



### Activ Fit (Young Adult Product) - Policy Terms and Conditions

#### Section A: 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. This Policy is a contract of insurance between You and Us which is subject to the 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/ Policy Schedule / Product Benefit Table of this Policy.

#### Key Notes:

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

The Policy Schedule shall specify which of the following covers are in force and available for the Insured Persons under the Policy during the Policy Period.

#### Section B: DEFINITIONS

##### I. Standard Definitions

1. **Accident** - sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **AYUSH Day Care Centre** - and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
  - i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
  - ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
  - iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
3. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
  - a. Central or State Government AYUSH Hospital; or
  - b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
  - c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
    - i. Having at least 5 in-patient beds;
    - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
    - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
    - iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
4. **Cashless Facility** - 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.
5. **Condition Precedent** - a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
6. **Congenital Anomaly** - 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.
7. **Cumulative Bonus** - any increase or addition in the Sum Insured granted by the insurer without any associated increase in premium.
8. **Day Care Treatment** - 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.
9. **Day Care Centre** - 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.

10. **Dental Treatment** - a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
11. **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.
12. **Domiciliary Hospitalization** - 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.
13. **Emergency Care** - management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.
14. **Grace Period** - 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.
15. **Hospital** - 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) of 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;
16. **Hospitalization** - admission in a Hospital for a minimum period of 24 consecutive 'In- patient Care 'hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.
17. **Illness** - 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.
18. **Intensive Care Unit (ICU)** - 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.
19. **ICU (Intensive Care Unit) Charges** - 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 intensivists charges.
20. **Injury** - 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.
21. **Inpatient Care** - treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
22. **Medical Advice** - any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow- up prescription.
23. **Medical Expenses** - 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.
24. **Medically Necessary Treatment** - any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
  - i) Is required for the medical management of the illness or injury suffered by the insured;
  - ii) Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
  - iii) Must have been prescribed by a medical practitioner;
  - iv) Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
25. **Medical Practitioner** - a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.
26. **Migration** - 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.
27. **Maternity Expenses** -
  - i) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization)
  - ii) Expenses towards lawful medical termination of pregnancy during the policy period.
28. **New Born Baby** - baby born during the Policy Period and is aged upto 90 days.
29. **Network Provider** - 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.
30. **Non- Network Provider** - any hospital, day care centre or other provider that is not part of the network.

31. **Notification of Claim** - the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
32. **OPD treatment** - 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.
33. **Pre-Existing Disease (PED)** - 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.
34. **Pre-hospitalization Medical Expenses** - 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.
35. **Post-hospitalization Medical Expenses** - 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.
36. **Portability** - 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.
37. **Qualified Nurse** - a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
38. **Reasonable and Customary Charges** - 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.
39. **Renewal** - 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.
40. **Room Rent** - the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
41. **Surgery or Surgical Procedure** - manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.
42. **Unproven/Experimental treatment** - the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

## II. Specific Definitions

43. **Age or Aged** shall mean the completed age as on last birthday, and which means completed years as at the Policy Start date.
44. **Activity of Daily Living**
  - i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
  - ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
  - iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
  - iv. Mobility: the ability to move indoors from room to room on level surfaces;
  - v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
  - vi. Feeding: the ability to feed oneself once food has been prepared and made available.
45. **Ambulance** - a road vehicle or aircraft operated by a licenced/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
46. **Annexure** - a document attached and marked as Annexure to this Policy
47. **Any Room** - any category room in a Hospital.
48. **Ayush Treatment** shall mean to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
49. **Assistance Service Provider** means the service provider specified in the Policy Schedule and/or Certificate of Insurance, appointed by Us from time to time.
50. **Associated Medical Expenses** Shall include the applicable nursing charges, operation theatre charges, fees of Medical Practitioner including surgeon/ anesthetist/ 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.
51. **City of Residence** Shall mean and includes any city, town or village in which the Insured Person is currently residing in India and as specified in the Insured Person's corresponding address in the Policy Schedule/Product Benefit Table of this Policy.
52. **Common Carrier** Shall means any commercial public airline operating under license issued by the appropriate authority for transportation of passengers.
53. **Dependent Child** shall mean a child (natural or legally adopted or stepchild), who is financially dependent on You does not have his / her independent source of income, is up to the Age of 25 years.

