Activ Assure - Prospectus

Coverage under the Product:

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Section I: Basic Covers:

Benefits under this Section B.I are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and/or the sub-limit for each Benefit under Section 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/applicable sub-limit for that Benefit.

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.

All claims must be made in accordance with the procedure set out in Section C(C). Claims paid under this Section will impact the Sum Insured and eligibility for No Claim Bonus and Super NCB.

(a) 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:

(1) 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;
(2) ICU Charges;
(3) Operation theatre expenses;
(4) Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
(5) Qualified Nurses charges;
(6) Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
(7) Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized;
(8) Anaesthesia, blood, oxygen and blood transfusion charges;
(9) Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Conditions

1) The Hospitalization is medically necessary and follows the written advice of a Medical Practitioner.
2) 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 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 Section "Associated Medical Expenses" shall include - Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioner/surgeon/ anaesthetist/ specialist and diagnostic tests conducted within the same Hospital where the Insured Person has been admitted.
3) If the Insured Person is admitted in an ICU category/limit that is higher or where the charges are higher than those specified in the Policy Schedule / Product Benefit Table of this Policy, then the Insured Person shall bear a rateable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the ICU Charges of the entitled category to the ICU Charges actually incurred, for the period of ICU stay. For the purpose of this Section "Associated Medical Expenses" shall include – ICU Charges, nursing charges, operation theatre charges, fees of Medical Practitioner/surgeon/ anaesthetist/ specialist and diagnostic tests conducted within the same Hospital where the Insured Person has been admitted.
4) If specifically mentioned in the Policy Schedule/Product Benefit Table of this Policy that the room type is "Single Private A/C Room (upgradable to next level, only if Single Private A/C Room is not available)" it means that such upgrade will trigger only if Single Private A/C Room is not available in the Hospital at the time of admission and Our liability will arise only after accepting required documentary proof for such room unavailability. In case such documentary proof is not furnished, then the maximum eligibility room category would be considered as Single Private A/C Room.
   Example: Mr. A (Having Activ Assure policy with a Sum Insured of 20 Lacs) met with a medical emergency and was taken to a hospital. At the time of admission to the Hospital a Single Private Room was not available. Hence Mr. A took a room category of next level upgrade above Single Private Room. Mr. A provides a documentary proof that a single private room was not available at the time of admission, hence as per eligibility of the policy, Mr. A chose a one level upgrade room above Single Private Room. In this case Mr. A's Hospitalization claim shall be adjudicated as per the room rent of one level upgrade room instead of room rent of Single Private Room.
5) In case of a planned Hospitalization, the Insured Person shall be eligible for "Single Private A/C Room (upgradable to next level, only if Single Private A/C Room is not available)" as mentioned in the Policy Schedule/Product Benefit Table of this Policy, only if We have been informed at least 2 days in advance of the admission date.

(b) 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 limit as 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 I (a) or Section I (d) or Section I (e) 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.

(c) Post – hospitalization Medical Expenses:

What is covered

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

Conditions

(i) We have accepted a claim for In-patient Hospitalization under Section I (a) or Section I (d) or Section I (e) below 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.

(d) 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 such Day Care Treatment is mentioned in Annexure D.

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

OPD treatment is not covered under this Benefit.

(e) Domiciliary Hospitalization (Home Care):

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 shall 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;

What is not covered

We shall not be liable to pay for any claim in connection with:

(1) Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
(2) Arthritis, gout and rheumatism;
(3) Chronic nephritis and nephritic syndrome;
(4) Diarrhea and all type of dysenteries, including gastroenteritis;
(5) Diabetes mellitus and insipidus;
(6) Epilepsy;
(7) Hypertension;
(8) Psychiatric or psychosomatic disorders of all kinds;
(9) Pyrexia of unknown origin.

(f) 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 medical Emergency occurs during the Policy Period.

Coverage shall also be provided under the below circumstances, if the Medical Practitioner certifies in writing that:

(i) We have accepted a claim for In-patient Hospitalization under Section B(I)(a) above for the same Illness/ Injury;
(ii) 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.
(iii) 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 registered;
(ii) We have accepted a claim for In-patient Hospitalization under Section B(I)(a) above;

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.

(g) 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 in respect of the organ donor, for organ transplant Surgery towards the harvesting of the organ donated.

Conditions

(i) The 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;

What is not covered

(1) Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
(2) Screening expenses of the organ donor.
(3) Any other Medical Expenses as a result of the harvesting from the organ donor.
(4) Costs directly or indirectly associated with the acquisition of the donor's organ.
(5) Transplant of any organ/tissue where the transplant is experimental or investigational.
(6) Expenses related to organ transportation or preservation.
(7) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

(h) 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 Accidental Hospitalization Booster (if any)/Cancer Hospitalization Booster (if any), accumulated No Claim Bonus (if any), Super NCB (if any) is insufficient 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 I (a) or Day Care Treatment under Section I (d).
(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 I (a) and Section I (d)
(v) The reloaded Sum Insured shall not be considered while calculating the No Claim Bonus or the Super NCB.
(vi) In case of an Individual Policy, reload 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.
(ix) During a Policy Year, any single claim amount payable, subject to admissibility of claim, shall not exceed the sum of:
  (1) The Sum Insured; and
  (2) Accidental Hospitalization Booster/Cancer Hospitalization Booster (if opted as specified in the Policy Schedule); and
  (3) No Claim Bonus (if earned); and
  (4) Super NCB (if opted as specified in the Policy Schedule).
(x) During a Policy Year, the aggregate of all claims amount payable, subject to admissibility of the claim, shall not exceed the sum of:
  (1) The Sum Insured; and
  (2) Accidental Hospitalization Booster/Cancer Hospitalization Booster (if opted as specified in the Policy Schedule); and
  (3) No Claim Bonus; and Super NCB (if opted and as specified in the Policy Schedule); and
  (4) The reloaded Sum Insured; and
  (5) Unlimited Reload of Sum Insured; and
  (6) HealthReturns™.

(i) Ayush (In-patient Hospitalization)

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.

