Group Activ Health - Policy Terms and Conditions

I. Preamble

This is a legal contract between the Policyholder and Us subject to the receipt of full premium, Disclosure to information norm including the information provided by the Policyholder in the Proposal Form and the terms, conditions and exclusions of this Policy.

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

II. Base Covers

The Benefits listed below shall be available to all Insured Persons as specified in the Policy Schedule or Certificate of Insurance.

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

Benefits under this Section are subject to the terms, conditions and exclusions of this Policy and the availability of the Sum Insured and subject always to any Sub-Limits for the Benefit as specified in the Policy Schedule or Certificate of Insurance.

All Claims must be made in accordance with the procedure set out in Section VI.

1. In-patient Hospitalization

1.1 In-patient Hospitalization

We will cover the Medical Expenses incurred towards 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 provided that:

(i) The Hospitalization is for Medically Necessary Treatment and follows written Medical Advice;

(ii) The Medical Expenses incurred are Reasonable and Customary Charges for one or more of the following:

(1) Room Rent and other boarding charges;
(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 and conducted within the same Hospital where the Insured Person is admitted;
(8) Anaesthesia, blood, oxygen and blood transfusion charges;
(9) Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

(iii) If the Insured Person is admitted in the Hospital in a room category/Room Rent higher than the eligibility as specified in the Policy Schedule/Certificate of Insurance, then We shall be liable to pay only a pro-rated proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent actually incurred and the entitled room category/eligible Room Rent 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 including surgeon/ anaesthetist/ specialist within the same Hospital where the Insured Person has been admitted. "Associated Medical Expenses" does not include cost of pharmacy and consumables, cost of implants and medical devices and cost of diagnostics;
- Proportionate deductions are not applicable for ICU charges; and
- Proportionate deductions are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

1.2 Day Care Treatment

We will cover the Medical Expenses incurred on the Insured Person's Day Care Treatment during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that:

(i) 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 and such list of Day Care Treatment is listed in Annexure I;

(ii) The Day Care Treatment is for Medically Necessary Treatment and follows the written Medical Advice;

(iii) We will not cover any OPD Treatment under this Benefit.

1.3 Domiciliary Hospitalization

We will cover Medical Expenses incurred for the Insured Person's Domiciliary Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that:

(i) The Domiciliary Hospitalisation continues for at least 3 consecutive days in which case We will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalisation;

(ii) The treating Medical Practitioner confirms in writing that Domiciliary Hospitalization was medically required and the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital or the Insured Person satisfies Us that a Hospital bed was unavailable;

(iii) If a claim is accepted under this Benefit then We shall not pay any Post-hospitalization Medical Expenses, but We will accept a claim for Pre-hospitalization Medical Expenses subject to the terms and conditions of Section <<1.4.>> below;
(iv) 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.

1.4 Pre - hospitalization Medical Expenses

We will cover, on a reimbursement basis, the Insured Person's Pre-hospitalization Medical Expenses incurred in respect of an Illness or Injury that occurs during the Policy Period upto the number of days as specified in the Policy Schedule or Certificate of Insurance, provided that:
(i) We have accepted a claim for In-patient Hospitalization under Section 1.1 above;
(ii) The Date of Admission to the 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 for which We have accepted an In-patient Hospitalization claim under Section 1.1 above.

1.5 Post - hospitalization Medical Expenses

We will cover, on a reimbursement basis, the Insured Person's Post-hospitalization Medical Expenses incurred following an Illness or Injury that occurs during the Policy Period upto the number of days as specified in the Policy Schedule or Certificate of Insurance, provided that:
(i) We have accepted a claim for In-patient Hospitalization under Section 1.1 above;
(ii) The Date of Discharge from the Hospital for the purpose of this Benefit shall be the date of the Insured Person's last discharge from the Hospital in relation to the same Illness for which We have accepted an In-patient Hospitalization claim under Section 1.1 above.

1.6 Organ Donor Expenses

We will cover the Medical Expenses incurred for an organ donor's treatment for the harvesting of the organ donated up to the limit as specified in the Policy Schedule or Certificate of Insurance provided that:
(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 organ transplant is medically required for the Insured Person as certified in writing by a Medical Practitioner;
(iii) We will not cover:
(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.

1.7 Road Ambulance Expenses

We will cover the costs incurred up to the limit as specified in the Policy Schedule or Certificate of Insurance on transportation of the Insured Person by Road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period. We will also cover the costs incurred on transportation of the Insured Person by road Ambulance in the following circumstances up to the limits specified in the Policy Schedule or Certificate of Insurance:
(i) It is medically required to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital;
(ii) It is medically required to transfer the Insured Person to another Hospital during the course of Hospitalization due to lack of super speciality treatment in the existing Hospital.

2. Hospital Cash Benefit

We will provide a Hospital Cash Benefit specified in the Policy Schedule or Certificate of Insurance for each continuous and completed period of 24 hours of Hospitalisation of the Insured Person during the Policy Period for treatment of an Illness or Injury provided that:
(i) This Benefit shall be payable for a maximum number of days specified in the Policy Schedule or Certificate of Insurance, per Hospitalization event in respect of an Insured Person;
(ii) A Deductible as specified in the Policy Schedule or Certificate of Insurance is applicable under the Benefit;
(iii) This Benefit shall not be payable for more than the number of days per Policy Year as specified in the Policy Schedule or Certificate of Insurance.

3. OPD Expenses

We will cover the Reasonable and Customary Charges incurred for medically required consultations, visit(s) to a doctor, diagnostic tests and pharmacy expenses which are incurred on an out-patient basis up to the limits as specified in the Policy Schedule or Certificate of Insurance.

Alternative Treatments shall also be covered under this Benefit.

4. Chronic Management Program

We will cover the out-patient expenses incurred on Medical Practitioner's visits, diagnostic tests and pharmacy for one or more conditions of Diabetes, Hypertension, Hyperlipidemia and Asthma up to the limits specified in the Policy Schedule or Certificate of Insurance.

In order to avail the benefit of Chronic Management Program, the Insured Persons would have to undergo a Health Assessment™ (under Section II.21), which is a measurement of parameters of Cholesterol, Blood Pressure, Blood Glucose, Body Mass Index, Hip Waist Ratio and smoking status.

The protocols under this Benefit are as defined in Annexure II. Cashless Facility under this Benefit is available only at Our Network Providers.

In case of addition of an Insured Person to the Policy post 6 months of Start Date, Annexure II.1 shall be applicable.

We shall obtain and retain the Insured Person's medical reports generated under this Chronic Management Program, subject to receipt of the Insured Person's consent at the time of enrollment into the program, and a copy of the medical check-up reports shall be sent to the Insured Person upon their request.

In the event of Insured Person ceasing to be a member of the group, we shall be refunding 75% of the unutilized amount from the limits specified for this benefit in the Policy Schedule or Certificate of Insurance for the Policy Year.

5. AYUSH Treatment (In-patient Hospitalization)

We will cover the Medical Expenses for medically required AYUSH Treatments undergone as an In-patient upto the limits specified in the Policy Schedule or Certificate of Insurance, where treatment has been taken in any AYUSH Hospital.

Comfort treatment involving steam bath/sauna/oil massages are excluded. Such treatments being combined with any stay packages at resorts where the treatment forms a part of an overall leisure package shall not be covered under this Benefit.

6. Psychiatric In-patient Care

We will cover the Medical Expenses up to the limit specified in the Policy Schedule or Certificate of Insurance for In-patient treatment in a recognised psychiatric unit of a Hospital including consultations, diagnostics, counselling and/or therapy and medication. The In-patient treatment under this Benefit must at all times be administered under the direct control of a registered psychiatrist.