54. **Diagnosis** shall mean diagnosis by a Medical Practitioner, supported by clinical, radiological, histological, histo-pathological and laboratory evidence and also surgical evidence wherever applicable.
55. **Emergency** shall mean 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.
56. **Empanelled Service Providers** - service provider (Doctor's clinic, Diagnostic centre, Medicine, Drug vendor, medical service provider and Home care treatment provider) enlisted by Us, TPA or jointly by Us and TPA to provide OPD medical services to an insured by a cashless facility.
57. **Family Floater Policy** - a policy named as a Family Floater Policy in the Policy Schedule under which the family members named as Insured Persons in the Policy Schedule are covered. The relationships covered in a Family Floater Policy are as follows:  
 i) Self.  
 ii) legally married spouse as long as they continue to be married.  
 iii) Dependent Children (up to 4) (i.e. natural or legally adopted) between the age 3 months to 25 years.
58. **Immediate Family Member** Shall mean an Insured Person's lawful spouse, Dependent Children and parents only;
59. **IRDAI** - the Insurance Regulatory and Development Authority of India.
60. **Individual Policy** - A policy named as an Individual Policy in the Policy Schedule under which one or more Persons are covered as Insured Persons. The following relationships shall be covered in an Individual policy: Self, legally married spouse as long as they continue to be married, son, daughter, brother, sister, grandson, granddaughter, son in-law, daughter in-law, brother in-law, sister in-law, nephew, niece.
61. **Insured Person** - the person(s) named in the Policy Schedule who are covered under this Policy and in respect of whom the appropriate premium has been received.
62. **Material facts** - 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.
63. **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 Health Returns Benefit under this Policy
64. **Policy** - this Terms & Conditions document, the Proposal Form, Policy Schedule, Add-On Benefit Details (if applicable) and Annexures which form part of the Policy contract including endorsements, as amended from time to time which form part of the Policy contract and shall be read together.
65. **Policy Period** - The period between the start date and the expiry date of the Policy as specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.
66. **Policy Year** - a period of 12 consecutive months commencing from the start date or any anniversary.
67. **Policy Schedule** - Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits 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.
68. **Single Private A/C Room** - 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/does not have an attached toilet (lavatory and/or bath).
69. **Shared Room** A basic (cheapest) category of Shared Room in a Hospital with/without air-conditioning with Two Or three patient beds.
70. **Start Date** of the Policy means the inception date of the current Policy Period as specified in the Policy Schedule.
71. **Sum Insured** -  
 a. For an Individual Policy, the amount specified in the Policy Schedule against an Insured Person which represents Our maximum, total and cumulative liability for any and all claims arising under any and all Benefits during a Policy Year in respect of that Insured Person.  
 b. For a Family Floater Policy, the amount specified in the Policy Schedule which represents Our maximum, total and cumulative liability for any and all claims arising under any and all Benefits during a Policy Year in respect of any and all Insured Persons.
72. **Third Party Administrator (TPA)** - A Company registered under the IRDAI (Third Party Administrators – Health Services) Regulations 2016 (as may be amended, replaced or modified) by the IRDAI, and is 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.
73. **We/Our/Us** - Aditya Birla Health Insurance Co. Limited.
74. **You/Your/Policyholder** - the person named in the Policy Schedule as the policyholder and who has concluded this Policy with Us.

**Section I: Basic Covers:**

Benefits under this Section C.I are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and/or the sub-limit for each Benefit under Section C.I is specified against that Benefit in the Policy Schedule / Product Benefit Table of this Policy. Payment of the Benefit shall be subject to the availability of the Sum Insured and the applicable sub-limit for that Benefit.

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

All claims must be made in accordance with the procedure set out in Section F.1. Claims paid under this Section will impact the Sum Insured and eligibility for No Claim Bonus And Super No Claim Bonus.

**(a) In-patient Hospitalization:****What is covered**

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

- (i) Reasonable and Customary Charges for Room Rent for accommodation in Hospital room and other boarding charges up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy;
- (ii) ICU Charges up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy;
- (iii) Operation theatre expenses;
- (iv) Medical Practitioner's fees, including fees of surgeon, consultants, physicians, specialists and anaesthetists treating the Insured Person;
- (v) Qualified Nurses charges;
- (vi) Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
- (vii) Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized;
- (viii) Anaesthesia, blood, oxygen and blood transfusion charges; Cost of Pacemaker, Diagnostic materials and X rays, Dialysis, Chemotherapy, radiotherapy;
- (ix) Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

**a.1 Modern Treatment coverage**

We shall cover the Medical Expenses for the following modern treatment procedures under section C .I. a. In-Patient Hospitalization or C.1.c Day Care Treatment arising out of an Insured Person's Hospitalization following an Illness or Injury that's diagnosed during the Policy Period up to the Sum Insured specified in the Policy Schedule / Product Benefit Table of this Policy.

- a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
- b. Balloon Sinuplasty
- c. Deep Brain stimulation
- d. Oral chemotherapy
- e. Immunotherapy - Monoclonal Antibody to be given as injection
- f. Intra vitreal injections
- g. Robotic surgeries
- h. Stereotactic radio surgeries
- i. Bronchical Thermoplasty
- j. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
- k. IONM - (Intra Operative Neuro Monitoring)
- l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

**a.2 HIV / AIDS and STD Cover**

We shall cover the Medical Expenses incurred by the Insured Person towards treatment taken during In-patient Hospitalisation (C.I.a) of the Insured Person arising out of condition caused by or associated with HIV or HIV related illnesses, including AIDS or AIDS related Complex (ARC) and/or any mutant derivative or variations there of or sexually transmitted diseases (STD) during the Policy Period up to the Sum Insured specified in the Policy Schedule / Product Benefit Table of this Policy.

**a.3 Mental Care Cover**

We shall cover the Medical Expenses incurred by the Insured Person towards treatment taken during In-patient hospitalisation (C.I.a) of the Insured Person arising out of a condition caused by or associated to medical illness, stress, anxiety, depression or a medical condition impacting mental health of the Insured Person ) during the Policy Period up to the Sum Insured specified in the Policy Schedule / Product Benefit Table of this Policy.

**Conditions:**

- (i) The Hospitalization of the Insured Person is medically necessary and follows the written advice of a Medical Practitioner.
- (ii) If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule / Product Benefit Table of this Policy, then the Insured Person shall bear a rateable proportion of the Room Rent (and the total Associated Medical Expenses, including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category to the Room Rent actually incurred.
- (iii) Proportionate deductions are not applicable for ICU charges.
- (iv) Such proportionate deductions, if any, will not be applied in respect of the Hospitals which do not follow differential billing, or for those Associated Medical Expenses in respect of which differential billing is not adopted based on the room category.