Conditions

(i) The treatment has been undergone in
  a. Teaching hospitals of AYUSH colleges recognised by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH)
  b. Any government Hospital or in any institute recognized by the government and/or accredited by the Quality Council of India or National Accreditation Board on Health.
  c. AYUSH Hospitals having registration with a Government authority under appropriate Act in the State/UT and complies with the following as minimum criteria:
    i. has at least fifteen in-patient beds
    ii. has minimum five qualified and registered AYUSH doctors;
    iii. has qualified paramedical staff under its employment round the clock;
    iv. has dedicated AYUSH therapy sections;
    v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel
(ii) Medical treatment should be rendered by a registered Medical Practitioner who holds a valid practicing license in respect of such Ayush Treatment(s); and
(iii) Treatment taken is within India; and
(iv) Permanent Exclusion mentioned in Section J (iv)10 does not apply to this Benefit

What is not covered

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

(j) Daily Allowance

We shall pay a fixed amount as specified in the Policy Schedule / Product Benefit Table of this Policy, for each continuous and completed period of 24 hours of Hospitalization of the Insured Person.

Conditions

We shall not be liable to make a payment under this benefit for more than 5 consecutive days of Hospitalization for every period of Hospitalization. We have accepted a claim for In-patient Hospitalization under Section I (a) above for the same Illness/ Injury.

(k) Vaccination Cover:

What is covered

We shall cover the Insured Person up to the limit as specified in the Policy Schedule / Product Benefit Table of this Policy, towards vaccination expenses for the Insured Person up to 18 years of Age, for protection against Diphtheria, pertussis, Tetanus, Polio, Measles, Hepatitis B and Tuberculosis, which fall under category of vaccine preventable diseases as per the grid provided below.

S.No	Vaccination & its presentation	Protection Against
1.	BCG (Bacillus Calmette Guerin)-Lyophilized vaccine	Tuberculosis
2.	OPV (Oral Polio Vaccine)-Liquid Vaccine	Poliomyelitis
3.	Hepatitis B - Liquid Vaccine	Hepatitis B
4.	DPT (Diphtheria, Pertussis and Tetanus Toxoid)-Liquid Vaccine	Diphtheria, Pertussis and Tetanus
5.	Measles-Lyophilized vaccine	Measles
6.	TT (Tetanus Toxoid) - Liquid Vaccine	Tetanus
7.	JE Vaccination - Lyophilized vaccine	Japanese Encephalitis (Brain Fever)
8.	Hib (Given as pentavalent containing Hib+DPT+Hep B)-Liquid Vaccine	Hib, Pneumonia and Hib meningitis

Section II: Additional Benefits

The Benefits listed below are in-built additional Policy benefits and shall be available with applicable 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 are subject to the terms, conditions and exclusions of this Policy.

Claims under this Section will not impact the Sum Insured or the eligibility for No Claim Bonus and Super NCB.

(l) No Claim 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 I in the Policy Schedule on a cumulative basis, provided that the Insured Person(s) has not made any claim under Section I in a Policy Year and has successfully Renewed the Policy with Us continuously and without any break. The accumulated No Claim Bonus shall not exceed 50% of the Sum Insured on the Renewed Policy. In the event of a claim impacting the eligibility of a No Claim Bonus, the accumulated No Claim Bonus shall be reduced by 10% of the Sum Insured at the commencement of subsequent Policy Year.

Conditions

(i) If the Policy is a Family Floater Policy, then No Claim Bonus will accrue only if no claims have been made in respect of all Insured Person(s) in the expiring Policy Year. No Claim Bonus which is accrued during the claim free Policy Year will only be available to those Insured Persons who were insured in such claim free Policy Year and continue to be Insured Persons in the subsequent Policy Year.
(ii) No Claim Bonus shall be not be applied if the Policy is not Renewed with Us by the end of the Grace Period.
(iii) If the Policy Period is two or three years, No Claim 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 claims made in the subsequent Policy Year.
(iv) The accumulated No Claim Bonus can be utilised for benefits covered under Section I.
(v) The accumulated No Claim Bonus can be utilised only when Sum Insured, Accidental Hospitalization Booster (if opted and as specified in the Policy Schedule)/ Cancer Hospitalization Booster (if opted and as specified in the Policy Schedule) have been completely exhausted.
(vi) The No Claim 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.
(vii) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated No Claim 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 No Claim Bonus to be carried forward for credit in such Renewed Policy shall be the lowest among all the Insured Persons.
(viii) 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 No Claim Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
(ix) If the Sum Insured has been reduced at the time of Renewal, the applicable No Claim Bonus shall be reduced in the same proportion to the Sum Insured.
(x) If the Sum Insured under the Policy has been increased at the time of Renewal the No Claim Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
(xi) The No Claim 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 No Claim Bonus shall be withdrawn only in respect of the expiring Policy Year in which the claim was admitted.
(xii) In case of Family Floater Policies, 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. No Claim Bonus earned on the Policy will stay with the Insured Person(s) covered under the original Policy.

(m) Health Check-up Program

What is covered

All Insured Persons in the Policy may avail a comprehensive health check-up once in a Policy Year in accordance with the table below: 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
CBC with ESR, Urine routine, Blood Group, Fasting Blood Sugar, Serum Cholesterol, SGPT, Serum Creatinine, ECG	Up to 4 Lacs
CBC with ESR, Urine routine, Blood Group, Fasting Blood Sugar, Lipid Profile, Kidney Function Test, ECG	5 Lacs -10 Lacs
CBC with ESR, Urine routine, Blood Group, Fasting 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
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

Medical tests covered in the Health Check-up Program, for Insured Persons who are aged less than 18 years on the Start date are as follows.