7. Worldwide Critical Illness Cover

We will cover the Medical Expenses incurred on In-patient Hospitalization or Day Care Treatment of the Insured Person outside India, in respect of any Critical Illness as specified below, provided that:

(i) For the purpose of this Benefit, the treatment should be taken in a registered Hospital or clinic as per law, rules and/ or regulations applicable to the country where the treatment is taken;
(ii) Any payment shall be made only on a reimbursement basis or Cashless Facility basis (where available);
(iii) The symptoms of the Critical Illness first occur or manifest itself during the Policy Period and after completion of the 90 day waiting period subject to applicability of any Waiting Periods mentioned in the Policy Schedule or Certificate of Insurance;
(iv) The rate of exchange as published by RBI as on the date of payment to the Hospital shall be used for conversion of foreign currency amounts into Indian rupees for payment of claim under this Benefit. If RBI rates are not published on the date of the Insured Person's discharge from the Hospital, the exchange rate next published by RBI shall be considered for conversion.

Critical Illnesses covered under this benefit are as follows:

1. Cancer of specified severity.
2. Myocardial Infarction (First Heart Attack of specific severity).
3. Open Chest CABG.
4. Open Heart Replacement or Repair of Heart Valves.
5. Coma of Specified Severity.
6. Kidney Failure Requiring Regular Dialysis.
7. Stroke Resulting in Permanent Symptoms.
8. Major Organ / Bone Marrow Transplant.
9. Permanent Paralysis of Limbs.
10. Motor Neuron Disease with Permanent Symptoms.
11. Multiple Sclerosis with Persisting Symptoms.

Permanent Exclusion no. 48 is not applicable in respect of this Benefit.

8. Sub-Limits for Specified Illness/ Conditions

We will cover the Medical Expenses arising out of an Insured Person's Hospitalization as specified in the Policy Schedule or Certificate of Insurance to the Insured Person for the listed specified Illness/ conditions, provided that the diagnosis is confirmed by a Medical Practitioner and such treatment is taken in a Hospital:

i. Typhoid: Diagnosis must be confirmed by a positive Widal Test.
ii. Malaria: Diagnosis must be confirmed by a positive blood test for Malarial Parasite.
iii. Dengue: Diagnosis must be confirmed by a positive Dengue Serology.
iv. Tuberculosis: Diagnosis must be confirmed by,
    a. AFB positive sputum or;
    b. Treatment with anti tubercular drugs.
v. Impacted Wisdom Tooth: Diagnosis must be confirmed by X- Ray reports.
vi. Maternity Complications - Gestational Diabetes: Diagnosis must be confirmed by laboratory and clinical confirmation of pregnancy induced diabetes.
vii. Maternity Complications - Ectopic Pregnancy: Diagnosis must be confirmed by Ultrasound / CT Scan.
viii. Kidney Stones: Diagnosis must be confirmed by Ultrasound / CT Scan.
ix. Tetanus: Diagnosis must be confirmed clinically.
x. Meningitis: Diagnosis must be confirmed by Lumbar puncture.

9. Package treatment for Specific Illnesses/ Conditions

We will cover the Medical Expenses arising out of an Insured Person's Hospitalization for the listed specified Illness/ Conditions mentioned in the applicable packages upto the limits specified in the Policy Schedule or Certificate of Insurance, provided that such diagnosis is confirmed by a Medical Practitioner. The room type eligibility for this Benefit shall be General/ Economy ward only. The list of such packages comprising of listed Illnesses / Conditions are provided in Annexure III.

10. Accidental In-Patient Hospitalization

If an Insured Person suffers an Injury due to an Accident and such Injury requires the Insured Person to be Hospitalized as an In-patient then We will cover the costs incurred on Medical Expenses up to the limit specified in the Policy Schedule or Certificate of Insurance provided that:

a) The Insured Person is Hospitalized in India.
b) The Hospitalization is for Medically Necessary Treatment and is on the written advice of a Medical Practitioner.
c) The Insured Person is admitted to Hospital within 7 days of the occurrence of the Accident.

If this benefit is chosen along with section 1.1, then in case of an inpatient hospitalization due to an accident, where the claim is admissible both under section 1.1 and section 10, the admissible claims shall be paid utilizing the limit as specified in the Policy Schedule or Certificate of Insurance under section 10 (Accidental Hospitalization) first and balance if any from available Sum Insured under Section 1.1. thereafter up to the limits as specified in the Policy Schedule or Certificate of Insurance.

III. Optional Covers

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

We will indemnify the Reasonable and Customary Charges incurred towards Medically Necessary 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.

11. Health Check-up Program

We will provide coverage for a Health Check-up Program as prescribed in the Policy Schedule or Certificate of Insurance.

(i) Where this Benefit is availed on a reimbursement basis, We will provide cover up to the limits as specified in the Policy Schedule or Certificate of Insurance;
(ii) Where the health check-ups are arranged by Us at Our Network Providers, We shall not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider in relation to the health check-up.

12. Daily cash for choosing lower category room

Daily cash amount will be payable per day as mentioned in the Policy Schedule or Certificate of Insurance, if the Insured Person is Hospitalized in a lower category room as compared to the highest eligibility as mentioned in the Policy Schedule or Certificate of Insurance for each continuous and completed period of 24 hours if the Hospitalization exceeds 24 hours. This Benefit is payable only if We have paid a claim under Section 1.1 in respect of the Insured Person.

13. Fitness Assessment

Fitness assessment is a physical fitness exam that measures the Insured Person's cardiovascular endurance, flexibility, strength, height to weight ratio and body fat percentage.

An Insured Person will receive a fitness assessment based on his/her measurements. We shall provide for the fitness assessment up to the limit specified in the Policy Schedule or Certificate of Insurance.

14. HealthReturns™

HealthReturns™ are rewards that an Insured Person can earn by being physically active on a regular basis. In order to get HealthReturns™, the Insured Person must complete the below steps:

a) Complete Health questionnaire and undergo a Health Assessment

(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.
(ii) Undergo a Health Assessment™ - which is a measurement of parameters of Cholesterol, Blood pressure, Blood Glucose, Body Mass Index, Hip Waist Ratio and smoking status through a blood test, measurement and declaration.

Based on the results of Health Assessment™, the Insured Person's vital statistics will be used to calculate a 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.

For Healthy Heart Score to be calculated, Health Assessment needs to be carried out at least each Policy Year.

b) Earn Active Dayz™ by being physically active on an ongoing basis

Active Dayz™ encourages and recognizes all types of exercise/fitness activities by making use of activity tracking apps, devices and visits to the gym or yoga centers to track and record the activities members engage in.

i. 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.
ii. In order to make it easier for the Insured Person to earn HealthReturns™, We provide two fitness assessments per Policy Year (Section III.13).
iii. 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 (i) or 'Fitness Assessment' under point (iii).

No of Active Dayz™ in a Calendar Month		Fitness Assessment Result*	Healthy Heart Score™		
13+		Level 5	Red	Amber	Green
10 – 12	**OR**	Level 4	<<As specified in the Policy Schedule or Certificate of Insurance>>		
7 - 9		Level 3			
4 – 6		Level 2			
0 – 3		Level 1			

In order to achieve a particular level of HealthReturn™ the Insured Person must achieve either the required number of Active Dayz™ or achieve a level (as shown in the table above) under Fitness Assessment.
The grid above is calculated on the Monthly Premium. The Insured Person can earn up to the percentage specified in the Policy Schedule or Certificate of Insurance based on the grid above.

