Group Protect - Policy Terms and Conditions

I. PREAMBLE

This Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided by You in respect of the Insured Persons in the Proposal Form, any application for insurance cover in respect of any Insured Person and any other information or details submitted in relation to the proposal form / enrolment form. This Policy is a contract of insurance between You and Us which is subject to receipt of premium in full and accepted by Us in respect of the Insured Persons and the terms, conditions and exclusions as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

Key Notes:
The terms listed in Section VII (Definitions) and which have been used elsewhere in the Policy shall have the meaning set out against them in Section VII (Definitions), wherever they appear in the Policy.

The Policyholder prior to inception of the Policy can propose to cover any of the Policy Benefit or combination of Policy Benefits as specified in Product Benefit Table of this Policy, as per requirement of the group, subject to acceptance by Us. The Policy Schedule / Certificate of Insurance of this Policy shall specify which of the following covers are in force and available for the Insured Persons under the Policy during the Policy Period.

II. BENEFITS UNDER THE POLICY

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

All claims must be made in accordance with the procedure set out in Section V.

1. OPD Expenses

We shall indemnify the Reasonable and Customary Charges incurred towards Medically Necessary Treatment taken by the Insured Person during the Policy Period for an Illness, Injury if it is contracted or sustained by an Insured Person during the Policy Period up to the limits as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

(a) Doctor Consultation:

What is covered

We shall indemnify the Reasonable and Customary Charges incurred towards the medically required consultations, visit(s) to a doctor (Medical Practitioner holding a minimum qualification of MBBS), E consultation and/or Tele consultation for the specialties listed in the Policy Schedule / Certificate of Insurance, within Our Network only if opted which are incurred on an out-patient basis up to the limits as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

What is not covered

(i) Any out-patient consultation which costs more than the limits as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

(b) Diagnostic Tests:

What is covered

We shall indemnify the Reasonable and Customary Charges incurred towards the medically required diagnostics tests listed in the Policy Schedule / Certificate of Insurance, which are incurred on an out-patient basis up to the limits as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

What is not covered

(i) Any out-patient diagnostic test which costs more than the limits as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

(c) Pharmacy Expenses:

What is covered

We shall indemnify the Reasonable and Customary Charges incurred towards the medically required pharmacy expenses which are incurred on an out-patient basis up to the limits as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

What is not covered

(i) Any out-patient pharmacy expenses which cost more than the limits as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

Exclusions applicable to Section II.1

We shall not be liable to make any payment for any claim under Section II.1 of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

1. In-patient treatment and day care procedures.
2. Naturopathy treatment(s).
3. CT & MRI

2. Cancer Secure Cover

The Sum Insured for each Benefit / Stage of Cancer under this Benefit shall be as specified against that Benefit in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

Additional Benefits mentioned under Sections II.2.1 to Section II.2.6 to Cancer Secure Cover can only be opted along with Option 2 of Cancer Secure Cover. Any claim paid for Additional Benefits mentioned under Sections II.2.1 to Section II.2.6 to Cancer Secure Cover cannot be renewed for the lives for which the claim(s) have been paid (except Section II.2.1 Second Opinion and / or Section II.2.3 Counselling Sessions).

Limits for the Additional Benefits mentioned under Sections II.2.1 to Section II.2.6 to Cancer Secure Cover are over and above the Sum Insured of Cancer Secure Cover as specified Benefit in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

What is covered

If the Insured Person suffers from a covered Illness of the nature as specified below, under the Option opted for, during the Policy Period and while the Policy is in force, then We shall pay the percentage of the Sum Insured as specified for that covered Illness under the Option opted for, provided that the covered Illness is first diagnosed or first manifests itself during the Policy Period as a first incidence.

For the purpose of this Benefit, covered Illness shall mean Early Stage Cancer, or Major Stage Cancer or Advanced Stage Cancer as defined under this Benefit and as specified to be covered under the Options set out below.

The coverage under this Benefit shall terminate for the Insured Person, on the occurrence of the earlier of the following:

(a) Once a claim for Major Stage Cancer or Advanced Stage Cancer becomes admissible.
(b) Death of the Insured Person.
(c) End of the Policy Period.

Conditions

(a) For Option 1:

i) Our maximum liability under this Option during the lifetime of the Insured Person: 100% of the Sum Insured as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.
ii) Maximum number of claims: Only one claim shall be admissible for either Major Stage Cancer or an Advanced Stage Cancer.
iii) On the diagnosis of a Major Stage Cancer as defined below, 100% of the Sum Insured shall be payable. Once a claim for Major Stage Cancer becomes admissible, this cover shall terminate. A claim for an Early Stage Cancer shall not be payable on the diagnosis of a Major Stage Cancer.
iv) On the diagnosis of an Advanced Stage Cancer as defined below, 100% of the Sum Insured shall be payable. Once a claim for Advanced Stage Cancer becomes admissible, this cover shall terminate. A claim for either Early Stage Cancer or Major Stage Cancer shall not be payable on the diagnosis of an Advanced Stage Cancer.
v) Grid for the Insured Events is as below:

Permutation	Event	Benefit Pay out as % of the Sum Insured	Cover terminates
1	Major Stage Cancer	100%	Yes
2	Advanced Stage Cancer	100%	Yes

vi) This Benefit will not be payable if the covered Illness is first detected at the time of post-mortem or at any time post death of the Insured Person.

(b) For Option 2:

i) Maximum liability under this Option during the lifetime of the Insured Person: 150% of the Sum Insured as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy for this cover.
ii) Maximum number of claims: Only one claim shall be admissible for Early Stage Cancer, and only one claim shall be admissible for either Major Stage Cancer and/or Advanced Stage Cancer.
iii) On the diagnosis of an Early Stage Cancer (Carcinoma-in-situ) as defined below, 50% of the Sum Insured or Rs. 10 Lacs, whichever is lower, shall be payable. Only once instance of Early Stage Cancer shall be admissible under this Option.
iv) On the diagnosis of a Major Stage Cancer: 100% of the Sum Insured shall be payable. Once a claim for Major Stage Cancer becomes admissible, this cover shall terminate.
v) On the diagnosis of an Advanced Stage Cancer, 150% of the Sum Insured shall be payable. Once a claim for Advanced Stage Cancer becomes admissible, this cover shall terminate.
vi) If subsequent to a payment under the Policy for Early Stage Cancer, a claim for Major Stage Cancer or Advanced Stage Cancer is admissible, the total payment under the Option shall be limited to 150% of the Sum Insured.
vii) If there is more than one covered Illness diagnosed within a period of 48 hours, then only one claim, with the highest Benefit pay-out shall be admissible.
viii) Transition grid for the Insured Events is as below:

Permutation	Event	Benefit Pay out as % of the Sum Insured	Cover terminates
1	Early Stage Cancer	50% or Rs. 10Lacs, whichever is lower	No
	Major Stage Cancer	100%	Yes
2	Major Stage Cancer	100%	Yes
3	Advanced Stage Cancer	150%	Yes
4	Early Stage Cancer	50% or Rs. 10Lacs, whichever is lower	No
	Advanced Stage Cancer	100%	Yes

ix) This Benefit will not be payable if the covered Illness is first detected at the time of post-mortem or at any time post death of the Insured Person.

For Cancer Secure Cover, various Stages are defined as below:

Early Stage Cancer:

This shall include the following:

1. Carcinoma in situ of the following sites: breast, uterus, ovary, fallopian tube, vulva, vagina, cervix uteri, colon, rectum, penis, testis, lung, liver, stomach, nasopharynx or bladder.
   Carcinoma in situ means the focal autonomous new growth of carcinomatous cells confined to the cells in which it originated and has not yet resulted in the invasion and/or destruction of surrounding tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The diagnosis of the Carcinoma in situ must always be supported by a histopathological report. Furthermore, the diagnosis of Carcinoma in situ must always be positively diagnosed upon the basis of a microscopic examination of the fixed tissue, supported by a biopsy result. Clinical diagnosis does not meet this standard.

2. Clinical diagnosis or Cervical Intraepithelial Neoplasia (CIN) classification which reports CIN I, CIN II, and CIN III (severe dysplasia without carcinoma in situ) shall not be considered to meet the required standard under this definition, and are specifically excluded. Carcinoma in situ of the biliary system is also specifically excluded.
3. Prostate Cancer that is histologically described using the TNM Classification as T1N0M0 or Prostate cancers described using another equivalent classification.
4. Thyroid Cancer that is histologically described using the TNM Classification as T1N0M0.
5. Tumours of the Urinary Bladder histologically classified as T1N0M0 (TNM Classification).
6. Chronic Lymphocytic Leukaemia (CLL) RAI Stage 1 or 2. CLL RAI Stage 0 or lower is excluded.
7. Malignant melanoma that has not caused invasion beyond the epidermis.
8. Other skin carcinoma & their complications are excluded.