**(b) Daily Cash Benefit (Shared Accommodation)****What is covered.**

If we have accepted a claim under section C.I.(a) (In-patient Hospitalization) and you have opted for a shared accommodation during hospitalisation then we shall pay the daily cash benefit specified in the Policy Schedule/Product Benefit Table, for each continuous and completed period of 24 hours of hospitalisation, during the Policy Period for treatment of an Illness/Injury.

**What is not covered**

Daily Cash Benefit for time spent by the Insured Person in an intensive care unit.

**(c) Day Care Treatment:**

**What is covered**

We shall cover the Medical Expenses incurred on the Insured Person's Day Care Treatment, up to the Sum Insured as specified in the Policy Schedule / Product Benefit Table of this Policy, during the Policy Period following an Illness/Injury that diagnosed during the Policy Period.

**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 undertaken by an insured person as Day Care Treatment which requires a period of specialized observation or care after completion of the procedure

**What is not covered**

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

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

**What is covered**

We shall cover on a reimbursement basis, up to the Sum Insured for the number of days in accordance with the limits specified in the Policy Schedule / Product Benefit Table of this Policy, the Insured Person's Pre-Hospitalization Medical Expenses incurred in respect of an Illness/ Injury that's diagnosed during the Policy Period.

**Conditions**

- (i) We have accepted a claim for In-patient Hospitalization under Section C.I.(a) or Day Care Treatment under Section C.I.(c) or Domiciliary Hospitalization under Section C.I. (f).(a) or Home Treatment C.I. (f) b. for the same Illness/Injury;
- (ii) The date of admission to Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Illness/ Injury.

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

**What is covered**

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

**Conditions**

- (i) We have accepted a claim for In-patient Hospitalization under Section C.I.(a) or Day Care Treatment under Section C.I.(d) or Domiciliary Hospitalization under Section C.I.(f).(a) or Home Treatment C.I.(f).(b) for the same Illness/Injury;
- (ii) The date of discharge from Hospital for the purpose of this Benefit shall be the date of the Insured Person's discharge from Hospital in relation to the same Illness/ Injury.

**(f) a. Domiciliary Hospitalization:**

**What is covered**

We shall cover the Medical Expenses incurred for the Insured Person's Domiciliary Hospitalization, up to the Sum Insured as specified in the Policy Schedule / Product Benefit Table of this Policy, during the Policy Period following an Illness or Injury that's diagnosed during the Policy Period.

**Conditions**

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

**b. Home Treatment:**

**What is covered**

We shall cover the treatment expenses up to the limits as specified in the policy schedule/Product Benefit Table of this policy incurred by the insured person towards medically necessary treatment taken at his/her home for illnesses/injuries that's diagnosed during the policy period on cashless basis availed through Our empanelled home care treatment providers.

For the purpose of this section Home Treatment shall means. Home Care Treatment means treatment availed by the Insured Person at home, which in normal course would require care and treatment at a hospital but is actually taken at home provided that

- a) The Medical practitioner advices the Insured person to undergo treatment at home.
- b) There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.
- c) Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

**Conditions**

- (i) Requisite pre-authorization is obtained from our Empanelled homecare treatment provider for the said Illness/Injury.
- (ii) OPD Treatment is not covered under this Benefit.
- (iii) Condition specified in the section C.I.A (Inpatient hospitalization) shall also be applicable for this section f.b(Home Treatment)
- (iv) Insured Person may avail a treatment in a network Hospital under Section C.I.(a) (Inpatient Hospitalisation) in case that Pre-Authorisation is not received by the Insured Person(s) from Empanelled home care treatment providers, as per the terms and conditions of Section C.I.(a) (Inpatient Hospitalisation).
- (v) We do not assume any liability towards, and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner and/or Empanelled homecare treatment provider or in any service under this Benefit or for any consequences of actions taken or not taken in reliance thereon.
- (vi) The exclusion no. 52 as specified in Annexure I – Non Medical Expenses are waived off to the extent of this Benefit(s) as specified in this Section C.I.(f).(b) (Home Treatment).
- (vii) We do not assume any liability towards any additional or incidental charges/expenses, including but not limited to any charges towards breakage, damage, deposit for equipment, and equipment transportation. All such charges/expenses shall be borne by the Insured Person.
- (viii) The foregoing home treatment services are provided through Empanelled homecare treatment Provider in selected cities only. Please contact Us or refer to Our website for updated list of cities where home treatment service is provided.

**(g) Road Ambulance Cover:**

**What is covered**

We shall cover the reasonable and customary charges incurred up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy, towards transportation of the Insured Person by road ambulance for any emergency illness/injury diagnosed during the policy period provided that

- (i) The medical condition of the insured person requires immediate ambulance services from the place of occurrence of an Emergency to a nearest Hospital and/or
- (ii) From the existing hospital, if the Medical Practitioner certifies in writing that It is medically necessary to transfer the Insured person to another hospital due to lack of super specialist treatment in the existing hospital or to a diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.