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

Dependent Children upto 25 years under a Family Floater Policy are not eligible for HealthReturns™.

Family size	Weightage
Self, spouse and Dependent Children (upto 25 years)	1:1:0:0
Self and spouse	1:1
Self, spouse and parents	1:1:2:2
Self, spouse and parents and parents in –law	1:1:2:2:2:2

Redemption of funds under HealthReturns™:
(i) In-patient Medical Expenses and Day Care Treatment, provided that the Sum Insured and Reloaded Sum Insured (if applicable) are exhausted during the Policy Year.
(ii) Payment of Co-Payment and Deductible (wherever applicable).
(iii) For non- payable claims, in case of an In-patient Hospitalization or Day Care Treatment.
(iv) Non-medical expenses.
(v) Out-patient expenses.
(vi) Alternative Treatments.
(vii) Preventative and wellness activities.
(viii) Payment of premium from 1st Renewal of the Policy.

Note: Permanent Exclusions and Waiting Periods are not applicable under this Benefit.
All coverage, Benefits, earning on HealthReturns™ shall automatically lapse upon cancellation of the Policy/ deletion or termination of the Insured Person from cover under the Policy.

Note:
1. In case of Employer- Employee Policy, where opted, HealthReturns™ earned will be divided between the Employer and Employee in the ratio as specified in the Policy Schedule or Certificate of Insurance.
2. In case Benefits under Section II.4 and Section III.13 are opted by a group or an Insured Person, then the Insured Person shall receive the monthly HealthReturns™ Benefit, as long as the treatment protocols under Section II.4 for that month specified by Us are complied with.

   If the Insured Person wishes to know the present value of the funds/points earned as HealthReturns™, then he/she may contact Us at our toll free number or through Our website.

   In any event, We shall send the Insured Person an updated statement of the funds earned as HealthReturns™ on a yearly basis or any other notifications/communication required to be sent hereunder on his/her or the Policyholder's registered email ID.

   Reimbursement claims under this section can be submitted quarterly in a Policy Year.

16. Infertility Treatment
We will cover the Reasonable and Customary Charges for infertility treatment incurred on OPD Treatment or Day Care Treatment or an In-patient Hospitalization by the Insured Person during the Policy Period up to the limit specified in the Policy Schedule or Certificate of Insurance.

17. Wellmother Cover
If an Insured Person who is less than 3 years of Age is Hospitalized in an ICU or a Neo-natal ICU or a Cardiac Care Unit of a Hospital, then We will cover the Room Rent and other boarding expenses of the Insured Person's mother to stay with the Insured Person in the same Hospital.

18. Preferred Provider Network
We will cover the Medical Expenses for an Insured Person only in Hospitals that are part of the Preferred Provider Network that agree on negotiated rates as defined and specified in the Policy Schedule or Certificate of Insurance.

19. Sports Activity Cover
We will cover the Reasonable and Customary Charges incurred towards the Hospitalization of Insured Person in relation to the Injury sustained by the Insured Person during the Policy Period while engaging in a sports activity or professional sport carried out in accordance with the guidelines, codes of good practice and recommendations for safe practices as laid down by a governing body or authority, and such Injury requires the Insured Person to be Hospitalized as an In-patient. Permanent Exclusion No.4 is not applicable in respect of this Benefit.

20. Second E - Opinion

We will cover charges for second E - opinion to be provided in respect of an Insured Person for a defined Critical Illness and/ or a medical condition occurring during the Policy Period and as per the frequency provided in the Policy Schedule or Certificate of Insurance provided that:

(i) It is agreed and understood that the Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it;

(ii) 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;

(iii) 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.

21. Health Assessment™

We will provide coverage for tests under Health Assessment™ for the Insured Person during the Policy Period which includes Cholesterol, Blood Pressure, Blood Glucose, Body Mass Index, Hip Waist Ratio and smoking status provided that:

(i) These tests will be provided at the frequency as prescribed in the Policy Schedule or Certificate of Insurance;

(ii) Where this Benefit is on a reimbursement basis, it will be covered up to the limits as specified in the Policy Schedule or Certificate of Insurance;

(iii) Where the Health Assessment™ is arranged by Us at Our Network Providers, We shall not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider in relation to the health check-up.

22. Recovery Benefit

We will pay the lump sum amount as specified in the Policy Schedule or Certificate of Insurance once in a Policy Year, in respect of an Insured Person's Hospitalization where the Hospitalisation continues for at least 10 consecutive days. This Benefit is payable only if We have paid a claim for the same Hospitalisation of the Insured Person under Section 1.1.

23. Maternity Benefit

We will cover Medical Expenses incurred in respect of a female Insured Person during the Policy Period between the Age 18 years to 45 years for the delivery of a child in a Hospital (including but not limited to caesarean section, vacuum birthing, water birthing, hypno birthing, midwife birthing) or for medically required and lawful medical termination of pregnancy.

Ectopic pregnancy shall not be covered under this Benefit, but any claims will be considered under In-patient Hospitalization under Section 1.1.

This Benefit will be available subject to the following:

(i) Up to the limits as specified in the Policy Schedule or Certificate of Insurance;

(ii) After the time period as specified in the Policy Schedule or Certificate of Insurance from the Start Date;

(iii) Up to a maximum number of deliveries/terminations as specified in the Policy Schedule or Certificate of Insurance, however not exceeding 2 deliveries (including twins), or 2 medically required and lawful terminations of pregnancies, or 1 delivery (including twins) and 1 medically required and lawful termination of pregnancy during the lifetime of the female Insured Person;

(iv) Pre or post-natal Maternity Expenses shall be covered within the Maternity Sum Insured if opted for and specified in the Policy Schedule or Certificate of Insurance.

24. New Born Baby Expenses

We will cover the Medical Expenses incurred towards In-patient Hospitalization of the New Born Baby during the Policy Period up to the limits as specified in the Policy Schedule or Certificate of Insurance provided that:

(i) The mother is covered as an Insured Person under the Policy and is Hospitalised as an In-patient for delivery;

(ii) Medical Expenses incurred on the New Born Baby during and post birth up to 90 days from the date of delivery shall be covered within the limits specified in the Policy Schedule or Certificate of Insurance.

25. Vaccination Expenses

We will, on a reimbursement basis, cover the Reasonable and Customary Charges in relation to vaccination expenses of an Insured Person up to the limits as specified in the Policy Schedule or Certificate of Insurance.
Permanent Exclusion No. 20 is not applicable in respect of this Benefit.

26. Domestic Emergency Medical assistance

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

a. 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.

b. Medical Repatriation (Transportation): When medically required, 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 or Certificate of Insurance, 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.

(i) No claims for reimbursement of Medical 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 of the name of the Insured Person and/ or Policyholder and Policy number, on the toll free number specified in the Policy Schedule or Certificate of Insurance for availing this Benefit.

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 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 travelling beyond the 28th week.
(4) With mental or nervous disorders unless Hospitalized.

27. International Emergency Medical assistance

We will provide Emergency Medical Assistance worldwide as described below when an Insured Person, during the Policy Period, is travelling 150 (one hundred and fifty) kilometres or more away from his/her residential address as mentioned in the Policy Schedule or Certificate of Insurance for a period of less than 90(ninety) days.

a. **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.
b. **Medical Repatriation (Transportation):** When medically required, 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 or Certificate of Insurance, 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.
   (i) No claims for reimbursement of Medical 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 of the name of the Insured Person and/ or Policyholder and Policy number, on the toll free number specified in the Policy Schedule or Certificate of Insurance for availing this Benefit.