Major Stage Cancer (Cancer of Specified Severity):

I. A malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukaemia, lymphoma and sarcoma.
II. All tumors and their complications are excluded as stated below -
    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 & 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 tumors & their complications in the presence of HIV infection or related to HIV Infection.

Advanced Stage Cancer (Metastatic Cancer):

All Stage IV malignant tumor with the presence of distant metastasis. A spread to lymph nodes only is not covered under this definition. The diagnosis of malignancy must be confirmed by histological evidence.
Metastatic cancer is a cancer that has spread from the part of the body where it started (the primary site) to other parts of the body. When cancer cells break away from a tumour, they can travel to other areas of the body through the bloodstream, the lymph system (which contains a collection of vessels that carry fluid and immune system cells) or through the peritoneum.
The following are excluded:

i. Locally advanced cancers (these will be considered as Early Stage Cancer/ Stage II of Major Stage Cancer for the purpose of this Policy)
ii. Any leukaemia and lymphoma (these will be considered as Stage II Major Stage Cancer for the purpose of this Policy)

(c) Initial Waiting Period (Applicable for both Options 1 and 2):

We shall not be liable to make any payment in respect of any of the covered Illnesses of the nature specified in this Section II.2 whose consultation, investigation, diagnosis, treatment or admission commencing within the number of days as specified in the Policy Schedule/ Certificate of Insurance, from the Start Date of this Policy.

(d) Survival Period (Applicable for both Option 1 and 2):

The payment of a Benefit under Section II.2 shall be subject to survival of the Insured Person for the number of days as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy following the first diagnosis of the covered Illness/undergoing the Surgical Procedure for the first time.

Exclusions applicable to Section II.2 "Cancer Secure Cover":

We shall not be liable to make any payment for any claim under Section II.2 "Cancer Secure Cover" of this Policy in respect of an Insured Person towards a covered Illness, directly or indirectly caused by, based on, arising out of or in any way attributable to any of the following:

1. Any Illness other than those specified as covered Illnesses under this Section II.2 of this Policy;
2. Narcotics used by the Insured Person unless taken as prescribed by a Medical Practitioner;

2.1 Second Opinion

What is covered

If the Insured Person is diagnosed with either any Early Stage Cancer, Major Stage Cancer or Advanced Stage Cancer during the Policy Period and the claim becomes admissible under Section II.2 Cancer Secure Cover, then the Insured Person may at his/her sole discretion choose to avail an e-opinion from Our panel of Medical Practitioners for any Surgical Procedure/Surgery/course of treatment related to Early Stage Cancer, Major Stage Cancer or Advanced Stage Cancer.

Conditions

It is agreed and understood that the e- opinion will be based only on the information and documentation provided to Us, which will be shared with the Medical Practitioner and is subject to the conditions specified below:

(i) This Benefit can be availed by the Insured Person only once during the Policy Period for the same covered Illness, i.e. not more than once for either Early Stage Cancer, Major Stage Cancer or Advanced Stage Cancer.
(ii) It is agreed and understood that the Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.
(iii) Appointments to avail of this Benefit may be availed through Our call centre on the toll free number specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.
(iv) Under this Benefit, We are only providing the Insured Person with access to an e-opinion and We shall not be deemed to substitute the Insured Person's physical visit to or consultation with an independent Medical Practitioner.
(v) The E-opinion provided under this Benefit shall be limited to the covered Illnesses and not be valid for any medico legal purposes.
(vi) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.
(vii) If this Benefit has been availed for an Early Stage Cancer, and renewed post the completion of the Policy Period along with Section II.2, the Insured Person is eligible to avail only Major Stage Cancer and / or Advanced Stage Cancer second E-Opinion, post such successful renewal.

2.2 Post Cancer OPD Consultations/Medication

What is covered

If the Insured Person is diagnosed with either the Major Stage Cancer or Advanced Stage Cancer during the Policy Period and the claim becomes admissible under Section II.2 Cancer Secure Cover , then We shall pay the limit applicable for this Benefit, divided equally and paid for the selected number of subsequent quarters as specified in the Policy Schedule / Certificate of Insurance of this Policy towards the cost of OPD consultations with Medical Practitioner and prescribed medication by the Medical Practitioner for the same Illness, post the said medication and consultation is availed.

Conditions

(i) The limit specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy is limited to per Insured Person per Policy Year.

2.3 Counselling Sessions

What is covered

If the Insured Person is diagnosed with either Early Stage Cancer, Major Stage Cancer or Advanced Stage Cancer during the Policy Period and the claim becomes admissible under Section II.2 Cancer Secure Cover, then We shall pay the limit per counselling session applicable for this Benefit for the selected number of counselling sessions as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy towards the cost of such counselling session(s), post the said counselling session is availed.

Conditions

(i) The limit specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy is limited to per Insured Person\ per Policy Year.

(ii) If this Benefit has been availed along with an Early Stage Cancer, the Insured Person is eligible to avail the Benefit under this Benefit only with Major Stage Cancer and / or Advanced Stage Cancer, for the subsequent Policy Year.

2.4 Reconstructive Surgery

What is covered

If the Insured Person is diagnosed with either Major Stage Cancer or Advanced Stage Cancer during the Policy Period and the claim becomes admissible under Section II.2 Cancer Secure Cover, then We shall pay the limit for this Benefit as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy towards the reconstructive surgery for the said condition, if medically required and availed.

Conditions

(i) The limit specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy is limited to per Insured Person per Policy Year.

2.5 Palliative Care

What is covered

If the Insured Person is diagnosed with an Advanced Stage Cancer during the Policy Period and the claim becomes admissible under Section II.2 Cancer Secure Cover, then We shall pay the daily limit for this Benefit, up to a maximum period as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy towards palliative care, post the said palliative care is availed.

Conditions

(i) The limit specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy is limited to per Insured Person per Policy Year.

2.6 Genetic Testing

What is covered

If the Insured Person is diagnosed with either the Major Stage Cancer or Advanced Stage Cancer during the Policy Period and the claim becomes admissible under Section II.2 Cancer Secure Cover, then We shall pay the limit for this Benefit as specified in the Policy Schedule / Certificate of Insurance /Product Benefit Table of this Policy towards the genetic testing of the Insured Person for the same detected Illness, post the said genetic testing is availed.

Conditions

(i) The limit specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy is limited to per Insured Person per Policy Year.

3. Income Protect

What is covered

We shall pay the monthly limit as specified for this Benefit in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy against this Benefit for each continuous and completed month, if the Insured Person is Hospitalized as an In-patient due to an Injury/Illness, in excess of 7 consecutive days and disables the Insured Person from engaging in activities of daily routine such as bathing and traveling, as a result, from performing duties of any employment or occupation during the Policy Period due to the same Injury/Illness and while the Policy is in force.

Conditions

a) Only Salaried Individuals are eligible for coverage under this Benefit, where such Primary Occupation is evidenced by their ITR (Income Tax Return) for the 2 years preceding the date of loss of income

b) The Insured Person is employed on the direct payroll of an organization or entity having a registered office in India for a minimum of six continuous months before the Start Date, or of an Indian branch of such organization or entity.

c) Our liability to make any payment under this Benefit shall be in excess of a Deductible of number of days for each claim as specified in Policy Schedule/ Certificate of Insurance, and subject to the maximum duration as specified in Policy Schedule / Certificate of Insurance against this Benefit.

d) The Deductible for the number of days as specified in Policy Schedule / certificate of Insurance commences from the 1st day of Inpatient Hospitalisation and subsequent days thereon satisfying the following
   a. Insured person is not able to engage in activities of daily routine such as bathing, traveling or performing duties of any employment or occupation owing to the same illness continuously for the number of deductible days as specified in Certificate of Insurance / Policy Schedule.

e) Such disablement owing to the Illness/ Injury is certified by a treating Medical Practitioner holding a minimum qualification of MBBS.

f) This Benefit shall be payable monthly for every 30 days of continuous disability of the Insured Person, upon completion of the Deductible, and until reinstatement of employment with the same or any other employer, whether confirmed or on probation or if the Insured Person has recovered to a stage where the Insured Person can engage in activities of daily routine.

g) If the disability to engage in activities of daily routine such as bathing, traveling or performing duties of any employment continues for less than 30 days after completion of the Deductible of 7 days, then this Benefit shall be payable for one monthly amount specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy against this Benefit.

h) In the event of the death of the Insured Person at any point in time after a claim has been registered with Us under this Benefit and is deemed payable, We shall be liable to pay the monthly amounts as specified in the Policy Schedule / Certificate of Insurance / Product

Benefit Table of this Policy, up to the maximum number of months specified against this Benefit in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy, after which the Policy shall cease to operate in relation to the Insured Person.

i) The onus of establishing that the loss of income was due to an involuntary reason, and providing proof of such reason where required by Us, shall lie on the Insured Person.

j) Once a claim has been considered admissible and payable by Us under this Section II.3, any subsequent Renewal of the cover under this Section II.3 will be solely as per Our discretion, on a case to case basis.

k) Any monthly amounts being paid under an admitted claim under this Section II.3 shall be discontinued if We reasonably believe that the Insured Person is demonstrably not undergoing the prescribed medical treatment as advised by the consulting Medical Practitioner, or as advised by Our medical team, which We believe can assist in timely and permanent recovery of the Insured Person and/or reinstatement of/employment in his/her Primary Occupation, or any occupation of similar nature.