List of Tests - During Annual Health Check up	Sum Insured
Physical examination (Height, weight and BMI). Eye examination, Dental Examination and scoring, Growth Charting, Dr Consultation, Urine Examination (Routine and microscopic)	All Sum Insured

Reference

MER - Medical Examiner's Report stamped and signed by a Medical Practitioner who is an MD physician,
BMI - Body Mass Index,
HWR – Hip waist ratio
CBC - Complete Blood Count,
ESR – Erythrocyte sedimentation rate
ECG – Electrocardiogram,
S.Creat - Serum Creatinine,
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 shall be eligible to avail a health check-up every Policy Year.
(iv) Section J (iv) (Permanent Exclusion 7), is not applicable in respect of coverage under this Benefit.
(v) 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 / Empanelled Service Providers in relation to the health check-up.

(n) Second E-Opinion on Critical Illnesses

What is covered

If an Insured Person is diagnosed with any of the following listed Critical Illness during the Policy Period, the Insured Person may at his/her sole discretion choose to avail a E-opinion from Our panel of Medical Practitioners.
For the purpose of this Benefit, Critical Illness shall mean the following:

1. CANCER OF SPECIFIED SEVERITY

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

2. MYOCARDIAL INFARCTION (First Heart Attack of specified severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
II. The following are excluded:
i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN CHEST CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
II. The following are excluded:
i. Angioplasty and/or any other intra-arterial procedures

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or 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. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i. no response to external stimuli continuously for at least 96 hours;
   ii. life support measures are necessary to sustain life; and
   iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

7. STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:
   i. Transient ischemic attacks (TIA)
   ii. Traumatic injury of the brain
   iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. MAJOR ORGAN/BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:
   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:
   i. Other stem-cell transplants
   ii. Where only islets of langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

10. MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS

I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

12. THIRD DEGREE BURNS

I. 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.

13. BLINDNESS

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

II. The Blindness is evidenced by
   i. corrected visual acuity being 3/60 or less in both eyes or;
   ii. the field of vision being less than 10 degrees in both eyes.

III. The diagnosis of blindness must be confirmed and must not be correctable by aides or surgical procedure.

14. BENIGN BRAIN TUMOR

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant specialist Medical Practitioner.
   i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
   ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded:
Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

15. END STAGE LUNG FAILURE

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
iii. Arterial blood gas analysis with partial oxygen pressures of 55mmHg or less (PaO2 <55 mmHg); and
iv. Dyspnea at rest.

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 Medical Practitioner and is subject to the conditions specified below:

(i) This Benefit can be availed by the Insured Person only once in the Policy Period for the same Critical Illness.
(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 then whether or not to act on it.
(iii) Appointments to avail of this 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 Benefit, We are only providing the Insured Person with access to an E-opinion and We shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.
(v) The E-opinion provided under this Benefit shall be limited to the covered Critical Illnesses and not be 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.

(o) 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.

(1) Emergency Medical Evacuation: When an adequate medical facility is not available in the proximity of the Insured Person, as determined by the Emergency service provider, 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.
(2) 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:

(1) Travel undertaken specifically for securing medical treatment.
(2) Injuries resulting from participation in acts of war or insurrection.
(3) Commission of an unlawful act(s).
(4) Attempt at suicide.
(5) Incidents involving the use of drugs unless prescribed by a Medical Practitioner.
(6) Transfer of the Insured Person from one medical facility to another medical facility of similar capabilities which provides a similar level of care.

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

(1) Without medical authorization.
(2) 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.
(3) 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.
(4) With mental or nervous disorders unless Hospitalized.

(p) 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.

(1) Emergency Medical Evacuation: When an adequate medical facility is not available in the proximity of the Insured Person, as determined by the Emergency service provider, 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.
(2) 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:
(1) Travel undertaken specifically for securing medical treatment.
(2) Injuries resulting from participation in acts of war or insurrection.
(3) Commission of an unlawful act(s).
(4) Attempt at suicide.
(5) Incidents involving the use of drugs unless prescribed by a Medical Practitioner.
(6) Transfer of the Insured Person from one medical facility to another medical facility of similar capabilities which provides a similar level of care.
(7) Trips exceeding 90 days from residential address without prior notification to Us.

We will not evacuate or repatriate an Insured Person in the following instances:
(1) Without medical authorization.
(2) 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.
(3) 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.
(4) With mental or nervous disorders unless Hospitalized.

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 are subject to the terms, conditions and exclusions of this Policy.

Claims under this Section III will not impact the Sum Insured or the eligibility for No Claim Bonus and Super NCB.

(q) HealthReturns™

(q.1) HealthReturns™
How to Earn HealthReturns™
Earned by way of a percentage of Premium through Healthy Heart Score™ and Active Dayz™
An Insured Person can earn HealthReturns™ by looking after his/her health and being physically active on a regular basis.

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. This is not mandatory to earn HealthReturns™.
(ii) Undergo a Health Assessment™ that 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.

Health Assessment™ can be undertaken at Our Network Providers / Empanelled Service Providers. An appointment for the medical examination can be scheduled at a time convenient to the Insured Person by calling Our call centre.

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 to the Network Providers / Empanelled Service Providers.

Conditions

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

Step 2 – 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 centers, OR;
(2) Recording 10,000 steps in a day (tracked through Our mobile application or a wearable device linked to the Policy number) OR;
(3) burning 300 calories 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 body fat percentage. 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 four activities under point (ii) or 'Fitness Assessment' under point (iii).
The Insured Person shall 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.

No of Active Dayz™ in a calendar month	OR	Fitness Assessment Result*	Healthy Heart Score™		
			Red	Amber	Green
13+		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 HealthReturns™ 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 to 30% of their Monthly Premium as HealthReturns™ based on the grid above.

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. Weightages for allowed family combinations are as described in the table below.
(Dependent Children upto 25 years of Age shall not eligible for HealthReturns™).

Family size	Weightage
Self , Spouse and Dependent Children (upto 25 yrs)	1:1:0:0
Self and Spouse	1:1

Earned HealthReturns™ can be utilized by any covered Insured Person under a Policy.
How can one spend HealthReturns™:
Funds under HealthReturns™ may be utilized for:
(i) In-patient Medical Expenses and Day Care Treatment, provided that the Sum Insured, No Claim Bonus(if any), Super NCB(if any), Accidental Hospitalization Booster(if opted as specified in the Policy Schedule)/ Cancer Hospitalization Booster (if opted as specified in the Policy Schedule), Reloaded Sum Insured (if any) and Unlimited Reload of Sum Insured (if opted and available) are exhausted during the Policy Year as specified in section C(Y).
(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 listed in Annexure B '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.