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(1) Travel undertaken specifically for securing medical treatment.
(2) Injuries resulting from participation in acts of war or insurrection.
(3) Commission of 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 travelling beyond the 28th week.
(4) With mental or nervous disorders unless Hospitalized.

28. Corporate Buffer

We will provide a Corporate Buffer as specified in the Policy Schedule or Certificate of Insurance during the Policy Period provided that:

(i) All other terms, exclusions and conditions contained in the Policy or endorsed thereon remain unchanged;
(ii) Coverage under this Benefit can be opted for the listed conditions as chosen by You based on the requirements of the group and as specified in the Policy Schedule or Certificate of Insurance;
(iii) This Benefit will be available for those Insured Persons, who have already exhausted their Sum Insured limit and Reloaded Sum Insured (if applicable, under Section III.28 or III.29) subject to a limit of per Insured Person/ family or for an Illness/Injury/ medical condition as listed in the Policy Schedule or Certificate of Insurance;
(iv) Any Benefit accrued under this cover cannot be carried forward to the subsequent Policy Year.

29. Reload of Sum Insured

Once in the Policy Year, We will provide for a 100% reload of the Sum Insured specified in the Policy Schedule or Certificate of Insurance, in case the available Sum Insured is insufficient as a result of previous claims or current claims in that Policy Year provided that:

(i) This Benefit will be available for those Sum Insured categories as specified in the Policy Schedule or Certificate of Insurance;
(ii) A claim will be admissible under this Benefit only if the claim is admissible under 'In-patient Hospitalization' or 'Day Care Treatment';
(iii) The Reload of Sum Insured shall not apply to the first claim in the Policy Year unless it is related to an Injury due to a road traffic Accident where the claim amount exceeds the Sum Insured;
(iv) The Reload of Sum Insured shall not be available for claims relating to an Illness/ Injury (including its complications) for which a claim has been paid in the current Policy Year for the same Insured Person;
(v) In case of an Individual Policy, reload of Sum Insured is available to each Insured Person and can be utilised by the Insured Person who is covered under the Policy before the Sum Insured was exhausted;

(vi) In case of a Family Floater Policy, the Reloaded Sum Insured will be available on a floater basis;
(vii) If the Reloaded Sum Insured is not utilised in a Policy Year, it shall not be carried forward to the subsequent Policy Year.

30. Ultra Modern Medicine

We will cover the Reasonable and Customary Charges up to the limit specified in the Policy Schedule or Certificate of Insurance incurred on the Insured Person's In-patient Hospitalization or Day Care Treatment during the Policy Period for ultra modern medicine provided that:

(i) The Hospitalization is for Medically Necessary Treatment and the In-patient Hospitalization or Day Care Treatment is in accordance with the conditions set out in Sections 1.1 and 1.2;
(ii) Coverage under this Benefit will include Stem Cell Therapy, Robotic Surgery, Bariatric Surgery, milk teeth banking, cyberknife treatment and peritonial dialysis subject to clinical policy related to clinical efficacy and quality outcomes.
Permanent Exclusion No.28 is not applicable in respect of this Benefit.

31. Coverage Continuity in case of Pink Slip

We will provide continuity of coverage under this Policy for an Insured Person until the end of the Policy Year in case of loss of employment of such Insured Person. This section will cover loss of employment of the Insured Person as a result of an Illness contracted during the period of employment.

32. Healthy Pregnancy Program

We will provide customised, online and telephonic general tips and suggestions to expectant parents on antenatal support, labour preparation and post-partum support.

These services include customised diet plan, fitness advice, emotional support, educating on changes in the body, caution signs, advises on tests and scans, labour pain management, lactation counseling and counselling on breathing exercises for the expectant mother. The services also provide counseling on emotional support and preparation for parenting to the father.

These services are in addition to and are not meant to be availed in replacement of the Medical Advice or treatment provided by a Medical Practitioner. These services are based on general tips and suggestions and may not be suitable for all pregnancies. The Insured Person must not avail or continue these services against the advice of her Medical Practitioner. We shall have no liability and shall not be deemed to have any liability if the Insured Person fails to follow the advice or her Medical Practitioner or avails any of these services against the advice of her Medical Practitioner.

The applicable plan will be as specified in the specified in the Policy Schedule or Certificate of Insurance.

33. Comprehensive Corporate Floater

We will cover the Reasonable and Customary Charges for any of the selected illness(s) below as specified in Policy Schedule or Certificate of Insurance arising out of an Insured Person's Hospitalization, Day Care Treatment and OPD Treatment for Medical Expenses:

i. Medical Expenses for a surrogate mother.
ii. Autism.
iii. Hormone therapy for Cancer (including post surgery).
iv. Cervical Cancer vaccination.
v. Cochlear implants.
vi. Stent transplants, oral chemotherapy.
vii. Contact lens.
viii. Lucentis Injection.
ix. Hospitalisation for investigation without any active line of treatment.
x. Hair Transplant.
xi. Any kind of cosmetic surgery.
xii. Liposuction where when not medically requiredhowever recommended by a Medical Practitioner as a safe way of weight management.
xiii. Spectacles.
xiv. Lens for spectacles.
xv. Tooth implant (including ceramic/silver).
xvi. Coverage for child outside marriage.
xvii. Alcohol exclusion waiver, when not it is not breach of law.
xviii. Insect's bite.
xix. One time to and fro transportation cost within India for immediate family member to location where the Insured Person is Hospitalised.
xx. Expenses on new clothes and footwear in case of a Hospitalization due to an Accident at location away from the Insured Person's home town.
xxi. Dental expenses including scaling and filling.
xxii. Inclusion of lawful and not medically necessary abortion even if it is not life threatening or not recommended by a Medical Practitioner.
xxiii. Vaccination expenses towards any kind of cancer.
xxiv. Vaccination expenses towards Yellow fever, Swine Flu or any other kind of flu.
xxv. ART as a treatment for HIV/AIDS.

34. Wellness Coach

In order to educate, empower and engage Insured Persons to become more aware of their health and proactively manage it, each Insured Person shall have access to wellness coaching in areas such as:

(i) Weight management.
(ii) Activity and fitness.
(iii) Nutrition.
(iv) Tobacco cessation.

These coaches will be available as a chat service on Our mobile application and website or as a call back service.

We will also provide the Insured Person access to online questionnaires which will enable Us to understand the Insured Person's wellbeing and health status.

<u>Doctor on call</u>

Upon the Insured Person's request, We will also provide access to a general Medical Practitioner, available as a chat service on Our mobile application and website or as a call back service.

35. Sub-Limits for Specific Treatments/ Surgery

We will apply a Sub-Limit as Specified in the Policy Schedule or Certificate of Insurance to the Treatment, whether Medical or Surgical and of the Illness/Conditions and their complications, provided the Hospitalization is for a Medically Necessary Treatment and follows the written Medical Advice of a Medical Practitioner.

The list of such Treatments/ Surgery is defined in Annexure IV.

IV. Waivers and Discounts available for Customization for the Coverage Number Mentioned

36. External Congenital Anomaly

We will cover Medical Expenses incurred towards treatment of External Congenital Anomalies and its complications up to the limits as specified in the Policy Schedule or Certificate of Insurance.

Exclusion towards External Congenital Anomaly under Permanent Exclusions shall not apply in respect of this Benefit.

37. Co-Payment

We will offer a Co-Payment as specified in the Policy Schedule or Certificate of Insurance that shall be applicable on the payable claims under the Policy.

38. Deductible per Claim

The Deductible specified in the Policy Schedule or Certificate of Insurance shall be applicable on each payable claims in a Policy Year.