(a) Initial Waiting Period

We shall not be liable to make any payment in respect of this Benefit as specified in this Section II.3 for any Hospitalization first commencing within the number of days as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy from the Start Date of initial Policy with Us.

(b) Exclusions applicable to Section II.3

We shall not be liable to make any payment for any claim under Section II.3 "Income Protect" of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

1. The Insured Event occurring prior to the Start Date or arising within the initial Waiting Period as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.
2. Any Involuntary Unemployment of the Insured Person that is attributed to any dishonesty, misconduct or fraud, or poor performance ratings of the Insured Person, or any wilful violation by the Insured Person of any internal rules/regulations/policies, or any laws or any directives issued by a Public Authority and in force, or any disciplinary action initiated against the Insured Person by his/her employer.
3. Unemployment from any occupation or job which is casual, temporary, seasonal or contractual in nature, or where the Insured Person is not on the direct payroll of the employer.
4. Any voluntary unemployment, self-resignation, or voluntary retirement.
5. Any Involuntary Unemployment or suspension of the Insured Person at his/her Primary Occupation, which is temporary in nature.
6. Any unemployment from any occupation or job in which no salary was ever provided to the Insured Person.
7. Any unemployment occurring while the Insured Person, who is a Salaried Individual, is still under his/her probation, including any unemployment resulting from non-confirmation of his/her employment by the employer during or after the period on probation.
8. Any suspension of the Insured Person from his/her Primary Occupation on account of any pending enquiry being conducted by the employer or a Public Authority.
9. Any unemployment due to non-extension of a maternity/paternity leave, either as per the Maternity Benefit Act 1961, as amended from time to time, or as per the employer's internal regulation/policy in force at the time of the Insured Event.
10. Any unemployment due to any strike or labour disturbance in which the Insured Person is directly or indirectly involved.
11. Any reasonable belief that the Insured Person was aware that such loss of income was likely to happen, whether or not any official communication was provided, at the time of Start Date.
12. Withdrawal of offer of employment by an employer.

4. Preferred Provider Network

What is covered

We shall cover the Medical Expenses incurred by an Insured Person only at Our applicable Network Providers / Empaneled Service Providers that are part of the 'Preferred Provider Network' as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy on a Cashless Facility basis.

Conditions

i. Only Cashless facilities can be availed at Our Network Providers/ Empaneled Service Providers.
ii. We shall not cover Medical Expenses incurred beyond Our applicable Network Providers / Empaneled Service Providers.
iii. This Benefit is applicable only along with Section II.1 "OPD Expenses".

5. Heart Secure Cover

What is covered

If the Insured Person suffers from any of the covered Illnesses of the nature as specified in the list of covered Illnesses below, under the Option opted for, during the Policy Period and while the Policy is in force, then We shall pay the Sum Insured as set out for that covered Illness provided that the said covered Illness is first diagnosed or first manifests itself during the Policy Period as a first incidence.

Once a claim for a covered Illness under this cover is admissible in respect of an Insured Person, the Policy terminates for that Insured Person and no further Renewals shall be allowed for that Insured Person under this Benefit.

Conditions

a) Our maximum liability during the lifetime of the Insured Person: 100% of the Sum Insured.
b) Maximum number of claims: Only one claim shall be admissible for any of the covered Illnesses provided below.
c) If there is more than one covered Illness diagnosed within a period of 48 hours, only one claim with the highest Benefit pay-out shall be admissible.

Covered Illnesses under this Benefit

Sr. No	Name of listed Illness	Payout as a % of S.I	Option A	Option B	Option C	Option D	Option E	Option F	Option G	Option H
1	First Heart Attack of specified severity	100%	Available	Available	Available	Available	Available	Available	Available	Available
2	Open Chest CABG	100%	Available	Available	Available	Available	Available	Available	Available	Available
3	Open Heart Replacement Or Repair Of Heart Valves	100%	Available	Available	Available	Available	Available	Available	Available	Not Available
4	Stroke Resulting In Permanent Symptoms	100%	Available	Available	Available	Available	Available	Available	Available	Not Available
5	Implantable Cardioverter Defibrillator	100%	Available	Available	Available	Available	Available	Available	Not Available	Not Available
6	Insertion of Pacemaker	100%	Available	Available	Available	Available	Available	Available	Not Available	Not Available
7	Angioplasty	100%	Available	Available	Available	Not Available	Not Available	Not Available	Not Available	Not Available
8	Minimally Invasive surgery of Aorta	100%	Available	Available	Available	Available	Available	Available	Not Available	Not Available
9	Major Surgery of Aorta	100%	Available	Available	Not Available	Available	Available	Not Available	Not Available	Not Available
10	Balloon Valvotomy or Valvuloplasty	100%	Available	Available	Not Available	Available	Available	Not Available	Not Available	Not Available
11	Heart Transplant	100%	Available	Not Available	Not Available	Available	Not Available	Not Available	Not Available	Not Available
12	Primary (Idiopathic) Pulmonary Hypertension	100%	Available	Not Available	Not Available	Available	Not Available	Not Available	Not Available	Not Available

Definition of covered Illnesses

1. **Myocardial Infraction (First Heart Attack – of Specified Severity)**
   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
   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.

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

3. **Open Heart Replacement Or Repair Of Heart Valves**
   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.

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

5. **Implantable Cardioverter Defibrillator**
   Insertion of a permanent cardiac defibrillator that is required as a result of serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac defibrillator must be certified to be medically necessary by a specialist in the relevant field. Documentary evidence of cardiac arrhythmia must be provided

6. **Insertion of Pacemaker**
   Insertion of a permanent cardiac pacemaker that is required as a result of serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be medically necessary by a specialist in the relevant field. Documentary evidence of cardiac arrhythmia must be provided.

7. **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.

8. **Minimally Invasive surgery of Aorta**
   The actual undergoing of minimally invasive surgical repair (i.e. via percutaneous intra-arterial route) of a diseased portion of an aorta to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

9. **Major Surgery of Aorta**
   The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. Surgery performed using only minimally invasive or intra-arterial techniques or catheter based techniques are excluded.

10. **Balloon Valvotomy or Valvuloplasty**
    The actual undergoing of Valvotomy or Valvuloplasty necessitated by damage of the heart valve as confirmed by a specialist in the relevant field and established by a cardiac echocardiogram or any other appropriate diagnostic test that is available.
    For purpose of this Benefit, procedures done for treatment of Congenital Heart Disease are excluded

11. **Heart Transplant**
    The actual undergoing of a transplant of human heart that resulted from irreversible end stage heart failure. The undergoing of a heart transplant has to be confirmed by a specialist medical practitioner.

12. **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.

(a) Initial Waiting Period (Applicable for all 3 Options):
We shall not be liable to make any payment in respect of any of the covered Illnesses of the nature specified in this Section II.5 whose signs or symptoms first occur within the number of days as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy from the Start Date of this Policy.

(b) Survival Period (Applicable for all 3 Options):
The payment of a Benefit under Section II.5 shall be subject to survival of the Insured Person for the number of days as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy, following the first diagnosis of the covered Illness/undergoing the Surgical Procedure for the first time.

6. Cancer Assure Cover

What is covered

We shall indemnify the Reasonable and Customary Charges incurred towards medical treatments of the nature specified below, which are taken by the Insured Person during the Policy Period for a covered Illness of the nature specified below, provided that it is first diagnosed or first manifests itself during the Policy Period as a first incidence.
The scope of this Benefit covers the following medical treatments related to the covered Illness:

1. Conventional treatments
- Chemotherapy
- Radiotherapy
- Organ transplantation, as part of Cancer treatment
- Surgeries for excision of cancerous tissue or removal of organs/ tissues (Onco-surgery)

2. Advanced treatments
- Immunotherapy including immunology agents e.g. Interferon, TNF etc.
- Personalised & Targeted therapy
- Hormonal Therapy or Endocrine manipulation
- Stem cell transplantation

For the purpose of this Benefit, covered Illness shall mean Cancer, as specifically defined below:

1. Cancer

i) A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

ii) Please note the following is Included -
   a. Any In-situ Cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues.
   b. Any pre-cancerous change in the cells that are cytologically or histologically classified as high grade dysplasia or severe dysplasia.