Alternatively, funds can also be utilized to pay Renewal Premium. Funds earned as HealthReturns™, once earned can be carried forward each month/ each Policy Year (as applicable) and as long as the Policy is Renewed with Us in accordance with the Renewal Terms under the Policy

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.

(q.2) Health Coach

All Insured persons Aged 18 Years or above, suffering from any one or more of the listed chronic conditions namely Asthma, Hypertension, Hyperlipidemia or Diabetes Mellitus is/are eligible for a health coaching session with Our expert Health Coach. Our Health Coach shall be coaching the Insured Person on better lifestyle management to take care of such chronic condition.

Conditions
a) These coaches shall be available over a telephonic discussion as a call back service. The request for call back may be placed through our toll free number or via E-mail.
b) A maximum of 2 coaching sessions may be availed by the Insured Person during a Policy Year.
c) It is agreed and understood that Our Health 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.
d) 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.

Section IV: Optional Covers

The following optional covers shall apply only if the premium in respect of the optional cover has been received and the Policy Schedule states that the optional cover is in force. The Policy Schedule shall specify which of the following optional covers are in force and available for the Insured Persons under the Policy.

Benefits under this Section IV are subject to the terms, conditions and exclusions of this Policy. The sub-limit for each Benefit 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 applicable sub-limit for that Benefit.

All claims under this section must be made in accordance with the procedure set out in Section C(C). Wherever a claim qualifies under more than one Benefit in Section IV, We shall pay for all such eligible covers opted and in force.

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 without any individual selection.

(r) Reduction in PED Waiting Period:

What is covered

If You have applied for this Optional Cover at the inception of the first policy with Us and We have accepted the same, then We shall reduce the applicable Pre Existing Disease waiting period for claims related to Pre-Existing Diseases to 24 months.

Conditions

(i) The provisions of Section J (iii) and definitions (Section D.48) continue to be valid in relation to this Section IV (r), except that the claims will be admissible for any Medical Expenses incurred for Hospitalization in respect of diagnosis/treatment of any Pre-Existing Disease after 24 months, as applicable and mentioned in the Policy Schedule, if continuous coverage has elapsed, since the inception of the first Policy with Us.

(ii) This optional cover will be available only at the time of inception of the first policy with Us and only for the Sum Insured opted at such inception.

(s) Unlimited Reload of Sum Insured

What is covered

We shall reload the Sum Insured, up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy, unlimited times during the Policy Year.

Conditions

(i) "Unlimited Reload of Sum Insured" is an extension of the Benefit mentioned in Section I (h) (Reload of Sum Insured) and therefore all the conditions and provisions stated under Section I (h) shall also be valid and applicable in relation to this Section IV (s), except that the reload of Sum Insured shall be available unlimited times during the Policy Period. It is, however clarified that in case of a single claim payout, Our maximum liability shall not exceed the limit as specified in the Policy Schedule/Product Benefit Table of this Policy.

(ii) No Claim Bonus (Section II (l)) and Super NCB (Section IV (t)) shall not be considered while calculating the Unlimited Reload of Sum Insured.

(t) Super NCB

What is covered

We shall apply a Super No Claim Bonus (Super NCB) (over and above No Claim Bonus as specified under Section II(l)) 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 I in the Policy Schedule on a cumulative basis, provided that the Insured Person(s) has not made any claim under Section I in a Policy Year and has successfully Renewed the Policy with Us continuously and without any break. The accumulated Super No Claim Bonus shall not exceed 100% of the Sum Insured on the Renewed Policy. In the event of a claim impacting the eligibility of Super No Claim Bonus, the accumulated Super No Claim Bonus shall be reduced by 50% of the Sum Insured at the commencement of subsequent Policy Year.

Conditions

(i) "Super NCB" is an extension to the Benefit mentioned in Section II(l) (No Claim Bonus) and therefore all the conditions and provisions stated under Section II(l) shall also be valid and applicable in relation to for this Section IV (t).

(ii) At the time of Renewal of this Policy, if the Policyholder chooses not to renew this optional cover, then the Super NCB under the expiring Policy shall be forfeited.

(iii) The reload amount (Reload of Sum Insured and Unlimited Reload of Sum Insured), Accidental Hospitalization Booster, Cancer Hospitalization Booster and accumulated NCB shall not be considered while calculating the Super NCB.

(u) Accidental Hospitalization Booster

What is covered

We shall provide an additional Sum Insured towards Medical Expenses incurred for In-patient Hospitalization, up to the limit specified in the Policy Schedule / Product Benefit Table of this Policy, following an Emergency caused solely and directly due to an Accident causing Injury, of the Insured Person who is Hospitalized for the treatment of such Injury.

We shall cover the following Medical Expenses:

- Reasonable and Customary Charges for Room Rent for accommodation in Hospital room up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy;
- ICU Charges;
- Operation theatre expenses;
- Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
- Qualified Nurses' charges;
- Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
- Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized and conducted within the same Hospital where the Insured Person is admitted;
- Anaesthesia, blood, oxygen and blood transfusion charges;
- Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Conditions

(i) This benefit shall be utilized only after the Sum Insured has been completely exhausted.
(ii) The total amount payable under this optional cover shall not exceed the sum total of the Sum Insured, No Claim Bonus (if earned), Super NCB (if opted and as specified in the Policy Schedule) and Accidental Hospitalization Booster.
(iii) This benefit shall be available only for such Insured Person for whom claim for Hospitalization following the Accident has been accepted under this Policy.
(iv) This benefit shall be available only once during the Policy Year.
(v) The conditions stipulated under Section I (a) shall be applicable.