39. Deductible on Aggregate Claims

The Deductible specified in the Policy Schedule or Certificate of Insurance shall be applicable on the aggregate of all payable claims in a Policy Year.

40. Coverage under Non- Medical Expenses

Non- medical expenses as listed under Annexure V shall be covered under the Policy, if opted and specified in the Policy Schedule or Certificate of Insurance.

41. Pre-Existing Disease Waiting Period

We will not make any payment for any claim in respect of any Insured Person directly or indirectly caused by, based on, arising out of, relating to or howsoever attributable to any Pre-Existing Diseases or any complication arising from the same, until the time period specified in the Policy Schedule or Certificate of Insurance in this regard has elapsed since the Start Date of the first Policy with Us.

42. Specified Disease / Procedure Waiting Period: (Code- Excl02)

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

	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	
6	Urogenital (Urinary and Reproductive system)	Stones in Urinary system (Stone in the Kidney, Ureter, Urinary Bladder)	Prostate Surgery Surgery for Hydrocele, Rectocele and Hernia
		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) Varicose veins, Varicose ulcers	Surgery for cyst, tumour, nodule, polyp unless malignant
		Congenital Internal Diseases or Anomalies	Surgery for Varicose veins and Varicose ulcers

If any of the Illness/conditions listed above are Pre-Existing Diseases, then they will be covered only after the completion of the Pre-Existing Disease Waiting Period described under Section <<41>>.

43. 30-day Waiting Period (Code- Excl03)

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
iii. The within referred Waiting Period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

44. Waiver of exclusion of-attempted Suicide

Where this benefit is in force for an Insured Person, Permanent Exclusion No.3 will not be applicable.

V. Permanent Exclusions

We shall not be liable to make any payment for any claim under any Benefit in respect of any Insured Person directly or indirectly caused by, based on, arising out of, relating to or howsoever attributable to any of the following:

1. Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, uprising, revolution, insurrection, military or usurped acts, nuclear weapons / materials, chemical and biological weapons, ionizing radiation, contamination by radioactive material or radiation of any kind, nuclear fuel, nuclear waste.
2. Breach of law: (Code- Excl10) - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
3. Willful or deliberate exposure to danger, intentional self- Injury, non- adherence to Medical Advice, participation or involvement in naval, military or air force operation.
4. Hazardous or Adventure sports: (Code- Excl09) - Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
5. Any Illness/Injury/Accident due to abuse of intoxicants or hallucinogenic substances smoking cessation programs and the treatment of nicotine addiction unless prescribed by a Medical Practitioner.
6. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code- Excl12)

7. Obesity/ Weight Control (Code- Excl06).
   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   1) Surgery to be conducted is upon the advice of the Doctor.
   2) The surgery/Procedure conducted should be supported by clinical protocols.
   3) The member has to be 18 years of age or older and;
   4) Body Mass Index (BMI).
      a. Greater than or equal to 40 or;
      b. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         i. Obesity-related cardiomyopathy.
         ii. Coronary heart disease.
         iii. Severe Sleep Apnea.
         iv. Uncontrolled Type2 Diabetes.
8. Refractive Error: (Code- Excl15) - Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
9. All routine examinations and preventive health check-ups.
10. Cosmetic or plastic Surgery: (Code- Excl08)
    Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
11. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment).
12. Change-of-Gender treatments: (Code- Excl07)
    Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
13. Non- allopathic treatment, except as per coverage of AYUSH Treatment.
14. Conditions for which treatment could have been done on an out-patient basis without any Hospitalization.
15. Experimental treatment, investigational treatment, devices and pharmacological regimens.
16. Unproven Treatments: (Code- Excl16)
    Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
17. Investigation & Evaluation (Code- Excl04)
    a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
    b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
    Diagnostic expenses means and includes Diagnostic tests/procedures/treatment/consumables.
18. Rest Cure, rehabilitation and respite care (Code- Excl05)
    Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
    i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
    ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
19. Convalescence (except as per the coverage as coverage defined in Section 11 - Recovery Benefit), cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing.
20. Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing.
21. Admission for nutritional and electrolyte supplements unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.
22. Hearing aids, spectacles or contact lenses including optometric therapy, multifocal lens.
23. Treatment for alopecia, baldness, wigs, or toupees, and all treatment related to the same.
24. Medical supplies including elastic stockings, diabetic test strips, and similar products.
25. Any expenses incurred on prosthesis, corrective devices external durable medical equipment of any kind, like wheelchairs crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident 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).
26. Parkinson and Alzheimer's disease, general debility or exhaustion ("rundown condition"), sleep-apnea, stress.
27. External Congenital Anomalies, diseases or defects.
28. Stem cell therapy or surgery (except Hematopoietic stem cells for bone marrow transplant for hematological conditions), or growth hormone therapy.
29. Venereal disease, all sexually transmitted disease or Illness including but not limited to genital warts, Syphilis, Gonorrhea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
31. Maternity Expenses (Code - Excl18):
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy.
    ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
32. Sterility and Infertility: (Code- Excl17)
    Expenses related to sterility and infertility. This includes:
    i. Any type of contraception, sterilization.
    ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI.
    iii. Gestational Surrogacy.
    iv. Reversal of sterilization.
33. 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).
34. Admission for Organ Transplant but not compliant under the Transplantation of Human Organs Act, 1994 (amended).
35. 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.
36. Dentures and artificial teeth, Dental Treatment and Surgery of any kind, unless requiring Hospitalization due to an Accident.

37. 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.
38. Treatment for Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.
39. Expenses which are medically not required 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.
40. Treatment taken from a person not falling within the scope of definition of Medical Practitioner.
41. Treatment charges or fees charged by any Medical Practitioner acting outside the scope of license or registration granted to him by any medical council.
42. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, save for the proven material costs are eligible for reimbursement as per the applicable cover.
43. Any treatment or part of a treatment that is not of a reasonable charge, is not a Medically Necessary Treatment; drugs or treatments which are not supported by a prescription.
44. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of hospitalization claim or day care procedure (Code- Excl14).
45. Excluded Providers: (Code- Excl11)
    Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer as per Annexure VII and as disclosed in website (www.adityabirlahealth.com/healthinsurance) / notified to the Policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
46. Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing, including MRD charges (medical records department charges).
47. Non-medical expenses including but not limited to RMO charges, surcharges, night charges, service charges levied by the Hospital under any head and as specified in the Annexure V for non-medical expenses.
48. Treatment taken outside India.
49. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons (Code- Excl13).
50. In respect of the existing diseases, disclosed by the insured and mentioned in the Policy Schedule (based on insured's consent), Policyholder is not entitled to get the coverage for specified ICD codes.

VI. Claims Process

A. Claims Administration & Process

The fulfillment of the terms and conditions of this Policy (including payment of premium in full and on time) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the following in relation to claims, shall be Conditions Precedent to admission of Our liability under this Policy:

(1) On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed.
(2) The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payments that are brought about or contributed to as a consequence of or failure to follow such directions, Medical advice or guidance.
(3) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalisation records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
(4) We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

1. Claims Procedure

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.
ii. We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities at Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers.

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

(I) We/TPA 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 which We or the associated TPA has issued to the Insured Person supported with the Insured Person's KYC documents.
    (2) The Policy number.
    (3) Name of the Policyholder/Employer.
    (4) Name and address of Insured Person/Employee/member 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 or the associated TPA to consider the request, We or the associated TPA will request additional information or documentation in respect of that request.
(iii) When We or the associated TPA have obtained sufficient details to assess the request, We or the associated TPA will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim, applicable Deductibles and non-payable items, if applicable, or We may 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.

