jockeys or circus personnel.
10. External Congenital Anamolies or diseases or defects.
11. Hazardous or Adventure sports: (Code- Excl09) - Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

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12. Any Critical Illness based on certification / diagnosis / treatment from persons not registered as Medical Practitioners, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for or is not Medically Necessary Treatment or any kind of self-medication and its complications.
13. Unproven Treatments: Code- Excl16
    Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
14. Cosmetic or plastic Surgery: (Code- Excl08)
    Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
15. Change-of-Gender treatments: (Code- Excl07)
    Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
16. Obesity/ Weight Control (Code- Excl06)
    Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
    1) Surgery to be conducted is upon the advice of the Doctor.
    2) The surgery/Procedure conducted should be supported by clinical protocols.
    3) The member has to be 18 years of age or older and;
    4) Body Mass Index (BMI).
        a) Greater than or equal to 40 or;
        b) Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
    5) Obesity-related cardiomyopathy.
    6) Coronary heart disease.
    7) Severe Sleep Apnea.
    8) Uncontrolled Type2 Diabetes.
17. Breach of law: (Code- Excl10) - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
18. In the event of the death of the Insured Person within the stipulated survival period as set out above.
19. Hormone replacement therapy.

**I. 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

**J. 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

**K. 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;
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

**L. 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.

   Provided that in case there is a request for Refund where claim has been made only under Health Assessment™ and / or Health Check-up Program, We shall process the refund in accordance with the grid below provided and after deduction of the charges for the claims made under the Sections referred hereinabove.

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| | Refund | | |
|---|---|---|---|
| In force Period-Up to | 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.

4. Treatment of HealthReturns™ on Cancellation
   All coverage, benefits, earning on HealthReturns™, shall automatically lapse upon cancellation of the Policy. However, any unclaimed and accrued HealthReturns™ (from Previous Policy Year / month) shall be available for a claim over the next 3 month period from the date of cancellation / termination.

**M. 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.

**N. 1. 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.

**2. Other Renewal Terms**

(i) We shall not be liable for any claim arising out of an ailment suffered or Hospitalization commencing or Disease / Illness / Condition contracted during the period between the expiry of previous Policy and date of inception of subsequent Policy and such Disease / Illness / Condition shall be treated as a Pre-Existing Disease.
(ii) Any unutilised funds under HealthReturns™ (from the previous Policy Year / month) will be available for claims during the Grace Period.
(iii) You shall not be able to earn HealthReturns™ during the Grace Period.
(iv) In case the Policy is not renewed before the end of the Grace Period, any unutilized funds under HealthReturns™ shall be available for a claim as up to a period of 12 months from the date of expiry of the Policy.
(v) If the Insured Persons in the expiring Policy are covered in an Individual Policy, and such expiring Policy has been Renewed with Us on a Family Floater Policy basis then the accumulated amount under HealthReturns™ that will be carried forward in such Renewed Policy shall be the total of all the Insured Persons moving out and shall be maintained on an Individual Policy basis.
(vi) If the Insured Persons in the expiring Policy are in a Family Floater Policy and such Insured Persons renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater Policy / Individual Policies then the accumulated amount under HealthReturns™ shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
(vii) You shall disclose to Us in writing of any chronic condition acquired by any Insured Person at the time of seeking Renewal of this Policy or during the Policy tenure, irrespective of any claim arising or made. If an Insured Person is found to be suffering from a covered chronic condition post any Waiting Period (if applicable), then We shall manage such conditions under Chronic Management Program as per the terms and conditions laid out under Section A.III.(27).
(viii) Alterations like Increase / Decrease in Sum Insured or Change in Plan / Product, Addition / Deletion of Insured Persons (except due to child Birth / Marriage or Death) will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the Proposal Form before the expiry of the Policy. We reserve Our right to carry out underwriting in relation to acceptance of request for changes on Renewal. The terms and conditions of the existing Policy will not be altered.

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(ix) Any enhanced Sum Insured during any Policy Renewals will not be available for an Illness, Disease, Injury already contracted under the preceding Policy Periods. All Waiting Periods as mentioned below shall apply afresh for this enhanced limit from the effective date of such enhancement.
(x) Wherever the Sum Insured is reduced on any Policy Renewals, the Waiting Periods as mentioned in the Policy Schedule shall be waived only up to the lowest Sum Insured as applicable to the relevant Waiting Periods of the Plan in force.
(xi) Where an Insured Person is added to this Policy, either by way of endorsement, all Waiting Periods under Section B.(H). will be applicable considering such Policy Year as the first year of Policy with Us with respect to the Insured Person.
(xii) Applicable Cumulative Bonus shall be accrued on each Renewal as per eligibility under the plan in force.
(xiii) In case of Family Floater Policies, Dependent Child attaining 25 years of Age at the time of Renewal will be moved out of the floater into an individual Policy. However, all continuity benefits for such Insured Person on the Policy will remain intact. Cumulative Bonus earned on the Policy will stay with the Insured Persons(s) covered under the original Policy.