(v) Cancer Hospitalization Booster

What is covered

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

We shall cover the following Medical Expenses:

- Reasonable and Customary Charges for Room Rent for accommodation in Hospital room up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy;
- ICU Charges;
- Operation theatre expenses;
- Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
- Qualified Nurses' charges;
- Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
- Investigative tests or diagnostic procedures directly related to Cancer of Specified Severity for which the Insured Person is Hospitalized and conducted within the same Hospital where the Insured Person is admitted;
- Anaesthesia, blood, oxygen and blood transfusion charges;
- Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Conditions

(i) This benefit shall be utilized only after the Sum Insured has been completely exhausted.
(ii) The total amount payable under this optional cover shall not exceed the sum total of the Sum Insured, No Claim Bonus (if earned), Super NCB (if opted and as specified in the Policy Schedule) and Cancer Hospitalization Booster.
(iii) This benefit shall be available only for such Insured Person for whom claim for Hospitalization following Cancer of Specified Severity has been accepted under the Policy.
(iv) The conditions stipulated under Section I (a) shall be applicable
(v) This benefit shall be available only once during the Policy Year.

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

CANCER OF SPECIFIED SEVERITY

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

(w) Any Room Upgrade

What is covered

The Insured Person shall be eligible to upgrade the room type category eligibility as specified in the Policy Schedule/ Product Benefit Table of the Policy to Any Room in a Hospital.

Section C. Terms and Conditions

A. Co-payment

At the time of inception of initial policy (first policy) with Us, if the Age (Age at entry) of the Insured Person or eldest Insured Person (in case of a Family Floater Policy) is 61 years or above, such Insured Person or all Insured Persons (in case of Family Floater Policy) shall bear a Co-payment per claim (over and above any other Co-payment, if any) as specified in Product Benefit Table/Policy Schedule

B. Eligibility and Coverage:

Minimum Age at entry:

a. Dependent Children from Age - 91 days to 5 years will be covered only if one adult is covered under family floater Policy. In case of an Individual policy, minimum age at entry is 5Yrs.
b. Children up to 25 years can be covered under the floater as dependents

Maximum entry age at entry: No Maximum age at entry .
Age is calculated as no. of years completed as on last birthday.

C. 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 for them. Relationships covered (Proposer's relationship with the Proposed Insured Member): 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.

b. In case of a floater Policy, one family will share a single Opted Sum Insured.
Relationships covered - Self, legally married spouse as long as they continue to be married, dependent children (upto 4)
Maximum floater cover can be offered to 2 Adults + 4 children.
Note: Son/Daughter/Child will include legally adopted Child and Step Child

D. Base Sum Insured and Optional Benefit

Sum Insured Options : Rs 2 Lac, 3 Lac, 4 Lac, 5 Lac, 7 Lac, 10 Lac, 15 Lac, 20 Lac, 25 Lac, 30 Lac, 40 Lac, 50 Lac, 75 Lac, 100 Lac, 150 Lac, 200 Lacs

Optional covers under family floater policies, if chosen, will be applicable to all members in the Policy.

Cancer Hospitalization Booster is available for the following adult members (above the age of 18 yrs.)

a. Family Floater: All members above the age of 18 yrs.
b. Individual / multi Individual: all relations above the age of 18 yrs.

E. Policy Period option

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

F. Discounts under the Policy

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

- Family Discount on multi individual policy: 2 or 3 members in a policy – 5% discount on premium applicable, 4 or more members in a policy – 10% discount on premium applicable.
- 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
- A 10% discount is applicable for employees of Aditya Birla Group upon purchase of this product.
- A 10% discount is applicable for employees of intermediaries of Aditya Birla Health insurance Company Limited upon purchase of this product.

G. Premium Payment

You can choose to buy Policy by paying single premium. In case of a family floater policy premium is calculated on the basis of age of eldest member and Sum Insured selected.
The calculation of premium is explained with the help of following example.
Mr.A and Mrs.A (spouse of Mr.A) wanted to purchase a health insurance cover for themselves on individual S.I. basis. Where Mr.A opted for 10 Lacs S.I and Mrs A opted for 7 Lacs S.I. The couple wanted to buy the policy for 2 years to avail the benefit of long term discount. The calculation for the same is explained as follows

Policy and Insured Details				
Insured	Plan	Sum Insured	Policy Tenure	Age in years
Mr A	Diamond	10 Lac	2 Years	45
Mrs. A	Diamond	7 Lac	2 Years	42

Premium calculation excluding GSTAmount in Rs.	**Amount in Rs.**
Premium for Age 45 for Mr. A	9,139
Premium for Age 46 for Mr. A	13,500
Premium for Age 42 for Mrs. A	8,203
Premium for Age 43 for Mrs. A	8,203
Policy Premium before discount and GST	**39,045**
Family Discount & Long term policy discount	4,734
Premium excluding GST	**34,311**

H. 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.

I. 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.

J. Waiting periods and Permanent Exclusions

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. All waiting periods and permanent exclusions shall apply individually for each Insured Person and claims shall be assessed accordingly.

i. First 30 days waiting period

We shall not be liable for any claim arising due to any condition for which appearance of signs/symptoms, consultation, investigation, treatment or admission commencing within 30 days from Policy Commencement Date, except for the claims arising due to an Accident. This waiting period does not apply for any Insured Person that is accepted under Portability and for subsequent and continuous Renewals of the Policy with Us.

ii. Two Year waiting periods

The conditions listed below, whether medical or surgical and of the Illness/conditions and their complications mentioned below, will be subject to a waiting period of 24 months from the commencement of the 1st Policy Year and will be covered from the commencement of the 3rd Policy Year as long as the Insured Person has been insured continuously under the Policy without any break.