(a) Cancer In-patient Hospitalization:

What is covered

We shall cover the Medical Expenses incurred towards the Insured Person for one or more of the following arising out of an Insured Person's Hospitalization during the Policy Period caused solely and directly due to the covered Illness that is first diagnosed or first manifests itself during the Policy Period:

(1) Reasonable and Customary Charges incurred towards the Room Rent of a Hospital room and other boarding charges, up to the Single Private A/C Room category ;
(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 covered Illness for which the Insured Person is Hospitalized;
(8) Anaesthesia, blood, oxygen and blood transfusion charges;
(9) Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.
(10) Medication applied as per the medical prescription issued by the treating Medical Practitioner while the Insured Person is Hospitalized for treatment of a covered Illness.

Conditions

a) The Hospitalization is towards Medically Necessary Treatment and follows the written advice of a Medical Practitioner.
b) If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy, then the Insured Person shall bear a rateable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category to the Room Rent actually incurred.
   - For the purpose of this Section "Associated Medical Expenses" shall include - Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioner 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.
   - 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.

(b) Day Care Treatment:

What is covered

We shall cover the Medical Expenses incurred towards the Day Care Treatment of the Insured Person, undertaken solely and directly due to a covered Illness as specified under Section II.6 (a) that is first diagnosed or first manifests itself during the Policy Period, up to the limits as specified in the Policy Schedule / Certificate of Insurance of this Policy.

Conditions

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

What is not covered
OPD treatment is not covered under this Benefit.

(c) OPD Treatment
What is covered
We shall cover the Reasonable and Customary Charges incurred for medically required consultations, visit(s) to a Medical Practitioner holding a minimum qualification of MBBS, diagnostic tests and pharmacy expenses which are incurred on an out-patient basis, undertaken solely and directly due to a covered Illness as specified under Section II.6 (a) that is first diagnosed or first manifests itself during the Policy Period, up to the limits as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.
Conditions
(i) OPD Treatment is Medically Necessary Treatment.
(ii) Benefits under this section shall be payable only when supported by the prescription obtained from the Medical Practitioner.

(d) Pre - hospitalization Medical Expenses:
What is covered
We shall cover the Insured Person's Pre-hospitalization Medical Expenses incurred in respect of a covered Illness as specified under Section II.6 (a) that is first diagnosed or first manifests itself during the Policy Period on a reimbursement basis, up to the limits specified against this Benefit, for the number of days specified in the Policy Schedule / Certificate of Insurance.
Conditions
(i) We have accepted a claim for In-patient Hospitalization under Section II.6 (a) for the same covered Illness;
(ii) The date of admission to Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same covered Illness.

(e) Post - hospitalization Medical Expenses:
What is covered
We shall cover the Insured Person's Post-hospitalization Medical Expenses incurred following in respect of a covered Illness as specified under Section II.6 (a) that is first diagnosed or first manifests itself during the Policy Period on a reimbursement basis, up to the limits specified against this Benefit, for the number of days specified in the Policy Schedule / Certificate of Insurance.
Conditions
(i) We have accepted a claim for In-patient Hospitalization under Section II.6(a) for the same covered Illness;
The date of discharge from Hospital for the purpose of this Benefit shall be the date of the Insured Person's discharge from Hospital in relation to the same covered Illness.

(f) Emergency Road Ambulance Cover:
What is covered
We shall cover the costs incurred up to the limits as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy, towards transportation of the Insured Person by road Ambulance to a nearest Hospital from the place of occurrence of an Emergency for treatment, where such Emergency is caused solely and directly due to a covered Illness as specified under Section II.6 (a) that is first diagnosed or first manifests itself during the Policy Period.
Coverage shall also be provided under the below circumstances, if the Medical Practitioner certifies in writing that:
(i) We have accepted a claim for In-patient Hospitalization under Section II.6(a) above for the same covered Illness ;
(ii) It is medically necessary to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.
(iii) It is medically necessary to transfer the Insured Person to another Hospital during the course of Hospitalization due to lack of super speciality treatment in the existing Hospital.
Conditions
(i) The Ambulance/ healthcare service provider is registered;
(ii) We have accepted a claim for In-patient Hospitalization under Section II.6(a) above;
What is not covered
Any expenses in relation to transportation of the Insured Person from Hospital to the Insured Person's residence are not payable under this Benefit.

(b) Follow Up care Post treatment
What is covered
We shall cover the costs incurred up to the limits as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy, towards medical examination of the Insured Person, twice in a Policy Year, provided that the treatment for the covered Illness has been discontinued basis recommendation of Medical Practitioner for at least six months with "No evidence of disease (NED)" declaration.
Conditions
(i) We have accepted a claim for In-patient Hospitalization under Section II.6(a) above;

Initial Waiting Period:
We shall not be liable to make any payment in respect of the covered Illness as specified under Section II.6 (a) of the nature specified in this Section II.6 whose signs or symptoms first occur within the number of days as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy from the Start Date of initial Policy with Us. The initial Waiting Period is not applicable for Renewal policies, if renewed continuously and without any break with Us.

Exclusions applicable to Section II.6
We shall not be liable to make any payment for any claim under Section II.6 of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:
1. Any Treatment other than for the covered Illness, ie, Cancer.
2. Non Allopathic treatment
3. Hospice care and palliative care.
4. Any external appliance and/or device used for diagnosis or treatment (except when used intra-operatively).
5. Prosthetic and other devices which are self-detachable /removable without surgery involving anaesthesia
6. Primary Hospitalization for treatment of Adjuvant Chemo / Supportive chemo & Oral Chemo (name of molecules to be added)

7. Hospital Cash Benefit
What is covered
We shall pay the daily cash benefit as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy for each continuous and completed 24 hours of Hospitalization, if the Insured Person is Hospitalized in India for Medically Necessary Treatment of an Illness or Injury that is contracted or sustained by an Insured Person during the Policy Period,
Conditions
(i) This Benefit shall be payable for a maximum number of days specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy, per Hospitalization event and per Policy Year in respect of an Insured Person;

(ii) The Deductible as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy is applicable under the Benefit;

Exclusions applicable to Section II.7

We shall not be liable to make any payment for any claim under Section II.7 of this Policy in respect of any Hospitalization, directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

1. Hospitalization as donor for another person's organ transplantation.

8. Major Illnesses Cover - Domestic Hospitalization

We shall indemnify the Reasonable and Customary Charges incurred towards medical treatment taken by the Insured Person during the Policy Period for an Illness/ Injury described in the Benefits below, that is first diagnosed or first manifests itself during the Policy Period.

All claims paid under this Section II.8 will impact the Sum Insured available under this Benefit.

(a) Major Illnesses In-patient Hospitalization:

What is covered

We shall cover the Medical Expenses incurred towards the Insured Person for one or more of the following arising out of an Insured Person's In-patient Care during the Policy Period caused solely and directly due to a covered Major Illness that is first diagnosed or first manifests itself during the Policy Period:

(1) Reasonable and Customary Charges incurred towards the Room Rent of a Hospital room and other boarding charges, up to the Single Private A/C Room category ;
(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 covered Major Illness for which the Insured Person is Hospitalized;
(8) Anaesthesia, blood, oxygen and blood transfusion charges;
(9) Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.
(10) Medication applied as per the medical prescription issued by the treating Medical Practitioner while the Insured Person is Hospitalized for treatment of a covered Major Illness.