(v) 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 or the associated TPA, We or the associated TPA will make the payment of the amounts assessed to be due directly to the Network Provider.

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

(i) We or the associated TPA must be contacted to pre-authorise Cashless Facility within 24 hours of the Insured Person's Hospitalization if the Insured Person has been Hospitalized in an Emergency. Each request for pre-authorisation must be accompanied with all the following details:
   (1) The health card We have issued to the Insured Person supported with the Insured Person's KYC documents.
   (2) The Policy number.
   (3) Name of the Policyholder/Employer.
   (4) Name and address of Insured Person/Employee/member 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.
   (9) Duly completed claim form / pre-authorization form.

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

(iii) When we have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim, applicable Deductibles and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.

(iv) The authorization letter shall be issued to the Network Provider within 24 hours of receiving the complete information.

(v) 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.

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/Employer.
   (3) Name and address of the Insured Person/Employee/member 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.
   (10) Duly completed claim form.

(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.

2. Claims Documentation:

We or the associated TPA shall be provided the following necessary information and documentation in respect of all claims at the Insured Person's expense within 30 days of the Insured Person's discharge from the Hospital:

(i) Claims for Pre-hospitalization Medical Expenses and Post-hosptialization Medical Expenses to be submitted to us within 30 days of the completion of the post- Hospitalisation treatment.

(ii) For those claims for which the use of Cashless Facility has been authorised, We will be provided these documents by the Network Provider immediately following the Insured Person's discharge from the Hospital:
   (1) Duly completed claim form.
   (2) Photo ID and Age proof.
   (3) Health Card, policy copy, photo ID, KYC documents.
   (4) Original discharge card / day care summary / transfer summary.
   (5) Original final Hospital bill with all original deposit and final payment receipt.
   (6) Original invoice with payment receipt and implant stickers for all implants used during Surgeries i.e. lens sticker and Invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery.
   (7) All previous consultation papers indicating history and treatment details for current ailment.
   (8) All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription and invoice / bill with receipt from diagnostic center.
   (9) All original medicine / pharmacy bills along with the Medical Practitioner's prescription.
   (10) MLC / FIR copy – in Accidental cases only.
   (11) Copy of death summary and copy of death certificate (in death claims only).
   (12) Pre and post-operative imaging reports – in Accidental cases only.
   (13) Copy of indoor case papers with nursing sheet detailing medical history of the Insured Person, treatment details and the Insured Person's progress (if available).
   (14) KYC documents.

Where 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.

Additional documents in case of below covers.

In case of Contribution claims:

- Photocopy of entire claim document duly attested by previous Insurer or TPA.
- Original payment receipts for expenses not claimed/settled by previous insurer.
- Discharge voucher/settlement letter by previous insurer.

3. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

IV. Claims Assessment & Repudiation:

(i) At Our discretion, We may investigate claims to determine the validity of a claim. This investigation will be conducted within 15 days of the date of assigning the claim for investigation and not later than 6 months from the date of receipt of claim intimation. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals/entities that are authorised by Us in writing.

If there are any deficiencies in the necessary claim documents which are not met or are partially met. We will send a maximum of 3 (three) reminders following which We will send a rejection letter or make a part-payment if we have not received the deficiency documents after 45 days from the date of the initial request for such documents.

(ii) We may decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if We observe that such a claim is otherwise valid under the Policy. However documents/ details received beyond such period shall be considered if there are valid reasons for any delay.

(iii) Payment for reimbursement claims will be made to the Insured Person. In the unfortunate event of the Insured Person's death, We will pay the nominee named in the Policy Schedule or Certificate of Insurance, or to the Insured Person's legal heirs or legal representatives holding a valid succession certificate.

For details on the claims process or assistance during the process, the claimant may contact Us at Our call centre on the toll free number specified in the Policy Schedule or Certificate of Insurance or through Our website. In addition, We will keep the claimant informed of the claim status and explain requirement of documents. Such means of communication shall include but not be limited to mediums such as letters, email, SMS messages, and information on Our Website.

VII. Terms and Conditions

B. Material Change

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

C. Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed and stamped by Us.

D. No Constructive Notice

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

E. Eligibility

Minimum Entry Age	1 day
Maximum Entry Age	No Limit

Following relationships can be covered as dependants:

Self, lawfully wedded spouse (more than one wife)/ Partner (including same sex partners), son (biological/ adopted), daughter (biological/ adopted), mother (biological/ foster), father (biological/ foster), brother (biological/ step) sister (biological/ step, mother in-law, father in-law, son in-law, daughter in-law, brother in-law, sister in-law.

For the purpose of this section, **Partner** shall be taken as declared at the time of Start Date and no change in the same would be accepted during a Policy Period. However, an Insured Person may request for change at the time of Renewal of the cover.

It is further clarified that for the purpose of availing this Policy, the Policyholder shall ensure that the minimum number of Employees/members who will form a group to avail the Benefits under this Policy shall be 7.

F. Grace Period

The Policy may be Renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable to pay for any claim arising out of an Illness/Injury/Accident 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.

G. Premium Payment in instalments

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

i. Grace Period of 15 days would be given to pay the instalment premium due for the policy.
ii. During such Grace Period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
iii. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the Grace Period, the Policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the Policy.

H. 1. Renewal Terms

The Policy may be renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy (as stated above).
Renewals will not be denied except on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material facts or non-co-operation by the Insured Person.

2. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the Policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of Waiting Period. as per IRDAI guidelines, provided the Policy has been maintained without a break.

3. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

I. Portability

Upon the Insured Person ceasing to be an Employee/member of the Policyholder or Us discontinuing/withdrawing this product, such Insured Person shall have the option to port to an approved retail health insurance policy available with to any other Indian General/Health Insurer offering indemnity health insurance policies, if applicable, in accordance with the Portability guidelines issued by the IRDAI.

For Detailed Guidelines on portability, kindly refer the link https://www.adityabirlacapital.com/healthinsurance/

J. Migration

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

For Detailed Guidelines on migration, kindly refer the link https://www.adityabirlacapital.com/healthinsurance/

K. Communication & Notices

Any communication or notice or instruction under this Policy shall be in writing and will be sent to:
i. The Policyholder's/Insured Person, at the address as specified in the Policy Schedule or Certificate of Insurance.
ii. To Us, at the address specified in the Policy Schedule or Certificate of Insurance.
iii. No insurance agents, brokers, other person or entity is authorised to receive any notice on the behalf of Us unless explicitly stated in writing by Us.

L. Disclosure of information:

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the Policyholder.
("Material facts" for the purpose of this Policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

M. Fraud

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:

a) The suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true.
b) The active concealment of a fact by the Insured Person having knowledge or belief of the fact.
c) Any other act fitted to deceive; and
d) Any such act or omission as the law specially declares to be fraudulent.

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

N. Premium

The premium for each Policy will be determined based on the available data of each group and applicable discounts and loadings. Payment of premiums will be available in single mode or instalment options of monthly/ quarterly/ half yearly as agreed with the Policyholder.

O. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

P. Multiple Policies

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

Q. Cancellation

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

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

Cancellation Grid	
Period* for which risk is retained	Refund
Less than 1 Month	75%
1 Month- less than 3 Month	50%
3 Months – less than 6 months	25%
Beyond 6 Months	Nil

The Company may cancel the Policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

The cancellation of Policy however is not applicable for Section 8 “Sub-Limit for Specified Illness/Conditions” and Section 4 “Chronic Management Program”.