	Body System	Illness	Treatment/ Surgery
1	Eye	Cataract	Cataract Surgery
		Glaucoma	Glaucoma Surgery
2	Ear Nose Throat	Serous Otitis Media	
		Sinusitis	Sinus Surgery
		Rhinitis	Surgery for the nose
		Tonsillitis	Tonsillectomy
		Tympanitis	Tympanoplasty
		Deviated Nasal Septum	Surgery for Deviated Nasal Septum
		Otitis Media	Surgery or Treatment for Otitis Media
		Adenoiditis	Adenoidectomy
		Mastoiditis	Mastoidectomy
		Cholesteatoma	Resection of the Nasal Concha
3	Gynecology	All Cysts & Polyps of the female genito urinary system	Dilatation & Curettage
		Polycystic Ovarian Disease	Myomectomy
		Uterine Prolapse	Uterine prolapsed Surgery
		Fibroids (Fibromyoma)	Hysterectomy unless necessitated by malignancy
		Breast lumps	Any treatment for Menorrhagia
		Prolapse of the uterus	
		Dysfunctional Uterine Bleeding (DUB)	
		Endometriosis	
		Menorrhagia	
		Pelvic Inflammatory Disease	
4	Orthopedic / Rheumatological	Gout	Joint replacement Surgery Surgery for Prolapse of the intervertebral disc
		Rheumatism, Rheumatoid Arthritis	
		Non infective arthritis	
		Osteoarthritis	
		Osteoporosis	
		Prolapse of the intervertebral disc	
		Spondylopathies	
5	Gastroenterology (Alimentary Canal and related Organs)	Stone in Gall Bladder and Bile duct	Cholestectomy / Surgery for Gall Bladder
		Cholecystitis	Surgery for Ulcers (Gastric / Duodenal)
		Pancreatitis	
		Fissure, Fistula in ano, hemorrhoids (piles), Pilonidal Sinus, Ano-rectal & Perianal Abscess	
		Rectal Prolapse	
		Gastric or Duodenal Erosions or Ulcers + Gastritis & Duodenitis	
		Gastro Esophageal Reflux Disease (GERD)	

		Cirrhosis	
		Acute & Chronic Appendicitis, Appendicular lump, Appendicular abscess	
6	Urogenital (Urinary and Reproductive system	Stones in Urinary system (Stone in the Kidney, Ureter, Urinary Bladder)	Prostate Surgery
		Benign Hypertrophy / Enlargement of Prostate (BHP / BEP)	
		Hernia, Hydrocele,	Surgery for Hydrocele, Rectocele and Hernia
		Varicocoele / Spermatocoele	Surgery for Varicocoele / Spermatocoele
7	Skin	Skin tumour (unless malignant)	Removal of such tumour unless malignant
		All skin diseases	
8	General Surgery	Any swelling, tumour, cyst, nodule, ulcer, polyp anywhere in the body (unless malignant)	Surgery for cyst, tumour, nodule, polyp unless malignant
		Varicose veins, Varicose ulcers	Surgery for Varicose veins and Varicose ulcers
		Congenital Internal Diseases or Anomalies	

If any of the Illness/conditions listed above are Pre-Existing Diseases, then they shall be covered only after the completion of the Pre-Existing Disease Waiting Period described in section J (iii) below.

iii. Pre-Existing Disease waiting Period

Pre-Existing Diseases shall not be covered until the time period specified in the Policy Schedule / Product Benefit Table of this Policy in this regard has elapsed since the inception of the first Policy with Us. Provided that the Insured Person(s) has/have been insured continuously under the Policy without any break with Us.

iv. Permanent Exclusions:

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. An Insured Person committing or attempting to commit a breach of law with criminal intent, intentional self Injury or attempted suicide while sane or insane.
3. Willful or deliberate exposure to danger, intentional self-Injury, participation or involvement in naval, military or air force operation, circus personnel, racing in wheels or horseback, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing, bungee jumping, paragliding, parasailing, ballooning, skydiving, river rafting, polo, snow and ice sports in a professional or semiprofessional nature.
4. Abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, including alcohol withdrawal, smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services, or supplies, impairment of Insured Person's intellectual faculties by abuse of stimulants or depressants
5. Weight management programs or treatment in relation to the same including vitamins and tonics, treatment of obesity (including morbid obesity).
6. Treatment for correction of eyesight due to refractive error including routine examination.
7. All routine examinations and preventive health check-ups.
8. Cosmetic, aesthetic and re-shaping treatments and Surgeries.
   Plastic Surgery or cosmetic Surgery or treatments to change appearance unless medically necessary and certified by the attending Medical Practitioner for reconstruction following an Accident, cancer or burns.
9. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment); aesthetic or change-of-life treatments of any description such as sex transformation operations.
10. Non allopathic treatment.
11. Conditions for which treatment could have been done on an outpatient basis without any Hospitalization.
12. Investigational treatments, Unproven / Experimental treatment, or drugs yet under trial, devices and pharmacological regimens.
13. Diagnostic tests/procedures/treatment/consumables not related to Illness for which Hospitalization has been done.
14. Convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care, treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification centre, home for the aged, mentally disturbed remodeling clinic or any treatment taken in an establishment which is not a Hospital.
15. Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing.
16. Admission for enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
17. Hearing aids, spectacles or contact lenses including optometric therapy, multifocal lens.
18. Treatment for alopecia, baldness, wigs, or toupees, and all treatment related to the same.
19. Medical supplies including elastic stockings, diabetic test strips, and similar products.
20. 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.), devices used for ambulatory monitoring of blood pressure, blood sugar, glucometers, nebulizers and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively. Cost of artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively). Sleep-apnea and other sleep disorders.
21. Psychiatric or psychological disorders, mental disorders (including mental health treatments), Parkinson and Alzheimer's disease, general debility or exhaustion ("rundown condition").
22. External Congenital Anomalies or diseases or defects.
23. Stem cell therapy or Surgery, or growth hormone therapy.