**Conditions**

- (i) The Ambulance/ healthcare service provider is duly registered;
- (ii) We have accepted a claim for In-patient Hospitalization under Section C.I.(a) and or Day Care Treatment under Section C.I.(c) above for the same Illness/Injury;

**What is not covered**

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

**(h) Organ Donor Expenses:**

**What is covered**

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

**Conditions**

- (i) The organ donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;
- (ii) The Insured Person is the recipient of the organ so donated by the organ donor;
- (iii) The organ transplant is medically necessary for the Insured Person as certified by a Medical Practitioner;

**What is not covered**

- (i) Pre-Hospitalization Medical Expenses or Post-Hospitalization Medical Expenses of the organ donor.
- (ii) Screening expenses of the organ donor.
- (iii) Any expenses for treatment or any complication as a result of harvesting from the organ donor.
- (iv) Costs associated with the acquisition of the donor's organ.
- (v) Expenses related to organ transportation or preservation.

**(i) AYUSH Cover**

**What is covered**

We shall cover Reasonable and Customary charges on a reimbursement basis, up to the Sum Insured as specified in the Policy Schedule / Product Benefit Table of this Policy, towards the Medical Expenses incurred by and in respect of medically necessary In-patient Hospitalization incurred with respect to the Insured Person's AYUSH Treatment undergone in any AYUSH Hospital/AYUSH Day care centre.

**What is not covered**

- (i) The Pre-Hospitalization Medical Expenses and Post- Hospitalization Medical Expenses related to AYUSH Treatments are not covered in this Benefit
- (ii) Outpatient Treatment
- (iii) Treatment taken outside India.

**(j) Binge Refill**

**What is covered**

If the Policy Sum Insured along with accumulated No Claim Bonus (if any), Super No Claim Bonus (if any), is completely exhausted or is insufficient for covering a claim as a result of previous claims, then We shall provide for a refill of the Sum Insured, unlimited times during the Policy Year up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy.

**Conditions**

- (i) A claim shall be admissible under this Benefit only if the claim is admissible under In-patient Hospitalization under Section C.I.(a) or Day Care Treatment under Section C.I.(c) or Section C.I.(i) (AYUSH Cover) or Section C.I.(f).(a) (Domiciliary Hospitalization) & C.I.(f).(b) Home Treatment or Section C.I.(h) (Organ Donor Expenses) arising in that Policy Year for any or all Insured Person(s).
- (ii) The Refill of Sum Insured shall be available for all subsequent claims also and to any Illness/Injury (including its complications) for which a claim has been admitted for the Insured Person during that Policy Year.
- (iii) The Refill of the Sum Insured shall apply to the first claim in the Policy Year
- (iv) Our total, maximum liability under a single claim under this Benefit shall not be more than the Sum Insured.
- (v) The Refill Sum Insured shall not be considered while calculating the No Claim Bonus or the Super No Claim Bonus.
- (vi) In case of an Individual Policy, Refill of the Sum Insured is available to each Insured Person and can be utilised by Insured Persons who are covered under the Policy.
- (vii) In case of a Family Floater Policy, the refill of Sum Insured shall be available on a floater basis for all Insured Persons in the family that are covered under the Policy.
- (viii) If the Refill of Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

**(k) Maternity Expense**

**What is covered**

We shall cover Maternity Expenses up to the limit specified in the Policy Schedule / Product Benefit Table of this Policy after a waiting period of 36 months from the inception of the 1st policy where maternity cover is available & renewed with Us without any break (continuity benefit in respect of the "Waiting Periods" shall not be available for this benefit in case of portability/migration if the erstwhile policy did not provide for such maternity coverage).

Coverage under this Benefit shall include:

- (i) Medical Expenses for a delivery of a child (including caesarean section) or lawful medical termination of pregnancy up to a maximum of 2 events in the lifetime of the Insured Person including:
  - (a) 2 deliveries (including twins) or
  - (b) 2 terminations or
  - (c) 1 delivery (including twins) and 1 termination

- (ii) Pre or Post - Natal Maternity Expenses;
- (iii) The coverage under this Benefit will be over and above the base policy Sum Insured. Any claim under this Benefit shall not impact the Opted Sum Insured, No Claim Bonus & Super No Claim Bonus (if opted).

**Conditions**

- This Benefit is available for You or Your spouse provided You and Your spouse, both are covered under the same Policy for a continued period of 36 months.
- Minimum Age at entry of the female insured is Age 18 to 45 Years, however claims can be made at any age even after Age 45 Years.
- Our maximum liability per pregnancy will be subject to the limits specified in the Policy Schedule.

**What is not covered**

- (i) Medical Expenses for ectopic pregnancy. However, these expenses will be covered under In-patient Treatment under C.I.(a) (In-Patient Hospitalization);
- (ii) Any Pre-Hospitalization Medical Expenses or Post – Hospitalization Medical Expenses under Section C.I.(d) (Pre-Hospitalization Medical Expenses) and C.I.(e) (Post-Hospitalization Medical Expenses), above will not be covered under this Benefit,
- (iii) Any refill of Sum Insured under Benefit (Section C.I. j) (Binge Refill) will not be available for coverage under this Benefit.

Note: Section D.I .18 is not applicable.

**(i) New Born Baby Expenses**

**What is covered**

We shall cover medical expenses towards the treatment of the New Born Baby as an In-patient, within the limit of the Maternity Sum Insured, while the Insured Person is Hospitalised as an in-patient for delivery, subject to a valid claim being accepted under Maternity Expenses.

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

**Conditions**

Any Refill of Sum Insured (Binge Refill Section C.I.j) will not be available for coverage under this Benefit

**(ii) Vaccination Cover:**

**What is covered**

We will cover vaccination expenses listed below of a New Born Baby from birth to until the New Born Baby completes two years.