Conditions

a) The Hospitalization is towards Medically Necessary Treatment and follows the written advice of a Medical Practitioner.
b) If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy, then the Insured Person shall bear a rateable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category to the Room Rent actually incurred.
   - For the purpose of this Section "Associated Medical Expenses" shall include - Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioner 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.
   - 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.
c) The symptoms of the Major Illness first occur or manifest itself during the Policy Period and after completion of the initial Waiting Period of 90 days, subject to applicability of any Waiting Periods specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

For the purpose of this Benefit, Major Illness shall mean the Illnesses, medical events or Surgical Procedures as specifically defined below:

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

4	Major Organ Transplantation	I. We will be covering the actual undergoing of a transplant of one of the following human organs: lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner. II.The following are excluded: a) Any transplant when the need for a transplant arises as a consequence of alcoholic liver disease. b) Any transplant when the transplant is conducted as a self-transplant. c) Any transplant when the Insured is a donor for a third-party. d) Any transplants from a dead donor. e) Any organ transplant that involves Stem Cells treatment. f) Where only islets of langerhans are transplanted g) The transplant made possible by the purchase of donor organs. h) Any disease which has been caused by an organ transplant save where the disease in question is qualified as a major illnesses covered under the product.
5	Bone Marrow Transplant	We will be covering Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured originating from: a. the Insured (Autologous bone marrow transplant); or b. from a living compatible donor (allogeneic bone marrow transplant).
6	Neurosurgery	We will be covering any I. Surgical intervention of the brain or any other intracranial structures; II. Surgical Treatment of benign solid tumours located in the spinal cord.
7	Pulmonary artery graft surgery	I. We will be covering the undergoing of Surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.
8	Aorta Graft Surgery	I. We will be covering the actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of “Aorta” shall mean the thoracic and abdominal aorta but not its branches. II. The following are excluded: 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.
9	Coronary Artery By-Pass surgery post occurrence of Myocardial Infraction	I. We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures, post the occurrence of myocardial infraction. The diagnosis must be supported by a coronary angiography and the realization of Surgery has to be confirmed by a cardiologist. II. The following are excluded: Angioplasty and/or any other intra-arterial procedures
10	Surgical treatment for Stroke	I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. II.We will be covering Surgical Treatment of Stroke limited to; a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy b. Stenting of Intra cranial blood vessels, needed for the treatment of Stroke III. The following are excluded: a. Transient ischemic attacks (TIA) b. Traumatic injury of the brain c. Vascular disease affecting only the eye or optic nerve or vestibular functions.
11	Surgical treatment for benign Brain tumour	I. We will be covering surgical treatment of Benign solid brain tumour limited to; a. Surgical Removal of solid brain tumour through Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy b. Embolization of Intra cranial blood vessels, needed for the treatment of solid brain Tumour II. Benign solid brain tumour is defined as a life threatening, non-cancerous tumour in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI. III. This brain tumour must result in at least one of the following and must be confirmed by the relevant medical specialist. a. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or b. Undergone surgical resection or radiation therapy to treat the brain tumour.

12	Lung Transplant Surgery in case of End Stage Lung Disease	I. We will be covering Lung Transplant Surgery due to following cases a. 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 pressure of 55mmHg or less (PaO2 < 55mmHg); and iv. Dyspnea at rest.
13	Kidney Transplant Surgery in case of End Stage Renal Failure	We will be covering Kidney Transplant Surgery due to following cases I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.
14	Skin grafting surgery for Major Burns	I. We will be covering the undergoing of skin transplantation due to accidental major burns where major burns is as defined below. a. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area. II. Skin grafting surgery for Major Burns should be medically required and not aesthetic/cosmetic in nature
15	Surgical treatment of Coma	I. We will be covering surgical treatment of Coma limited to; a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy II. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following: a. no response to external stimuli continuously for at least 96 hours; b. life support measures are necessary to sustain life; and c. The condition has to be confirmed by a specialist medical practitioner. III. The following are excluded: Coma resulting directly from alcohol or drug abuse is excluded.
16	Surgery for Pheochromocytoma	I. We will be covering the actual undergoing of surgery to remove the tumour II. Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines and the Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who is an endocrinologist.

(b) Pre – hospitalization Medical Expenses:

What is covered

We shall cover the Insured Person's Pre-hospitalization Medical Expenses incurred in respect of a Major Illness as specified under Section II.8 (a) that is first diagnosed or first manifests itself during the Policy Period on a reimbursement basis, up to the Sum Insured, for the number of days specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

Conditions

(i) We have accepted a claim for In-patient Hospitalization under Section II.8 (a) for the same Major Illness;
(ii) The date of admission to Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Major Illness.

(c) Post – hospitalization Medical Expenses:

What is covered

We shall cover the Insured Person's Post-hospitalization Medical Expenses incurred following a Major Illness as specified under Section II.8 (a) that is first diagnosed or first manifests itself during the Policy Period on a reimbursement basis, up to the Sum Insured, for the number of days specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

Conditions

(i) We have accepted a claim for In-patient Hospitalization under Section II.8(a) for the same Major Illness;
(ii) The date of discharge from Hospital for the purpose of this Benefit shall be the date of the Insured Person's discharge from Hospital in relation to the same Major Illness.

(d) Emergency Road Ambulance Cover:

What is covered

We shall cover the costs incurred up to the limits as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy, towards transportation of the Insured Person by road Ambulance to a nearest Hospital from the place of occurrence of an Emergency for treatment, where such Emergency is caused solely and directly due to a Major Illness as specified under Section II.8 (a) that is first diagnosed or first manifests itself during the Policy Period.

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

(i) We have accepted a claim for In-patient Hospitalization under Section II.8(a) above for the same covered Illness ;
(ii) It is medically necessary to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.
(iii) It is medically necessary to transfer the Insured Person to another Hospital during the course of Hospitalization due to lack of super speciality treatment in the existing Hospital.

Conditions

(i) The Ambulance/ healthcare service provider is registered;
(ii) We have accepted a claim for In-patient Hospitalization under Section II.6(a) above;

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

e) Initial Waiting Period:
We shall not be liable to make any payment in respect of any Major Illness of the nature specified in this Section II.8 whose signs or symptoms first occur within the number of days as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy from the Start Date of initial Policy with Us. The initial Waiting Period is not applicable for Renewal policies, if renewed continuously and without any break with Us.

9. Credit Protect
What is covered
In the event of AD or PTD of the Insured Person solely and directly due to an Accident which occurs during the Policy Period, We shall pay an amount commensurate with the balance outstanding loan amount of the Insured Person's loan account number, as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy as on the date of the Accident, subject to the maximum limit specified in the Policy Schedule/ Certificate of Insurance / Product Benefit Table of this Policy.
Conditions
(i) The amount payable under this Section II.8 shall not include any arrears in the outstanding loan amount due to any reasons whatsoever.
(ii) In the event that the outstanding loan is taken jointly by several borrowers, the claim to be settled shall only be in respect of the Insured Person's respective portion of balance outstanding loan amount.
(iii) The cover for the Insured Person under this Section II.8 shall terminate immediately in the event of admissible claim and settlement of Benefit under this cover.

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

(b) Permanent Total Disablement (PTD) means the permanent total disablement of the Insured Person due to an Injury of the nature as specified in the table below within 365 days from the date of the Accident.

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

- Limb means a hand at or above the wrist or a foot above the ankle;
- Physical separation of one hand or foot means separation at or above wrist and/or at or above ankle, respectively.

In this Benefit, **Loss** means the physical separation of a body part, or the total loss of functional use of a body part or organ provided this has continued for at least 365 days from the onset of such disablement and provided further that We are satisfied based on a written confirmation by a Medical Practitioner at the expiry of the 365 days that there is no reasonable medical hope of improvement.
Loss caused directly or indirectly due to the following shall not be considered as Permanent Total Disablement:
a) due to infections (except pyogenic infections which occur due to a cut or wound) or any other kind of disease; or
b) any Surgical Procedure except as may be necessary solely as a result of the Injury.

Exclusions applicable to Section II.9
We shall not be liable to make any payment for any claim under Section II.9 of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:
1. Any consequential losses of any kind, and/or any actual or alleged legal liability of the Insured Person.
2. Any loss suffered by the Insured Person on account of his participation as the driver, codriver or passenger of a motor vehicle during motor racing or trial runs.
3. Curative treatments or interventions that the Insured Person performs or has had performed on his/her body against Medical Advice or without Medical Advice.

10. Heart Assure Cover
We will indemnify the Reasonable and Customary Charges incurred towards medical treatment taken by the Insured Person during the Policy Period for a covered Illness described in the Benefits below if it is first diagnosed or first manifests itself during the Policy Period as a first incidence. This Benefit covers only treatments taken within India.

(a) Cardiac Indemnity In-patient Hospitalization:
What is covered
We shall cover the Medical Expenses incurred towards the Insured Person for one or more of the following arising out of an Insured Person's In-patient Hospitalization during the Policy Period caused solely and directly due to a covered Illness that is first diagnosed or first manifests itself during the Policy Period:

(1) Reasonable and Customary Charges incurred towards the Room Rent of a Hospital room and other boarding charges, up to the Single Private A/C Room category of the Hospital where the Insured Person is hospitalized;
(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 covered Illness for which the Insured Person is Hospitalized;
(8) Anaesthesia, blood, oxygen and blood transfusion charges;
(9) Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.
(10) Medication applied as per the medical prescription issued by the treating Medical Practitioner while the Insured Person is Hospitalized for treatment of a covered Illness

Conditions

a) The Hospitalization is towards Medically Necessary Treatment and follows the written advice of a Medical Practitioner.
b) If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy, then the Insured Person shall bear a rateable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category to the Room Rent actually incurred.
   - For the purpose of this Section "Associated Medical Expenses" shall include - Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioner 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.
   - 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.