24. Venereal disease, all sexually transmitted disease or Illness including but not limited to HPV, Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
25. "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus) including Opportunistic infections but not limited to any conditions related to or arising out of HIV/AIDS such as ARC (AIDS Related Complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis, Pneumocystis Carinii Pneumoniae etc.
26. Complications arising out of pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or birth (including caesarean section) except in the case of ectopic pregnancy for in-patient only.
27. Treatment for sterility, infertility, sub-fertility or other related conditions and complications arising out of the same, assisted conception, surrogate or vicarious pregnancy, birth control, and similar procedures; contraceptive supplies or services including complications arising due to supplying services.
28. 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).
29. Admission for Organ Transplant but not compliant under the Transplantation of Human Organs Act, 1994 (amended).
30. 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.
31. Dentures, implants and artificial teeth, Dental Treatment and Surgery of any kind, unless requiring Hospitalization due to an Accident.
32. 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.
33. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.
34. Treatment for developmental problems, learning difficulties eg. Dyslexia, behavioral problems including attention deficit hyperactivity disorder (ADHD).
35. Treatment for Age Related Macular Degeneration (ARMD), Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy, high intensity focused ultrasound, balloon sinuplasty, Deep Brain Simulation, Holmium Laser Enucleation of Prostate, KTP Laser Surgeries, cyber knife treatment, Femto laser surgeries, bioabsorbable stents, bioabsorbable valves, bioabsorbable implants, oral chemotherapy, use of Infliximab, rituximab, avastin, lucentis.
36. 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.
37. Treatment taken from a person not falling within the scope of definition of registered Medical Practitioner with any state medical council/ medical council of India.
38. Treatment charges or fees charged by any Medical Practitioner acting outside the scope of license or registration granted to him by any medical council.
39. 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 .
40. 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.
41. Administrative charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, bio-medical, linen, documentation and filing, including MRD charges (medical records department charges).
42. Non-Medical Expenses including but not limited to RMO, CMO, DMO charges, surcharges, night charges, service charges levied by the Hospital under any head and as specified in the Annexure for Non- Medical Expenses and on Our website adityabirlahealthinsurance.com
43. Treatment taken outside India
44. Insured Person whilst flying or taking part in aerial activities except as a fare-paying passenger in a regular scheduled airline or air charter company.
45. Robotic surgery (whether invasive or non-invasive) unless specifically approved by Us.
46. All forms of Bariatric surgery.
47. Use of Radio Frequency (RF) probe for ablation or other procedure unless specifically approved by Us in writing in advance.
48. Admission primarily for diagnostic purposes not consistent with the treatment taken.
49. Treatment in any Hospital or by any Medical Practitioner or any other provider of services that We have blacklisted as listed on Our website.
50. Treatment provided by anyone with the same residence as Insured Person or who is a member of the Insured Person's immediate family.

V. Four Year waiting period

The conditions listed below, whether medical or surgical and of the Illness/conditions and their complications mentioned below, will be subject to a waiting period of 48 months from the commencement of the 1st Policy Year and will be covered from the commencement of the 5th Policy Year as long as the Insured Person has been insured continuously under the Policy without any break.

1. Genetic Disorders

K. Portability & Continuity Benefits

1. From another Insurer to Us

(i) If the proposed Insured Person was insured continuously and without a break under another Indian retail health insurance policy with any other Indian General Insurance company or standalone Health Insurance company, it is understood and agreed that:

a) If the Insured Person wishes to avail the Portability benefit, he/she must apply to Us with the completed application form and Portability Form with complete documentation at least 45 days before, but not earlier than 60 days, from the expiry of the existing health insurance policy.

b) This benefit is available only at the time of Renewal of the existing health insurance policy.

c) This benefit is available only up to the existing cover. If the proposed sum insured is higher than the sum insured under the expiring policy, then waiting periods would be applied on the amount of proposed increase in sum insured only subject to the existing guidelines regarding Portability issued by the IRDAI.

d) Waiting period credits shall be extended to Pre-Existing Diseases and time bound exclusions/waiting periods in accordance with the existing IRDAI guidelines as applicable.
e) Subject to the applicable Portability norms issued by the IRDAI, Portability benefit shall be applied by Us within 15 days of receiving the Insured Person's completed application form and Portability Form subject to the following:
- The Insured Person shall give Us all additional documentation and/or information We request;
- The Insured Person shall pay Us the applicable premium in full;
- We may, subject to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be in Our sole and absolute discretion and in accordance with Our board approved underwriting policy;
- There is no obligation on Us to insure all the Insured Persons or to insure all the Insured Persons on the proposed terms, even if the Insured Person(s) have given Us all documentation;
- We have received necessary details of medical history and claim history from the previous insurance company for the Insured Person's previous health insurance policy through the IRDAI's web portal.

(ii) No additional loading or charges shall be applied by Us exclusively for porting the policy.

2. From Our existing health insurance Policy to this Policy

(i) If the proposed Insured Person was insured continuously and without a break under another health insurance policy with Us, it is understood and agreed that:
a) If the Insured Person wishes to avail the Portability benefit, he/she must apply to Us with the completed application form and Portability Form with additional documentation as may be required at least 45 days before, but not earlier than 60 days, from the expiry of the existing health insurance policy with Us.
b) This benefit is available only at the time of Renewal of the existing health insurance policy.
c) This benefit is available only up to the existing cover. If the proposed sum insured is higher than the sum insured under the expiring policy, then waiting periods would be applied on the amount of proposed increase in sum insured only subject to the existing guidelines regarding Portability issued by the IRDAI.
d) Waiting period credits shall be extended to Pre-Existing Diseases and time bound exclusions/waiting periods in accordance with the existing IRDAI guidelines as applicable.
e) Subject to the applicable Portability norms issued by the IRDAI, Portability benefit shall be applied by Us within 15 days of receiving the Insured Person's completed application form and Portability Form subject to the following:
- The Insured Person shall give Us all additional documentation and/or information We request;
- The Insured Person shall pay Us the applicable premium in full;
- We may, subject to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be in Our sole and absolute discretion and in accordance with Our board approved underwriting policy;
- There is no obligation on Us to insure all the Insured Persons or to insure all the Insured Persons on the proposed terms, even if the Insured Person(s) have given Us all documentation.