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

**Conditions**

- (i) Coverage will be subject to claims admitted under Maternity Expenses cover and will be within the limits of Maternity Sum Insured.
- (ii) Vaccination expenses will be covered only if the Insured Person whose maternity claim has been accepted by Us continues to Renew the Policy with Us during the period.
- (iii) Reimbursement claims for vaccination expenses can be submitted quarterly in a Policy Year.
- (iv) Section D.II.21. d is not applicable.

**Note:**

- (i) Our total liability under Maternity Expenses inclusive of New born baby expenses, vaccination expenses & Stem Cell Preservation will be ₹40,000 per event subject to maximum of 2 events during the lifetime, if the insured person has a normal delivery.
- (ii) Our total liability under Maternity Expenses inclusive of New born baby expenses, vaccination expenses & stem cell preservation will be ₹60,000 per event subject to maximum of 2 events during the lifetime, if the insured person has a C-Section delivery.

**(iii) Stem cell preservation**

**What is covered**

We will cover onetime Medical Expenses up to the limit specified in the Policy Schedule towards the harvesting and storage of stem cells of the New Born Baby.

**Conditions**

- (i) The harvesting and storage of the stem cells of the New Born Baby is carried out as a preventive measure against possible future illnesses.
- (ii) The stem cells of the New Born Baby are preserved in an India based Stem Cell Bank only.
- (iii) The payment under this Benefit is subject to a valid claim being accepted by Us under Maternity Expenses under section C.I.(k).



(iv) The coverage under this Benefit will be within the limits of Maternity Sum Insured as Specified in the Policy Schedule and Product Benefit Table.

(v) We shall be covering stem cell preservation for a maximum up to 2 New Born Baby(s) during the lifetime of an Insured Person.

## Section II: Additional Benefits

The Benefits listed below are additional Policy benefits and shall be available with applicable limits, if any to all Insured Persons as specified in the Policy Schedule / Product Benefit Table of this Policy.

Benefits under this Section C.II are subject to the terms, conditions and exclusions of this Policy. Claims under this Section C.II will not impact the Sum Insured or the eligibility for No Claim Bonus and Super No Claim Bonus.

### (l) No Claim Bonus:

We shall apply a cumulative bonus in the form of No Claim Bonus at such 10% of the Sum Insured of the expiring policy year, provided that the insured person(s) has not made any claim under Section C.I in a policy year, and has successfully renewed the policy with us continuously and without any break on or before the Grace Period. The accumulated No Claim Bonus shall not exceed 100% of the Sum Insured on the Renewal Policy.

#### Conditions

- (i) If the Policy is a Family Floater Policy, then No Claim Bonus will accrue only if no claims have been made in respect of the Insured Person(s) in the expiring Policy Year. No claim Bonus which is accrued during the claim free Policy Year, will only be available to those Insured Person(s) who were insured in such claim free Policy Year and continue to be Insured Person(s) in the subsequent Policy Year.
- (ii) If the Policy Period is two or three years, any No Claim Bonus that has accrued for the first/second Policy Year will be credited at the end of the first/second Policy Year as the case may be and will be available for any claims made in the subsequent Policy Year.
- (iii) The No Claim Bonus can be utilised for Benefits covered under Section C.I.(a) (In-patient Hospitalization), C.I.(d) (Pre-hospitalization Medical Expenses), C.I.(e) (Post-hospitalization Medical Expenses), C.I.(c) (Day Care Treatment), C.I. (f).(a) (Domiciliary Hospitalization), C.I.(f).(b) (Home Treatment), C.I.(g) (Road Ambulance Cover), C.I.(h) Organ Donor & C.I.(i) AYUSH Cover.
- (iv) The accumulated No Claim Bonus can be utilised only when Sum Insured specified in the Policy Schedule/ Product Benefit Table have been completely exhausted.
- (v) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated No claim bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater Policy basis then the No claim Bonus to be carried forward for credit in such Renewed Policy shall be the lowest accrued amongst all the Insured Persons.
- (vi) If the Insured Persons in the expiring Policy are covered on a Family Floater Policy basis and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater Policies/Individual Policies, then the No Claim Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
- (vii) If the Sum Insured has been reduced at the time of Renewal, the applicable No Claim Bonus shall be reduced in the same proportion to the Sum Insured.
- (viii) If the Sum Insured under the Policy has been increased at the time of Renewal the No Claim Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
- (ix) The No Claim Bonus is provisional and is subject to revision if a claim is made in respect of the expiring Policy Year, which is notified after the acceptance of Renewal premium. Such awarded No Claim Bonus shall be withdrawn only in respect of the expiring Policy Year in which the claim was admitted.
- (x) In case of Family Floater Policies, Dependent Children attaining Age 25 years at the time of Renewal will be moved out of the Family Floater Policy into an Individual Policy. However, all continuity benefits for such Insured Person on the Policy will remain intact. No Claim Bonus earned on the Policy will stay with the Insured Person(s) covered under the original Policy.
- (xi) In the event of a claim impacting the eligibility of a No Claim Bonus, the accumulated No Claim Bonus shall be reduced by the percentage of Sum Insured as accumulated in the previous Policy Year and as mentioned in Policy Schedule/ Product Benefit Table of this Policy.