For the purpose of this Benefit, covered Illness shall mean cardiac conditions, as specifically defined below:

Sr. No.	Cardiac Condition	Definition
1	Coronary Artery By-Pass surgery	I. We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. II. The following are excluded: Angioplasty and/or any other intra-arterial procedures
2	Heart Valve Replacement	I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. II. The following are excluded: Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.
3	Heart Transplant	The actual undergoing of a transplant of human heart that resulted from irreversible end stage heart failure. The undergoing of a heart transplant has to be confirmed by a specialist medical practitioner.
4	Pulmonary artery graft surgery	I. We will be covering the undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.
5	Aorta Graft Surgery	I. We will be covering the actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches. II. The following are excluded: 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.
6	Coronary Artery By-Pass surgery post occurrence of Myocardial Infraction	I. We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures, post the occurrence of myocardial infraction. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. II. The following are excluded: Angioplasty and/or any other intra-arterial procedures
7	Surgical treatment for Stroke	I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. II.We will be covering surgical treatment of Stroke limited to; a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy b. Stenting of Intra cranial blood vessels, needed for the treatment of Stroke III. The following are excluded: a. Transient ischemic attacks (TIA) b. Traumatic injury of the brain c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8	Angioplasty	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). Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.
9	Implantable Cardioverter Defibrillator	Insertion of a permanent cardiac defibrillator that is required as a result of serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac defibrillator must be certified to be medically necessary by a specialist in the relevant field. Documentary evidence of cardiac arrhythmia must be provided
10	Insertion of Pacemaker	Insertion of a permanent cardiac pacemaker that is required as a result of serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be medically necessary by a specialist in the relevant field. Documentary evidence of cardiac arrhythmia must be provided.
11	Minimally Invasive surgery of Aorta	The actual undergoing of minimally invasive surgical repair (i.e. via percutaneous intra-arterial route) of a diseased portion of an aorta to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.
12	Balloon Valvotomy or Valvuloplasty	The actual undergoing of Valvotomy or Valvuloplasty necessitated by damage of the heart valve as confirmed by a specialist in the relevant field and established by a cardiac echocardiogram or any other appropriate diagnostic test that is available. For purpose of this benefit, procedures done for treatment of Congenital Heart Disease are excluded
13	Surgery of Cardiac Arrhythmia – RF Ablation / Maze procedure	Procedures like Maze surgery, RF Ablation therapy or any relevant procedure/surgery deemed absolutely necessary by a cardiologist to treat life threatening arrhythmias. Diagnosis must be evidenced by monitoring through a Holter monitor, event monitor or loop recorder and should be confirmed by a consultant cardiologist. The following are excluded: · Cardio version and any other form of non-surgical treatments · Claim arising due to Internal Congenital Anomalies within 4 years from the date of commencement of cover or revival of coverage, whichever occurs later.
14	Surgery to place Ventricular Assist Devices or Total Artificial Hearts	The actual undergoing of open heart surgery to place a Ventricular Assist Device or Total Artificial Heart medically necessitated by severe ventricular dysfunction or severe heart failure, with cardiac echocardiographic evidence of reduced left ventricular ejection fraction of less than 30%.
15	Carotid Artery Surgery	The actual undergoing of surgery to the Carotid Artery to treat carotid artery stenosis of fifty percent (50%) or above, as proven by angiographic evidence, of one (1) or more carotid arteries. Both criteria (a) and (b) below must be met: (a)Either: i).Actual undergoing of endarterectomy to alleviate the symptoms; or ii).Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy to alleviate the symptoms; and (b)The Diagnosis and medical necessity of the treatment must be confirmed by a Registered Medical Practitioner who is a specialist in the relevant field.
16	Pericardiectomy	The undergoing of a pericardectomy performed by open heart surgery or keyhole techniques as a result of pericardial disease. The surgical procedures must be certified to be medically necessary by a consultant cardiologist. The following are excluded: Other procedures on the pericardium including pericardial biopsies and pericardial drainage procedures by needle aspiration.
17	Coronary Angiography	The undergoing of Medically necessary coronary angiography confirmed by a cardiologist

(b) Pre – hospitalization Medical Expenses:

What is covered

We shall cover the Insured Person's Pre-hospitalization Medical Expenses incurred in respect of a covered Illness as specified under Section II.10 (a) that is first diagnosed or first manifests itself during the Policy Period on a reimbursement basis, up to the Sum Insured, for the number of days specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

Conditions

(I) We have accepted a claim for In-patient Hospitalization under Section II.10 (a) for the same covered Illness;

(ii) The date of admission to Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same covered Illness.

(c) Post – hospitalization Medical Expenses:

What is covered

We shall cover the Insured Person's Post-hospitalization Medical Expenses incurred following a covered Illness as specified under Section II.10 (a) that is first diagnosed or first manifests itself during the Policy Period on a reimbursement basis, up to the Sum Insured, for the number of days specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

Conditions

(I) We have accepted a claim for In-patient Hospitalization under Section II.10(a) for the same covered Illness;

(ii) The date of discharge from Hospital for the purpose of this Benefit shall be the date of the Insured Person's discharge from Hospital in relation to the same covered Illness.

(d) Emergency Road Ambulance Cover:

What is covered

We shall cover the costs incurred up to the limits as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy, towards transportation of the Insured Person by road Ambulance to a nearest Hospital from the place of occurrence of an Emergency for treatment, where such medical Emergency is caused solely and directly due to a covered Illness as specified under Section II.10 (a) that is first diagnosed or first manifests itself during the Policy Period.

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

(i) We have accepted a claim for In-patient Hospitalization under Section II.10 (a) above for the same covered Illness
(ii) It is medically necessary to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.
(iii) It is medically necessary to transfer the Insured Person to another Hospital during the course of Hospitalization due to lack of super speciality treatment in the existing Hospital.

Conditions

(i) The Ambulance/ healthcare service provider is registered;
(ii) We have accepted a claim for In-patient Hospitalization under Section II.10(a) above;

What is not covered

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

(e) Initial Waiting Period:

We shall not be liable to make any payment in respect of any covered Illness as specified under Section II.10 (a) of the nature specified in this Section II.10 whose signs or symptoms first occur within the number of days as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy from the Start Date of Initial Policy with Us. The Initial Waiting Period is not applicable for renewal policies, if renewed continuously and without any break with Us.

Section III. Waivers available along with specified Benefits

Benefits under this Section III are subject to the terms, conditions and exclusions of this Policy. The availability of this Benefit shall be as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.

1. Pre-Existing Disease (Code- Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of number of months of continuous coverage after the Date of inception of the first policy with insurer, as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of the number of months as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

Waiver for Pre Existing Disease Waiting Period shall be opted only along with the following Sections:

1. Section II.1 – OPD Expenses
2. Section II.4 – Preferred Provider Network
3. Section II.7 – Hospital Cash Benefit

2. 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
Eye	Cataract	Cataract Surgery
	Glaucoma	Glaucoma Surgery
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

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

If any of the Illness/conditions listed above are Pre-Existing Diseases, then they will be covered only after the completion of the Pre-Existing Disease Waiting Period described under Section III.1.

Waiver for Two Year Waiting Period shall be opted only along with the following Sections:
1. Section II.1 – OPD Expenses
2. Section II.4 – Preferred Provider Network
3. Section II.7 – Hospital Cash Benefit

3. First 30 Days 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.

Waiver for first 30 Days Waiting Period shall be opted only along with the following Sections:
1. Section II.1 – OPD Expenses
2. Section II.4 – Preferred Provider Network
3. Section II.7 – Hospital Cash Benefit

Section IV. 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. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code- Excl12)
6. Any Illness/Injury/Accident due to abuse of intoxicants, smoking cessation programs and the treatment of nicotine addiction, unless prescribed by a Medical Practitioner.
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 unless mentioned as part of inclusions in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy.
14. Conditions for which treatment could have been done on an out-patient basis without any Hospitalization (This exclusion is not applicable for Section II.1 "OPD Expenses").
15. Experimental treatment, investigational treatments, 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)
    a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
       i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
       ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
19. Convalescence, cure, sanatorium treatment, private duty nursing.
20. Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment); any 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 products as specified in the Annexure B of this Policy – Non Medical Expenses , and on Our website www.adityabirlahealth.com/healthinsurance.
25. Any expenses incurred on prosthesis, corrective devices external durable medical equipment of any kind, like wheelchairs crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident. Cost of artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment.
26. Parkinson disease, general debility or exhaustion ("rundown condition"), sleep-apnea, stress.
27. External Congenital Anomalies, diseases or defects.
28. Stem cell therapy (except Hematopoietic stem cells for bone marrow transplant for haematological conditions) or surgery, or Growth hormone therapy or Hormone Replacement Therapy.
29. 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.
30. 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
31. 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).
32. Admission for Organ Transplant but not compliant under the Transplantation of Human Organs Act, 1994 (amended).
33. 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.
34. Dentures and artificial teeth, Dental Treatment and Surgery of any kind, unless requiring Hospitalization due to an Accident.
35. 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.