(ii) No additional loading or charges shall be applied by Us exclusively for porting the policy.
We reserve the right to modify or amend the terms and the applicability of the Portability benefit in accordance with the provisions of the regulations, circulars and guidelines issued by the IRDAI from time to time.

L. Free Look Period

We shall provide You a period of 15 days (30 days in case of contracts with a term of 3 years, offered over distance marketing mode) from the date of receipt of the Policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You may cancel the Policy stating the reasons for cancellation and provided that no claims have been made under the Policy, We shall refund the premium paid by You after deducting the amounts spent on any medical check-ups, stamp duty charges and proportionate risk premium for the period on cover. All rights and benefits under this Policy shall immediately stand extinguished on the free look cancellation of the Policy.
Free look period shall not be available on Renewals or on Portability.

M. Cancellation (other than Free Look Cancellation)

1. Cancellation by You
In case You are not satisfied with the Policy or our services, You can request for a cancellation of the Policy by giving 15 days' notice in writing. We shall cancel the Policy and refund the premium in accordance with the grid below provided that no claim has been made under the Policy by or on behalf of any Insured Person.

<table>
<tr><td></td><td colspan="3">Refund</td></tr>
<tr><td>In force Period-Up to</td><td>1 Year</td><td>2 Year</td><td>3 Year</td></tr>
<tr><td>1 Month</td><td>75.00%</td><td>85.00%</td><td>90.00%</td></tr>
<tr><td>3 months</td><td>50.00%</td><td>75.00%</td><td>85.00%</td></tr>
<tr><td>6 months</td><td>25.00%</td><td>60.00%</td><td>75.00%</td></tr>
<tr><td>12 months</td><td rowspan="6">NIL</td><td>50.00%</td><td>60.00%</td></tr>
<tr><td>15 months</td><td>30.00%</td><td>50.00%</td></tr>
<tr><td>18 months</td><td>20.00%</td><td>35.00%</td></tr>
<tr><td>24 months</td><td rowspan="3">NIL</td><td>30.00%</td></tr>
<tr><td>30 months</td><td>15.00%</td></tr>
<tr><td>30+ months</td><td>NIL</td></tr>
</table>

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:
You further understand and agree that We may cancel the Policy by giving 15 days' notice in writing to Your last known address on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material fact by You or the Insured Person and all premium paid thereon shall be forfeited by Us.

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 12 month period from the date of cancellation/termination.

N. 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 expiry date of the Policy and in no case later than the Grace Period of 30 days from the expiry date. We shall not be liable to pay for any claim arising out of an Illness/Injury/ Accident that occurred during the Grace Period. The provisions of Section 64VB of the Insurance Act 1938 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.

O. Renewal Terms

(i) The Policy will automatically terminate at the end of the Policy Period. The Policy is ordinarily renewable on mutual consent for life, subject to realization of Renewal premium.
(ii) The premium payable on Renewal shall be paid to Us on or before the Policy Period end date and in any event before the expiry of the Grace Period. Policy would be considered as a fresh policy if there would be break of more than 30 days between the previous Policy expiry date and current Policy Start date.
(iii) We however 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.
(iv) Any unutilised funds under HealthReturns™ (from the previous Policy year/ month) will be available for claims during the Grace Period.
(v) You shall not be able to earn HealthReturns™ during the Grace Period.
(vi) 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.
(vii) 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.
(viii) 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.
(ix) Renewals will not be denied except on grounds of misrepresentation, fraud, non-disclosure of material facts or non-co-operation by You.
(x) Where We have discontinued or withdrawn this product/plan You will have the option to renew under the nearest substitute Policy being issued by Us, however benefits payable shall be subject to the terms contained in such other Policy which has been approved by IRDAI. We shall intimate You/ the Insured Person regarding the withdrawal of the Policy at least 3 months in advance.
(xi) We may revise the Renewal premium payable under the Policy or the terms of cover, provided that the Renewal premiums are approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premiums will not alter based on individual claims experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.
(xii) 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.
(xiii) 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.
(xiv) 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.
(xv) Where an Insured Person is added to this Policy, either by way of endorsement, all waiting periods under Section J will be applicable considering such Policy Year as the first year of Policy with Us with respect to the Insured Person.
(xvi) Applicable No Claim Bonus shall be accrued on each Renewal as per eligibility under the plan in force.
(xvii) In case of Family Floater Policies, children attaining 25 years at the time of Renewal will be moved out of the floater into an individual cover. However, all continuity benefits for such Insured Person on the Policy will remain intact. No Claim Bonus earned on the Policy will stay with the Insured Persons(s) covered under the original Policy.

P. Claims Process

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 / Empanelled Service Providers. The complete list of Network Providers and Empaneled Service Providers is available on Our website and at Our branches and can also be obtained by contacting Us over the telephone.

ii. Empanelled Service Providers means service provider (Doctor's clinic, Diagnostic centre, Medicine and Drug vendor) enlisted by Us, TPA or jointly by Us and TPA to provide OPD medical services to an insured by a cashless facility

iii. 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.

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 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) 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 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 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) Hospital where treatment/Surgery is to be taken;
   (8) 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 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.

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.

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.

Q. Grievances Redressal Procedure

In case of a grievance, the Insured Person/ Policyholder can contact Us with the details through:
Our website: adityabirlahealthinsurance.com
Email: care.healthinsurance@adityabirlacapital.com
Toll Free: 1800 270 7000
Address: Aditya Birla Health insurance Co. Limited
10th Floor, R-Tech, Nirlon IT park, Western Express highway,
Goregaon East, Mumbai - 400063

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

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

If the Insured Person/Policyholder is not satisfied with Our redressal, he/she may use the Integrated Grievance management Services (IGMS). For registration in IGMS please visit IRDAI website www.irda.gov.in
If the Insured Person/Policyholder are still not satisfied, he/she may approach the nearest Insurance Ombudsman. The contact details of the Ombudsman offices are provided on Our website and in this Policy at Annexure [A].

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: Table of Benefits
- Annexure B: List of Non-Medical Expenses
- Annexure C: Rate Chart
- Annexure D: Day Care Treatment List