R. Electronic Transactions

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

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

S. Policy Dispute

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

T. Records to be maintained

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

U. Complete Discharge

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

V. Assignment

An Insured Person may assign the Benefits or any specific Benefit(s) under the Policy by giving written notice of the assignment and the terms and conditions of the assignment to Us. We will record the assignment in accordance with Section 38 of the Insurance Act 1938.

W. Redressal of Grievance

In case of a grievance, the Insured Person/ Policyholder can contact Us with the details through:

Our website: www.adityabirlacapital.com/healthinsurance

Email: care.healthinsurance@adityabirlacapital.com

Toll Free: 1800 270 7000

Address: Aditya Birla Health Insurance Co. Limited, 9th Floor, Tower 1, One Indiabulls Centre, Jupiter Mills Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai 400013.

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

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the Grievance officer - https://www.adityabirlacapital.com/healthinsurance/

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

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

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

X. Condition Precedent to Admission of Liability

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

Y. Moratorium Period

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

Z. Nomination:

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

VIII. Definitions

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

2. **Age** or **Aged** is the age as on last birthday, and which means completed years as at the Start Date.

3. **Alternative Treatments** are forms of treatments other than "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

4. **Ambulance** means a motor vehicle operated by a licenced/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

5. **Annexure** means a document attached and marked as Annexure to this Policy.

6. **Associated Medical Expenses** shall include Room Rent, Qualified Nurses' charges, Medical Practitioners' fees including surgeon/ anaesthetist/specialist, within the same Hospital where the Insured Person has been admitted. "Associated Medical Expenses" does not include cost of pharmacy and consumables, cost of implants and medical devices and cost of diagnostics.

7. **AYUSH Treatment** refers to the medical and / or Hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

8. An **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

   a. Central or State Government AYUSH Hospital; or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy.

   or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
   i. Having at least 5 in-patient beds.
   ii. Having qualified AYUSH Medical Practitioner in charge round the clock.
   iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out.
   iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

9. **Benefit** means any benefit shown in the Policy.

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

11. **Certificate of Insurance** means the certificate We issue to the Insured Person confirming the Insured Person's cover under the Policy.

12. **Co-Payment** means a cost sharing requirement under a health insurance Policy that provides that the Policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

13. **Condition Precedent** means a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

14. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

   a) **Internal Congenital Anomaly** - Congenital anomaly which is not in the visible and accessible parts of the body.
   b) **External Congenital Anomaly** - Congenital anomaly which is in the visible and accessible parts of the body.

15. **Critical Illness**

1. CANCER OF SPECIFIED SEVERITY

I. A malignant tumour characterised 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 leukaemia, 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 tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0 .
   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 tumours in the presence of HIV infection.

2. MYOCARDIAL INFARCTION

(First Heart Attack of specific 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 key hole 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 (hemodialysis 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 embolization 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 NEURON DISEASE WITH PERMANENT SYMPTOMS
   I. Motor neurone 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. ANGIOPLASTY
   I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50% of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).
   II. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.
   III. Diagnostic angiography or investigation procedures without angioplasty / stent insertion are excluded.

13. 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 medical specialist.
      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.

14. 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 aids or surgical procedure.

15. DEAFNESS

I. Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing" in both ears.

16. 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 mm Hg); and
   iv. Dyspnea at rest.

17. END STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
   i. Permanent jaundice; and
   ii. Ascites; and
   iii. Hepatic encephalopathy.

II. Liver failure secondary to alcohol or drug abuse is excluded.

18. LOSS OF SPEECH

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by and Ear, Nose, Throat (ENT) specialist.

II. All psychiatric related causes are excluded.

19. LOSS OF LIMBS

I. The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

20. MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:
   i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
   ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
   iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa.
   iv. Mobility: the ability to move indoors from room to room on level surfaces.
   v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.
   vi. Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:
   i. Spinal cord injury.

21. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:
   i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
   ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

22. 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.

23. PARKINSON'S DISEASE

The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist acceptable to us.
The diagnosis must be supported by all of the following conditions:

a. The disease cannot be controlled with medication.
b. Signs of progressive impairment; and

c. Inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

Activities of daily living:

i. Washing: The ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene.
ii. Dressing: The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
iii. Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa.
iv. Toileting: The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.
v. Feeding: The ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
vi. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence.

Parkinson's disease secondary to drug and/or alcohol abuse is excluded.

24. ALZHEIMER'S DISEASE

Alzheimer's disease is a progressive degenerative Illness of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.

Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a specialist Medical Practitioner (Neurologist) and supported by Our appointed Medical Practitioner, evidenced by findings in cognitive and neuro radiological tests (e.g. CT scan, MRI, PET scan of the Brain). The disease must result in a permanent inability to perform three or more Activities with Loss of Independent Living" or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days.

The following conditions are however not covered:

a. Non-organic diseases such as neurosis and psychiatric Illnesses.
b. Alcohol related brain damage; and
c. Any other type of irreversible organic disorder/dementia.

25. AORTA GRAFT SURGERY

The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.

The Insured Person understands and agrees that we will not cover:

a. Surgery performed using only minimally invasive or intra arterial techniques.
b. Angioplasty and all other intra arterial, catheter based techniques, "keyhole" or laser procedures.

The aorta is the main artery carrying blood from the heart. Aortic graft surgery benefit covers surgery to the aorta wherein part of it is removed and replaced with a graft.

26. APLASTIC ANAEMIA

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

a. Blood product transfusion.
b. Marrow stimulating agents.
c. Immunosuppressive agents; or
d. Bone marrow transplantation.

The diagnosis must be confirmed by a haematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following:

a. Absolute neutrophil count of 500/mm^3 or less.
b. Platelets count less than 20,000/mm^3 or less.
c. Absolute Reticulocyte count of 20,000/mm^3 or less.

Temporary or reversible Aplastic Anaemia is excluded.

In this condition, the bone marrow fails to produce sufficient blood cells or clotting agents.

27. BACTERIAL MENINGITIS

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal chord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks resulting in permanent inability to perform three or more Activities for Loss of Independent Living.

This diagnosis must be confirmed by:

a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
b. A consultant neurologist certifying the diagnosis of bacterial meningitis.

Bacterial Meningitis in the presence of HIV infection is excluded.

28. APALLIC SYNDROME OR PERSISTENT VEGETATIVE STATE (PVS)

Apallic Syndrome or Persistent vegetative state (PVS) or unresponsive wakefulness syndrome (UWS) is a universal necrosis of the brain cortex with the brainstem remaining intact. The patient should be in a vegetative state for a minimum of four weeks in order to be classified as UWS, PVS, Apallic Syndrome.

The diagnosis must be confirmed by a Neurologist acceptable to Us and the condition must be documented for at least one month.

In this condition, the patient with severe brain damage progresses who was in coma, progresses to a wakeful conscious state, but not in a state of true awareness.

29. ENCEPHALITIS

Severe inflammation of the brain tissue due to infectious agents like viruses or bacteria which results in significant and permanent neurological deficits for a minimum period of 30 days, certified by a specialist Medical Practitioner (Neurologist)

The permanent deficit should result in permanent inability to perform three or more Activities for Loss of Independent Living.
Exclusions:

- Encephalitis in the presence of HIV infection is excluded.

30. FULMINANT HEPATITIS

A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

a. Rapid decreasing of liver size.
b. Necrosis involving entire lobules, leaving only a collapsed reticular framework.
c. Rapid deterioration of liver function tests.
d. Deepening jaundice; and
e. Hepatic encephalopathy.

Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

31. CHRONIC RELAPSING PANCREATITIS

An unequivocal diagnosis of Chronic Relapsing Pancreatitis, made by a Registered Doctor who is a specialist in gastroenterology and confirmed as a continuing inflammatory disease of the pancreas characterised by relapses in the form of sub lethal attacks of acute pancreatitis, irreversible morphological change and typically causing pain and/or permanent impairment of function. The condition must be confirmed by elevated levels of pancreatic function tests including serum amylase, serum lipase, and radiographic and imaging evidence. Relapsing Pancreatitis caused directly or indirectly, wholly or partly, by alcohol is excluded.

32. MEDULLARY CYSTIC DISEASE

A progressive hereditary disease of the kidneys characterised by the presence of cysts in the medulla, tubular atrophy and intestitial fibrosis with the clinical manifestations of anaemia, polyuria and renal loss of sodium, progressing to chronic renal failure. The diagnosis must be supported by renal biopsy.

33. MUSCULAR DYSTROPHY

A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist acceptable to Us, with confirmation of at least 3 of the following 4 conditions:

a. Family history of muscular dystrophy.
b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction.
c. Characteristic electromygrom; or
d. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

34. POLIOMYELITIS

The unequivocal diagnosis of infection with the polio virus must be established by a Consultant Neurologist. The infection must result in irreversible paralysis as evidenced by impaired motor function or respiratory weakness. Expected permanence and irreversibility of the paralysis must be confirmed by a Consultant Neurologist after at least 6 months since the beginning of the event.
Exclusions:

- Cases not involving irreversible paralysis will not be eligible for a claim.
- Other causes of paralysis such as Guillain-Barré Syndrome are specifically excluded.

35. SYSTEMIC LUPUS ERYTHEMATOUS

A multi-system, multifactorial, autoimmune disorder characterised by the development of auto- antibodies directed against various self-antigens. Systemic lupus erythe-matosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V lupus nephritis, established by renal biopsy, and in accordance with the World Health Organization (WHO) classification). The final diagnosis must be confirmed by a registered Medical Practitioner specialising in Rheumatology and Immunology acceptable to Us, Other forms, discoid lupus, and those forms with only haematological and joint involvement are however not covered:
The WHO lupus classification is as follows:

a. Class I: Minimal change – Negative, normal urine.
b. Class II: Mesangial – Moderate proteinuria, active sediment.
c. Class III: Focal Segmental – Proteinuria, active sediment.
d. Class IV: Diffuse – Acute nephritis with active sediment and/or nephritic syndrome.
e. Class V: Membranous – Nephrotic Syndrome or severe proteinuria.

36. BRAIN SURGERY

The actual undergoing of surgery to the brain under general anesthesia during which a craniotomy is performed.
Exclusion:
Burr hole surgery / brain surgery on account of an accident.

16. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:

i. Undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
ii. Which would have otherwise required hospitalization of more than 24 hours.

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

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

18. **Deductible** means a cost sharing requirement under a health insurance Policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

19. **Dependent Child** means a child (natural or legally adopted or stepchild), who is financially dependent on the Insured Person, does not have his / her independent source of income, and is up to the Age of 25 years.

20. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

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

22. **Domiciliary Hospitalization** means medical treatment for an illness/disease/ injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    i) The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    ii) The patient takes treatment at home on account of non-availability of room in a hospital.

23. **Emergency** means a serious medical condition or symptom resulting from Injury or Illness which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an Emergency anymore.

24. **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the insured person's health.

25. **Employee** means any member of the Policyholder's staff under full time employment who is nominated and sponsored by the Policyholder and who becomes an Insured Person under the Policy.

26. **Expiry Date** means the date on which this Policy expires as specified in the Policy Schedule or Certificate of Insurance.

27. **Family Floater Policy** means a Policy named as a Family Floater Policy in the Policy Schedule or Certificate of Insurance under which the family members named as Insured Persons in the Policy Schedule are covered.

28. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as Waiting Periods and coverage of Pre-Existing Diseases. Coverage is not available for the period for which no premium is received.

29. **Hospital** means any institution established for in- patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:
    i) Has qualified nursing staff under its employment round the clock.
    ii) Has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places.
    iii) Has qualified Medical Practitioner (s) in charge round the clock.
    iv) Has a fully equipped operation theatre of its own where surgical procedures are carried out.
    v) Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

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

31. **IRDAI** means the Insurance Regulatory and Development Authority of India.

32. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

    (a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.

    (b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
    1. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests.
    2. It needs ongoing or long- term control or relief of symptoms.
    3. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it.
    4. It continues indefinitely.
    5. It recurs or is likely to recur.

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

34. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

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

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

37. **In-patient** means an Insured Person who is admitted to a Hospital and stays for at least 24 hours for the sole purpose of receiving treatment.

38. **Inpatient Care** means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.

39. **Insured Person** means the person(s) named in the Policy Schedule to whom a Certificate of Insurance has been issued, who is/are covered under this Policy, and in respect of whom the appropriate premium has been received.

40. **Maternity Expenses** means:
    a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).
    b) Expenses towards lawful medical termination of pregnancy during the Policy period.

41. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow- up prescription.

42. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

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

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

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

46. **Monthly Premium** shall mean the applicable annual premium with respect to the Insured Person(s) split in 12 months in equal proportion only for the purpose of calculation of Benefit(s) under this Policy.

47. **New Born Baby** means baby born during the Policy Period and is aged upto 90 days.

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

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

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

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

52. **Policy** means this Policy document containing the Terms and Conditions, the Proposal Form, Policy Schedule, Add-On Benefit Details (if applicable) and Annexures which form a part of the Policy including endorsements, as amended from time to time which form a part of the Policy and shall be read together.

53. **Policy Period** means the period between the Start Date and the Expiry Date as specified in the Policy Schedule or the Certificate of Insurance or the date of cancellation of this Policy, whichever is earlier.

54. **Policy Schedule** means the schedule attached to and forming part of this Policy mentioning the details of the group, the period and the limits to which Benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

55. **Policy Year** means a period of 12 consecutive months commencing from the Start Date.

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

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

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

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

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

61. **RBI** means the Reserve Bank of India.

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

63. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the renewal continuous for the purpose of gaining credit for Pre-Existing Diseases, time- bound exclusions and for all Waiting Periods.

64. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated Medical Expenses.

65. **Single Private Room** means a basic (cheapest) category of single room in a Hospital with/without air-conditioning facility where a single patient is accommodated and which has an attached toilet (lavatory and bath).

66. **Shared Room** means a basic (cheapest) category of shared room in a Hospital with/without air-conditioning with two or three patient beds.

67. **General Ward Or Economy Ward** means the cheapest category room in a Hospital with more than three patient beds.

68. **Start Date** of the Policy means the inception date of this Policy as specified in the Policy Schedule or Certificate of Insurance.

69. **Sum Insured** means:
    a. For an Individual Policy, the amount specified in the Policy Schedule or Certificate of Insurance against an Insured Person which is Our maximum, total and cumulative liability for any and all claims arising during a Policy Year in respect of that Insured Person.
    b. For a Family Floater Policy, the amount specified in the Policy Schedule or Certificate of Insurance which is Our maximum, total and cumulative liability for any and all claims arising during a Policy Year in respect of any and all Insured Persons.

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

71. **Third Party Administrator (TPA)** means a Company registered with the IRDAI, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services. The updated list of TPAs (along with complete address and contact numbers) shall be available on Our website.

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

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

74. **We/Our/Us** means Aditya Birla Health Insurance Company Limited.

75. **You/Your/Policyholder** means the person named in the Policy Schedule or Certificate of Insurance as the Policyholder and who has concluded this Policy with Us.

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