36. Treatment for, Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy, KTP Laser Surgeries, cyber knife treatment, Femto laser surgeries, bioabsorbable stents, bioabsorbable valves, bioabsorbable implants, use of Infliximab, rituximab, avastin, lucentis & similar molecules
37. 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 Non-Medical Expenses including but not limited to RMO, CMO, DMO charges, surcharges, night charges, service charges levied by the hospital under any head as specified in the Annexure B of this Policy, for Non- Medical Expenses and on Our website.
38. Treatment taken from a person not falling within the scope of definition of registered Medical Practitioner with any state medical council/ medical council of India.
39. Treatment charges or fees charged by any Medical Practitioner acting outside the scope of license or registration granted to him by any medical council.
40. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's immediate family or stays with him in the same residence, except if pre-approved by Us.
41. 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.
42. 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)
43. 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).
44. Treatment taken outside India.
45. In the event of the death of the Insured Person within the stipulated survival period as specified in the Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy for the applicable Benefits.
46. Use of Radio Frequency (RF) probe for ablation or other procedure unless specifically approved by Us in writing in advance.
47. 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 C to this Policy and 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.
48. 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).
49. 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.

Section V. Claims Process

A. Duties and Obligations of the Insured Person for Section II.9 'Credit Protect'

It is a Condition Precedent to Our liability under the Credit Protect Benefit, that in the event of any Injury that may give rise to a claim:

1. You / Nominee shall immediately and in any event within 14 days provide Us with written notification of a claim, and the Insured Person shall immediately and without any delay, consult a physician and follow such advice and treatment that the physician might recommend, and
2. You / Nominee shall take every other reasonable step and/or measure to minimize the consequences of the Injury, and
3. In the event of the Insured Person's death, written notice accompanied by a copy of the post-mortem report (if any) is given to Us within 14 days (regardless of whether any other notice might already have been given to Us), and
4. You shall expeditiously provide Us with or arrange for Us to be provided with any and all information and documentation in respect of the claim and/or Our liability hereunder that may be requested, and submit himself/herself for examination by Our medical advisers as often as may be considered reasonably necessary by Us at Our cost.

B. Intimation of Claim

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

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

The following minimum details are required to be provided at the time of intimation of claim:

1. The Policy number;
2. Name of the Policyholder;
3. Name and address of the Insured Person in respect of whom the request is being made
4. Details of Benefits to be claimed needs to be added (e.g. date of loss, nature of loss, etc.)

C. Claims terms applicable to all Benefits under the Policy

The fulfillment of the terms and conditions of this Policy (including timely payment of premium in full) insofar as they relate to anything to be done or complied with by the 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 event that may give rise to a claim under this Policy, the claims procedure set out in the Policy shall be followed.
(2) The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed.
(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 Hospitalization 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.

D. Claims Assessment– Applicable to all Benefits under the Policy

a) At Our discretion, We may investigate claims to determine the validity of a claim. This investigation shall be conducted not later than 45 days (or such other period as may be prescribed under the applicable regulations for the time being in force) from the date of receipt of claim intimation. All costs of investigation shall be borne by Us and all investigations shall be carried out by those individuals/entities that are authorised by Us.
b) If there are any deficiencies in the necessary claim documents which are not met or are partially met, We shall send a deficiency letter. If the deficiency is not met or partially met then We shall 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. However, documents/details received beyond such period shall be considered if there are valid reasons for any delay.

c) We shall settle or reject a claim, as the case may be, within 30 days of the receipt of the last necessary information and documentation set out above. In case of any suspected fraud, the last "necessary" document may include the receipt of the investigation report from Our investigator/representatives.
d) Payment for reimbursement claims shall be made to the Insured Person. In the unfortunate event of the Insured Person's death, We shall pay the Nominee named in the Policy Schedule / Certificate of Insurance or their legal heir or legal representatives holding a valid succession certificate.

E. 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)

F. Claim Documents:

The claims documents as specified in below sections for various covers must be provided to Us within 30 days of occurrence of the event giving rise to a claim under the Policy at Your own/ Insured Person's expenses.
Where there is a delay in intimation of claim and/or submission of claim documents is proved to be genuine and for reasons beyond the control of the claimant, We may condone such delay and process the claim. We reserve the right to decline such requests for claim process where there is no merit behind such delay.
All necessary claim documents are required in original / self attested / document collected via electronic medium / any other mode suggested by Us from time to time.
We may call for any additional documents/information as necessarily required by Us based on the circumstances of the claim under any of the Benefits under the Policy.

a. Claim Documents for Section II.1 OPD Expenses, Section II.2 Cancer Secure Cover with its Additional Benefits (Section II.2.1 to Section II.2.6)

i. Claim Form (in original) duly completed and signed as prescribed by Us
ii. Photo ID and Age proof of Insured Person / Nominee (if Insured Person is not alive)
iii. Copy of the claim intimation, if any
iv. Original bills, receipts and copy of prescription, clinical notes from the Medical Practitioner / medical facility
v. Original bills from pharmacy supported by proper prescription (as applicable)
vi. Investigation reports (Including CT scan/ MRI /USG / Histopathology or Biopsy report) and original bills, payment receipts
vii. Doctor's prescriptions (as applicable)
viii. Cancelled cheque for NEFT
ix. Any other document as required by Us or the TPA to investigate the claim or Our obligation to make any payment for it

b. Additional documents for submission of claims under Section II.2 Cancer Secure Cover:

The Insured Person at their own expenses shall submit the following documents within 30 (thirty) days of the earliest of the date of first diagnosis of the covered Illness/ date of Surgical Procedure or date of occurrence of the Insured Event, as the case may be:

a) Medical certificate confirming the diagnosis of the covered Illness
b) Certificate from attending Medical Practitioner confirming that the claim does not relate to any Pre-Existing Disease or any Illness or Injury which was diagnosed within the Initial Waiting Period
c) Photocopy of discharge certificate/ card from the Hospital, if any
d) Photocopy of investigation test reports confirming the diagnosis
e) Photocopy of first consultation letter and subsequent prescriptions
f) Photocopy of indoor case papers if applicable
g) Specific documents (if any) listed under the respective covered Illness.

c. Claim Documents for Sections II.3 Income Protect

On the occurrence of an Insured Event which may give rise to a claim under the Section II.3 of the Policy, We shall be provided with the following necessary and mandatory information and documentation specified in relation to the Benefit being claimed within 30 (thirty) days of occurrence of the Insured Event:

1. Duly filled claim form by the Insured Person/claimant
2. Appointment letter issued by employer
3. Salary structure as stated in offer letter, or in letter of compensation structure
4. Last 3 months salary slips
5. Last 3 year performance appraisal letters
6. Form-16 from employer
7. Income Tax Return of the last 3 preceding years
8. Medical/OPD papers/Discharge papers, where Illness or Injury was the reason for termination
9. Contact details of Human Resource Personnel - Mobile, Email id, Address and name of employer and HR personnel
10. If the claim amount is more than ₹1 lakh, AML Documents - Pan Card Copy, Residence Proof, and 2 passport sized colour photos of Insured Person/claimant
11. Cancelled cheque and NEFT mandate form - duly filled in by the Insured Person/claimant

d. Claim Documents for Sections II.5 Heart Diseases Cover

The Insured Person at their own expenses shall submit the following documents within 30 (thirty) days of the earliest of the date of first diagnosis of the covered Illness/ date of Surgical Procedure or date of occurrence of the medical event, as the case may be:

a) Medical certificate confirming the diagnosis of covered Illness
b) Certificate from attending Medical Practitioner confirming that the claim does not relate to any Pre-Existing Disease or any Illness or Injury which was diagnosed within the Initial Waiting Period
c) Photocopy of discharge certificate/ card from the Hospital, if any
d) Photocopy of investigation test reports confirming the diagnosis
e) Photocopy of first consultation letter and subsequent prescriptions
f) Photocopy of indoor case papers if applicable
g) Specific documents (if any) listed under the respective covered Illness
h) Legal heir certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized (If Nominee name is not mentioned on Policy Schedule or Nominee is a minor, then legal guardian.)

e. Claim Documents for Sections II.6 Cancer Assure Cover

The Insured Person or someone claiming on the Insured Person's behalf has to provide Us with the list of documentation, medical records and information mentioned below within 15 days of the event as mentioned above. We may request for medical records, documentation and information to establish the circumstances, its quantum or Our liability for the claim. We may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured.