### (m) Health Check Up Program

#### What is covered

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

Medical tests covered in the Health Check-up Program are as follows:

List of Tests - During Annual Health Check up	Sum Insured
MER, CBC with ESR, Urine routine, Blood Group, Blood Sugar, Serum Cholesterol, SGPT, Serum Creatinine, ECG	Up to 4 Lacs
MER, CBC with ESR, Urine routine, Blood Group, Blood Sugar, Lipid Profile, Kidney Function Test, ECG	5 Lacs -10 Lacs
MER, CBC with ESR, Urine routine, Blood Group, Blood Sugar, Lipid Profile, TMT, Kidney Function Test	15 Lacs -75 Lacs
MER, CBC with ESR, ABO Group & Rh type, Urine routine, Stool routine, S Bilirubin(total/direct), SGOT, SGPT, GGT, Alkaline phosphatase, Total Protein, Albumin: Globulin, Liver Function Test, TMT, ECG, Cholesterol, LDL, HDL, Triglycerides, VLDL, Creatinine, Blood Urea Nitrogen, Uric acid, Hba1C, Chest X ray, USG Abdomen	Above 75 Lacs

#### Reference:

MER - Medical Examiner's Report stamped and signed by a Medical Practitioner who is an MD physician,

BMI - Body Mass Index,

CBC - Complete Blood Count,

ESR - Erythrocyte Sedimentation Rate,

ECG - Electrocardiogram,

TMT - Treadmill Test,

SGPT - Serum Glutamic Pyruvic Transaminase,

SGOT - Serum Glutamic Oxaloacetic Transaminase,

GGT - Gamma-Glutamyl Transferase,

LDL - Low Density Lipoprotein,

HDL - High Density Lipoprotein,

VLDL - Very Low Density Lipoprotein,

Hba1c - Glycated Hemoglobin Test,

USG - Ultrasonography.

### Conditions

- (i) The health check-ups shall be arranged by Us only on cashless basis at Our Network Providers/ Empanelled Service Providers;
- (ii) The Network Provider /Empanelled Service Provider shall be assigned by us post receiving customer's request to avail this Benefit;
- (iii) The Insured Person shall be eligible to avail a health check-up every Policy Year.
- (iv) Annual Health Check Up will have to be carried out at one go (together).
- (v) Section D.II.21.a is not applicable in respect of coverage under this Benefit.
- (vi) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider / Empanelled Service Providers in relation to the health check-up.

### (n) Domestic Emergency Assistance Service

#### What is covered

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

- i. Emergency Medical Evacuation: When a Hospital with adequate medical facility is not available in the proximity of the Insured Person, as determined by Our Empanelled Service Provider for providing Emergency Services, Air Ambulance under appropriate medical supervision will be arranged by Our Empanelled Service Provider, through an appropriate mode of transport to the nearest Hospital with adequate medical facility which is able to provide the required care.
- ii. Medical Repatriation (Transportation): When medically necessary as determined by Empanelled Service Provider and the consulting Medical Practitioner transportation under medical supervision shall be provided in respect of the Insured Person to the residential address as mentioned in the Policy Schedule, provided that the Insured Person is medically cleared for travel via common carrier, and provided further that the transportation can be accomplished without compromising the Insured Person's medical condition.

#### Conditions

- No claims for reimbursement of expenses incurred for services arranged by Insured Person will be allowed unless agreed by Us or Our authorized representative. However in a situation where it is an emergency and when our service provider is unable to provide the service or in case of an emergency where the insured person is unable to inform the empanelled service provider, the Insured person can arrange for air ambulance service and can claim the same with Us.
- Please call Our call centre with details on the name of the Insured Person and/ or Policyholder and Policy number, on the toll free number specified in the Policy Schedule for availing this Benefit.

#### What is not covered

We will not provide services in the following instances:

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

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

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

### Section III: Value Added Benefits

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

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

### (o) Health Assessment

#### What is covered

Health Assessment measures MER including BP (Blood Pressure), BMI (Body Mass Index), HWR (Height –to- Weight Ratio), smoking status, Blood Sugar and Total Cholesterol. Charges for the same shall be borne by Us once in a policy year. Insured can undergo health assessment anytime during the Policy Year. All tests mentioned as a part of Health Assessment shall be conducted together.

#### Conditions

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

### (p) Health Returns™

#### I. What is Health Returns™

Health Returns is a percentage of premium calculated by means of Healthy Heart Score which can be earned by an Insured Person by looking after his/her health and being physically active on a regular basis which is determined by the following Health Activities:

1. Activ Dayz™
2. Fitness Assessment

A Healthy Heart Score can be calculated by undergoing one of the following Medical Assessment:

- i. Pre Policy Medical Check Up before the start of the policy OR
- ii. Health Assessment (Section C. III. o) during the policy year OR
- iii. Health Check Up Program (Section C.II.m)

Please note:

- Health Assessment ((Section C. III. o)) and Health Check-up Program (Section C.II.m) can be done once a year.
- If an insured has done HA first, then insured can undergo AHC for all the listed medical tests.
- However, if an Insured has done AHC first then HA is not mandatory and HHS can be calculated basis the AHC also.

1. **Activ Dayz™**

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

(i) One Active Dayz™ can be earned by:

- Completing a Fitness centre or yoga centre activity for a minimum of 30 minutes at Our panel of Fitness or yoga centre, OR;
- Recording 10,000 steps or more in a day for all Insured Persons (tracked through Our mobile application or a wearable device linked to the Policy number) OR;
- Burning 300 calories or more in one exercise session per day OR;
- Participating in a recognized marathon/ walkathon/ cyclothon or a similar activity which offers a completion certificate with timing.