**3. 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.

**4. Possibility of Revision of Terms of the Policy Including the 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.

## O. Claims Administration & Process

**i. Claims Procedure for Sections other than Personal Accident, Critical Illness and International Coverage for Major Illnesses**

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

**a. For Availing Cashless Facility**

(i) Cashless Facilities can be availed only at Our Network Providers. The complete list of Network Providers is available on Our website and at Our branches and can also be obtained by contacting Us over the telephone.
(ii) We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities at Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers.

**b. Process for Obtaining Pre-Authorisation for Planned Treatment:**

(i) We must be contacted to pre-authorise Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Each request for pre-authorisation must be accompanied with all the following details:
(1) The health card We have issued to the Insured Person supported with the Insured Person's KYC documents.
(2) The Policy Number.
(3) Name of the Policyholder.
(4) Name and address of Insured Person in respect of whom the request is being made.
(5) Nature of the Illness / Injury and the Treatment / Surgery required.
(6) Name and address of the attending Medical Practitioner.
(7) Hospital where Treatment / Surgery is proposed to be taken.
(8) Proposed date of admission.

(ii) If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.
(iii) When we have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim, applicable Deductibles and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.
(iv) The Authorization letter shall be issued to the Network Provider within 24 hours of receiving the complete information.

**c. Process to be followed for Availing Cashless Facilities in Emergencies:**

(i) We must be contacted to pre-authorise Cashless Facility within 24 hours of the Insured Person's Hospitalization if the Insured Person has been Hospitalized in an Emergency. Each request for pre-authorisation must be accompanied with all the following details:
(1) The health card We have issued to the Insured Person supported with the Insured Person's KYC documents.
(2) The Policy Number.
(3) Name of the Policyholder.
(4) Name and address of Insured Person in respect of whom the request is being made.
(5) Nature of the Illness / Injury and the Treatment / Surgery required.
(6) Name and address of the attending Medical Practitioner.
(7) Hospital where Treatment / Surgery is proposed to be taken.
(8) Proposed date of admission.

(ii) If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.
(iii) When we have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim, applicable Deductibles and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.
(iv) Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, Hospital and locations, match with the details of the actual treatment received. For Hospitalization where Cashless Facility is pre-authorised by Us, We will make the payment of the amounts assessed to be due directly to the Network Provider.
(v) The Authorization letter shall be issued to the Network Provider within 24 hours of receiving the complete information.

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**d. For Reimbursement Claims:**

(i) For all claims for which Cashless Facilities have not been pre-authorised or for which treatment has not been taken at a Network Provider, We shall be given written notice of the claim along with the following details within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier:
(1) The Policy Number.
(2) Name of the Policyholder.
(3) Name and address of the Insured Person in respect of whom the request is being made.
(4) Health Card, Photo ID, KYC documents.
(5) Nature of Illness or Injury and the Treatment / Surgery taken.
(6) Name and address of the attending Medical Practitioner.
(7) Hospital where Treatment / Surgery was taken.
(8) Date of admission and date of discharge.
(9) Any other information that may be relevant to the Illness / Injury / Hospitalization.

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

**II. Claim Procedure for Personal Accident Cover (AD, PTD), Critical Illness Cover / Premium waiver.**

**a. Intimation of Claim**

You or anyone on behalf of the Insured Person(s) shall intimate a claim to Us within 7 days from the date of the Accident or diagnosis of the Critical Illness or admission in the Hospital (as the case may be) by any of the following means.

- Call centre.
- Email.
- Fax.
- Writing to Our office address.

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.

**III. Claims Procedure for - International Coverage for Major Illnesses**

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

**a. For Availing Cashless Facility**

i. Cashless Facility can be availed only at Our Network Providers / Empaneled Service Providers.
ii. We reserve the right to modify, add or restrict any Network Provider / Empaneled Service Provider for Cashless Facilities at Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers and Empaneled Service Providers on Our website.