List of documentation as referred above will include but is not limited to the following:

a) Our claim form duly completed and signed for on behalf of the Insured Person.
b) Original bills with detailed breakup of charges (including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.
c) Original payment receipts
d) All original reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.
e) Original Discharge Summary containing details of Date of admission and discharge detailed clinical history, detailed past history, procedure details and details of treatment taken
f) Medical certificate confirming the diagnosis/treatment of Cancer from Medical Practitioner.
g) A precise diagnosis of the treatment for which a claim is made.
h) A detailed list of the individual medical services and treatments provided and a unit price for each.
i) Original Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Medical Practitioner's invoice.
j) Indoor case papers on case to case basis if required.
k) Legal heir certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized (If Nominee name is not mentioned on Policy Schedule or Nominee is a minor, then legal guardian.)

The Insured Person shall have to undergo medical examination by Our authorised Medical Practitioner, as and when We may reasonably require, to obtain an independent opinion for the purpose of evaluating the admissibility of the claim. We will bear the cost towards performing such medical examination (at the specified location) of the Insured Person.

f. Claim Documents for Section II.7 Hospital Cash Benefit, Section II. 8 Major Illness Cover – Domestic Hospitalization

i. Claim Form (in original) duly completed and signed as prescribed by Us
ii. Photo ID and Age proof of Insured Person / Nominee (if Insured Person is not alive)
iii. Copy of the claim intimation, if any
iv. Final Hospital bill
v. Hospital discharge summary / day care summary / transfer summary
vi. Operation theatre notes
vii. Investigation reports (Including CT scan/ MRI /USG / Histopathology or Biopsy report)
viii. Doctor's prescriptions (as applicable)
ix. Cancelled cheque for NEFT
x. Others

g. Claim Documents for Sections II.9 Credit Protect

(a) Claim Form (in original) duly completed and signed as prescribed by Us
(b) Photo ID and Age proof of Insured Person / Nominee (if Insured Person is not alive)
(c) Claim intimation or claim reference number (if any)
(d) Attested copy of medico legal certificate copy / first information report copy / Panchnama (spot / inquest)
(e) Copies of consultation letters detailing the treatment taken immediately after Accident
(f) Radiological investigation reports like X ray, CT scan, MRI etc with films supporting the diagnosis of Injury
(g) Cancelled cheque for NEFT
(h) Current Outstanding Loan Certificate from financer, along with copies of documents submitted
(i) Loan disbursement letter along with payment record till the date of Accident
(j) Repayment schedule showing the EMI details
(k) Legal heir certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized (If Nominee name is not mentioned on Policy Schedule or Nominee is a minor, then legal guardian.)

Additional documents required basis nature of claim

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

1) Due to Accidental Death (AD)

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

2) Due to Permanent Total Disablement (PTD)

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

Section VI. Terms and Conditions

A. 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.

B. 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.

C. 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.

D. Eligibility

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.

E. 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 or their complications 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.

F. 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.

G. 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.

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.

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.

H. 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.

I. 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/#!/homepage

J. 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.

K. 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.

L. 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.

M. 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.

N. 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.

O. 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.

P. 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.

<table>
<tr><td colspan="6">Refund Grid</td></tr>
<tr><td rowspan="2">In-forced period of Policy
(in Months)</td><td colspan="5">Policy Tenure</td></tr>
<tr><td>12</td><td>24</td><td>36</td><td>48</td><td>60</td></tr>
<tr><td>1</td><td>73%</td><td>77%</td><td>78%</td><td>78%</td><td>79%</td></tr>
<tr><td>3</td><td>60%</td><td>70%</td><td>73%</td><td>75%</td><td>76%</td></tr>
<tr><td>6</td><td>40%</td><td>60%</td><td>67%</td><td>70%</td><td>72%</td></tr>
<tr><td>12</td><td rowspan="10">Nil</td><td>40%</td><td>53%</td><td>60%</td><td>64%</td></tr>
<tr><td>18</td><td>20%</td><td>40%</td><td>50%</td><td>56%</td></tr>
<tr><td>24</td><td rowspan="9">Nil</td><td>27%</td><td>40%</td><td>48%</td></tr>
<tr><td>30</td><td>13%</td><td>30%</td><td>40%</td></tr>
<tr><td>36</td><td rowspan="8">Nil</td><td>20%</td><td>32%</td></tr>
<tr><td>42</td><td rowspan="7">Nil</td><td>24%</td></tr>
<tr><td>48</td><td rowspan="6">Nil</td><td>16%</td></tr>
<tr><td>54</td><td>8%</td></tr>
<tr><td>60</td><td>Nil</td></tr>
</table>

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.

Q. 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.

R. 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.

S. 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.

T. 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.

U. Free Look Period
The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

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

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

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

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. 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.

X. 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 claim under this Policy shall be contestable except for proven fraud and permanent exclusions specified in the Policy. The Policy would however be subject to all limits, sub limits, co-payments as per the terms and conditions of the Policy

Y. Grievances Redressal Procedure
In case of a grievance, the Insured Person/ Policyholder can contact Us with the details through:
Our website: https://www.adityabirlacapital.com/healthinsurance
Toll Free : 1800 270 7000
Email: care.healthinsurance@adityabirlacapital.com
Address : 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 at
For updated details of grievance officer, refer the link https://www.adityabirlacapital.com/healthinsurance/#!/homepage

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

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

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

Z. 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.

Section VII. 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. **Alternate 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** 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.

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

8. **Benefit** means any benefit under the Policy, as opted and available for the Insured Person and specified in the Policy Schedule/ Certificate of Insurance.

9. **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.

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

11. **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.

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

13. **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.

14. **Date of Diagnosis** means to the date specified on the histopathology report, basis which Medical Practitioner confirms the initial diagnosis of Cancer (Applicable for Section II.6)

15. **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.

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. **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.

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

19. **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.

20. **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.

21. **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.

22. **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.

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

24. **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.

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

26. **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.

27. **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;

28. **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.

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

30. **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.

31. **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.

32. **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.

33. **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.

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

35. **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.

36. **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.

37. **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.

38. **Insured Event** means any event or occurrence specifically mentioned as covered under this Policy for which applicable premium has been received by Us.

39. **Involuntary Unemployment** means a termination, lay off, retrenchment or permanent dismissal of the Insured Person from his/her Primary Occupation due to Injury sustained, Illness contracted, as the case may be, taking place during the Policy Period. For the purpose of this Policy, Involuntary Unemployment does not include any unemployment caused due to or arising from poor performance, dismissal due to a fraudulent act, non-compliance of any company or organization's internal rules/guidelines, or any disciplinary action, is not covered.

40. **Major Illness** means any of the Illnesses, medical events or Surgical Procedures as specifically defined and listed under Section II.8.(a).

41. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance 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. **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.

48. **Nominee** means the person named in the Policy Schedule or Certificate of Insurance (as applicable) who is nominated to receive the Benefits in respect of an Insured Person covered under the Policy in accordance with the terms and conditions of the Policy, if such person is deceased when the Benefit becomes payable.

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

50. **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.

51. **Policy** means this Policy document containing the Terms and Conditions, the Proposal Form, Policy Schedule / Certificate of Insurance / Product Benefit Table of this Policy, 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.

52. **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.

53. **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.

54. **Policy** Year means a period of 12 consecutive months commencing from the Start Date, or any subsequent Policy anniversary.

55. **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 hospitalization was required, and
    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

56. **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.

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

58. **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 Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

59. **Primary Occupation** means an occupation in which a Salaried Individual works under an employer, and is predominantly engaged in for a salary which constitutes more than 75% of his/her total income, and is evidenced as such by his/her ITR (Income Tax Return) for the 2 years preceding the date of loss of income.

60. **Public Authority** means any governmental or quasi-governmental organization, statutory body, or duly authorized organization which exercises autonomous authority over an industry in a regulatory or supervisory capacity.

61. **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.

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. **Salaried Individuals** means those Insured Persons who work as an employee or a worker, whether confirmed or on probation as on the Start Date, and earn a fixed amount of compensation at a fixed frequency as salary.

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. **Single Private A/C Room** means a basic (most economical of all accommodation) category of single room in a Hospital with air-conditioning facility where a single patient is accommodated and which has an attached toilet (lavatory and bath).

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

69. **Sum Insured** means 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.

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.

Aditya Birla Health Insurance Co. Limited. IRDAI Reg.153. CIN No. U66000MH2015PLC263677.
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