Once Activ Days are earned, Healthy Heart score is calculated basis the Medical assessment done and Health returns are allotted to the Insured Person.

**Bonus Active Dayz:**

In case the insured person is unable to earn Active Dayz we offer bonus active days to pass on the benefit for days engaged in maintaining good health.

Bonus Active dayz will be calculated basis details below:

	Bonus Active Dayz calculation	Range	Bonus Active Dayz	Maximum % of Health Returns earned
Grid 1 – Monthly Earning Slabs	No of steps completed in a month / No of days in a calendar month	5000-7499	4 Bonus Active Dayz	Upto 30% of the premium excluding premium for optional benefit(s) & taxes
	<b>OR</b>			
	Burnt 150-200 calories on an average in one exercise session per day at the end of the month			
Grid 2 – Monthly Earning Slabs	No of steps completed in a month / No of days in a calendar month	= or > 7500	6 Bonus Active Dayz	
	<b>OR</b>			
	Burnt more than 200 calories on an average in one exercise session per day at the end of the month			
Grid 3 – Monthly Earning Slabs	13 Active Dayz or more every month in a Policy Year		275 Active Dayz™ (including Bonus Active Dayz) in the same Policy Year	Upto 50% Health Returns™ (30% accumulated every month + 20% on achieving 275 Active Dayz)

Please refer example in Annexure A for Bonus Active Dayz calculation.

If an Insured Person has completed less than 10000 steps per day but however if monthly average step count is between 5000-7499 OR has burnt 150-200 calories on an average in one exercise session per day at the end of the month, then We shall reward 4 bonus Active Dayz.

In case if an Insured Person has earned Active Dayz, then he will be rewarded bonus Active Dayz in addition to the Active Dayz earned during the month.

Similarly, If an Insured Person If an Insured Person has completed less than 10000 steps per day but however if monthly average step count is equal to or greater than 7500 per day OR has burnt more than 200 calories on an average in one exercise session per day at the end of the month, then We shall reward 6 bonus Active dayz.

In case if an Insured Person has earned Active Dayz, then he will be rewarded bonus Active Dayz in addition to the Active Dayz earned during the month.

Maximum Active dayz that can be earned including Bonus Active days is the number of days in that calendar month.

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

In addition to the above monthly earning slabs, the Insured Person will earn additional HealthReturns™ based on the Healthy Heart Score™ and the number of Active Dayz™ recorded based on the below grid which shall be calculated basis the number of Active Dayz™ achieved on yearly basis.

Note -Fitness Assessment Results shall not be considered for earning the following annual Slabs. The below mentioned slabs are in addition to the monthly slabs, and are independent of the monthly slabs. e.g. Insured Person with Healthy Heart Score™ who on a monthly basis has accomplished 13 Active Dayz or more every month in a Policy Year, and has achieved at least 275 Active Dayz™ (including Bonus Active Dayz) in the same Policy Year then shall be rewarded with 50% Health Returns™ (30% accumulated every month + 20% on achieving 275 Active Dayz)

No of Active Dayz™ in a year	Healthy Heart Score™		
	Red	Amber	Green
275	4.0 %	8.0%	20.0%

The sum total earning under this benefit shall not exceed 50% of the premium excluding premium for optional benefit(s) & taxes.

## 2. Fitness Assessment

Cardiorespiratory fitness is an element of physical fitness requiring a combination of the circulatory, respiratory, and muscular systems to supply oxygen to the working tissues during physical activity. An Insured Person needs to undergo fitness tests under following 4 components to assess Cardiorespiratory fitness:

- Cardiovascular Endurance
- Muscular Endurance and Strength
- Flexibility
- Body Composition

Fitness Score Methodology

- An insured person is then instructed to undergo fitness test (as defined in Annexure A) under each component as per their age.

Fitness Components	Perform Test as per the Age criteria
<b>Body Composition:</b>	18 yrs to 80 yrs:
	Waist Hip circumference measurement
<b>Cardio-Vascular Endurance (Stamina) Level</b> ( Any one of the given test option to be conducted & result to be recorded )	18 yrs to 65 yrs:
	Modified 3 – minutes Step test
	Modified Spot Jogging Test
<b>Muscular Strength &amp; Endurance Level</b> ( Any one of the given test option to be conducted & result to be recorded )	18 yrs to 55 yrs:
	Knee Push-ups
	Plank
<b>Flexibility Level</b> Any one of the given test option to be conducted & result to be recorded )	18 yrs to 65 yrs:
	V Sit & Reach
	Shoulder Reach Stretch

- Post completion of Test, result is recorded and Individual Level is allotted as per the normative reference table.
- The final total Fitness level is generated based on weighted average score from the result of individual parameters
- Once Fitness Assessment is completed by the Insured Person, Healthy Heart score is calculated basis the Medical assessment done and Health returns are allotted to the Insured Person as per the final level achieved.

Please Note:

- In order to make it easier for the Insured Person to earn HealthReturns™, We provide Two fitness assessments per Policy Year. These fitness assessments will measure the Insured Person's cardiovascular endurance, flexibility, strength, height to weight ratio and waist to hip ratio. The Insured Person will receive fitness assessment results based on his/her measurements.
- The fitness assessment results will be valid for six months and the best of the fitness assessment result and number of Active Dayz™ will be used in a given month to calculate HealthReturns™.

Kindly refer to Annexure A for complete details and Illustration.