**b. Process for Obtaining Pre-Authorisation for Planned Treatment:**

i. We / Empaneled Service Provider must be contacted to pre-authorise Cashless Facility for planned treatment at the earliest possible prior to the proposed treatment. Each request for pre-authorisation must be accompanied with all the following details:
1) The health card issued by Us to the Insured Person, along with the Insured Person's KYC documents.
2) The Policy Number.
3) Name of the Policyholder.
4) Name and address of Insured Person in respect of whom the request is being made.
5) Nature of the Illness / Injury and the Treatment / Surgery required.
6) Name and address of the attending Medical Practitioner.
7) The Insured Person on diagnosis of Major Illness should share the following for e-opinion.
(i) First consultation paper from treating medical practitioner in India.
(ii) Final Diagnosis paper.
(iii) Treating doctor certification on final diagnosis.
(iv) All investigation reports supporting documents.
(v) Consent Form to collect documents from various source.
(vi) Any other relevant documents to ascertain eligibility of claim.
8) On the basis of the Insured Person's medical condition, We / Our Empaneled Service Provider will identify 3 Hospitals from Our Network.
9) The Insured Person may choose one of the Hospitals / treatment centres out of the 3 choices given by Us / Our Empaneled Service Provider.
10) Medical Reports and all other information is shared with the chosen Hospital / clinic.
11) After the receipt of all medical information, a detailed Medical Opinion from the selected Hospital / Treatment center would be delivered to You at the earliest.
12) Insured Person must notify Us of the willingness to take the treatment abroad and the country of choice.
13) On receipt of the Insured Person's confirmation of his / her decision to receive treatment abroad at the selected country for treatment, We / Our Empaneled Service Provider will identify 3 Hospitals from our Network.
14) You may choose one of the Hospitals / Treatment Centres out of the 3 Choices given by Us / Our Empaneled Service Provider or You may choose from a fourth option from Our / Empaneled Service Provider's network Hospitals.
15) We will organize the necessary logistical, travel, accommodation and medical arrangements for the correct admission of the Insured Person and will issue a Preliminary Medical Certificate valid only for that Hospital.
16) We will provide coverage only in the indicated Hospital in the Preliminary Medical Certificate. Any expense incurred in a different Hospital from the one specified in the Preliminary Medical Certificate will not be covered.
17) Any expense incurred before the issuance of the Preliminary Medical Certificate will not be covered.
18) The list of recommended Hospitals and the Preliminary Medical Certificate are issued on the basis of the medical condition of the Insured Person at the time of issue of Preliminary Medical Certificate. Since the health condition of the Insured Person may change over time, both documents will have a validity of three months.
19) In the event that the Insured Person does not select a Hospital from the list of recommended Hospital or does not initiate treatment within 3 months of issuance of Preliminary Medical Certificate within 3 months of issue, We on the request of customer shall reinitiate the process of Pre-Authorisation for planned treatment based on the health condition of the Insured Person at that time.

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20) Reimbursement of expenses is not available under (In-patient Hospitalization (outside India), (Organ Donor), Travel Expenses, (Accommodation Expenses) under section B.IV.31 and B.V.36, as this benefit is meant to cover planned treatment outside India and does not cover Emergencies occurring while the Insured Person is overseas or within India.

ii. If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.
iii. When we have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.
iv. The authorization letter shall be issued to the Network Provider within 24 hours of receiving the complete information.

**c. For Reimbursement Claims:**

i. For all claims under benefit Post-hospitalization Medical Expenses and Repatriation of mortal remains of Section B.IV.31 and B.V.36 for which pre-authorization under Cashless Facility has not been accepted or for which treatment has not been taken at a Network Provider, We shall be given written notice of the claim along with the following details within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier:
(1) The Policy Number.
(2) Name of the Policyholder.
(3) Name and address of the Insured Person in respect of whom the request is being made.
(4) Health Card, Photo ID, KYC documents.
(5) Nature of Illness or Injury and the Treatment / Surgery taken.
(6) Name and address of the attending Medical Practitioner.
(7) Hospital where Treatment / Surgery was taken.
(8) Date of admission and date of discharge.
(9) Any other information that may be relevant to the Illness / Injury / Hospitalization.

ii. If the claim is not notified to Us within the earlier of 72 hours of the Insured Person's admission to the Hospital or within 72 hours of the Insured Person's discharge from the Hospital, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

**Claim Documents:**
**The claims documents as specified in the Policy 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.

Other documents may also be required as per the Benefits opted and claimed for under the Policy.

**P. 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.

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

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

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

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

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

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://igms.irda.gov.in/

**Statutory Warning - Prohibition of Rebates**

**(Under Section 41 of Insurance Act 1938)**

1) No person shall allow or offer to allow, either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property, in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the Insurer.
2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Annexures to Prospectus:

- Annexure A: Product Benefit Table
- Annexure B: Rate Chart
- Annexure I: List of Non-Medical Expenses
- Annexure II: Day Care Treatment List

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**Aditya Birla Health Insurance Co. Limited. IRDAI Reg.153. CIN No. U66000MH2015PLC263677.**
Product Name: Activ Health, Product UIN: ADIHLIP21574V032021.
Address: 9th Floor, Tower 1, One World Centre, Jupiter Mills Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai 400013. Email: care.healthinsurance@adityabirlacapital.com, Website: adityabirlahealthinsurance.com, Telephone: 1800 270 7000. Trademark/Logo Aditya Birla Capital is owned by Aditya Birla Management Corporation Private Limited and Trademark/logo HealthReturns, Healthy Heart Score and Active Dayz 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).