## II. Healthy Heart Score (HHS) and its calculation

Coronary artery disease (CAD) is one of the leading causes of mortality and morbidity in cardiovascular disease (CVD) in India. The HHS is a simplified scientific tool for the assessment of risk level of CAD over 10 years created on the basis of the individual and multi-factorial risk assessment done by monitoring following medical test based parameters:

S. No.	Parameter
1	Age:
2	Gender:
3	Total Cholesterol
4	Systolic blood pressure:
5	Smoking Status:
6	Random Blood Sugar:

**Healthy Heart Score Methodology:**

- Once an Insured person completes the medical test based parameters as given above, the actual value received for these parameters is compared with the cut off value of each parameter. Kindly refer to Annexure A for complete details and illustration.
- Based on the actual value received for each tests compared to the cut off value, Individual Points are allocated to each parameter
- The calculated risk score (Sum of individual Points) is then converted into an absolute risk probability in percentage of developing coronary heart disease (CHD) events separately for men and women.
- The risk probability estimate is then categorized into Red, Amber and Green for different age and gender

Kindly refer to Annexure A for cut –off values, complete details and Illustration

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

### III. How to calculate Health Returns

**Step 1** –The first step in Earning Health Return is to generate Healthy Heart Score. Each Insured Person in the Policy should complete Medical Assessment TM by undergoing any of the following

- i. Health Assessment (Section III.15) during the policy year OR
- ii. Health Check Up Program (Section C.II.m)
- iii. Pre Policy Medical Check Up before the start of the policy

Basis the medical assessment, an Insured Person will be categorised into one of the three HHS categories:

1. Red
2. Amber
3. Green

Once categorised, an Insured Person needs to undergo Physical Assessment as mentioned in Step 2 to earn Health Returns.

**Step 2** – Post completion of Medical Assessment , an Insured Person should earn Active Dayz™/ Bonus Active Days, by achieving daily step count goal on monthly basis and/or can achieve fitness level by completing the Fitness Assessment , twice in a Policy Year after a gap of 6 months. The health return accrued post completion of Fitness Assessment will stay applicable every month for next 6 months only The fitness assessment results will be valid for six months and the best of the fitness assessment result and number of Active Dayz™ will be used in a given month to calculate HealthReturns™.

Please refer to Annexure for Illustration

#### Step 3 - Health Returns Grid

The Insured Person will earn HealthReturns™ based on the Healthy Heart Score™, the fitness assessment result and the number of Active Dayz™ recorded.

HealthReturns™ is accrued on a monthly basis according to the following grid.

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

Note: Please refer Annexure A for Measurement of Fitness Assessment level and Healthy Heart Score Status

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

### IV. Health Returns Eligibility

#### (I) Individual Policy

In case of an Individual Policy, each Insured Person would be tracked separately and shall earn HealthReturns™ based on individual performance as per grid of Healthy Heart Score™ and Active Dayz™.

The following relations up to Age of 18 years shall not be eligible for earning HealthReturns™ /Health Assessment (Section III.15) namely son, daughter, brother, sister, grandson, granddaughter, brother in-law, sister in-law, nephew, niece.

#### (II) Family Floater Policy

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

Dependent Children up to 25 years of Age are not eligible for HealthReturns™/Health Assessment™ (Section III.15) .

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

### V. Utilization Of HealthReturns™

Health Returns can be utilized by any covered member under a Policy towards the following expenses:

- payment of Renewal Premium/EMI or payment of premium for any retail policy with Us.
- For hospitalization expenses not payable as per the Policy terms and conditions
- For non-payable expenses in case of an In-patient Hospitalization or Day Care Treatment
- Non-Medical expenses listed in Annexure I 'Non-Medical Expenses' that would not otherwise be payable under the Policy.
- Out-patient expenses up to the value of accrued funds
- Reimbursement claims for Outpatient can be submitted quarterly in a Policy Year.

#### Note:

- Funds earned as HealthReturns™, can be carried forward each month as long as the Policy is Renewed with Us in accordance with the Renewal Terms under the Policy.
- Permanent Exclusions and Waiting Periods do not apply under this Benefit.
- The claim for accumulated HealthReturns™ can be made a maximum 4 times in a Policy Year. If You /Insured Person wish to know the present value of the funds earned as HealthReturns™, then You may contact Us at our toll free number or through Our website or through Our mobile application, which is available on installing the same

There will no change in the parameter and scoring mechanism. However there may be changes in cut off values arriving at the scoring mechanism based on the emerging medical experience. Please refer our website for updated Annexure.

**(q) Mental Health Assessment Program**

**What is covered**

You may avail a confidential professional assistance based Mental Health Assessment program to assess Your current mental health & wellbeing, supported by mental health coaching.

Mental Health Assessment includes

**1. Guidance on knowing Your Mental Health status**

The Insured Person will be guided to take an online mental health assessment tool. The result of this assessment will be given on a scale of 'healthy' to 'extremely severe' risk for anxiety, depression and stress.

- Healthy: Needs sustenance support;
- Mild: Needs Self-care support;
- Moderate: Needs intervention and support;
- Severe: Needs intervention and support;
- Extremely Severe: Needs intervention and support.

**2. Guidance on Improving Your Mental Health**

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

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

Conditions applicable to Mental Health Coaching

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

**(r) Upfront Good Health Discount:**

If You are above 18 Years of Age and not a Dependent Child under this Policy, You can earn Good Health discount by undergoing a Health Risk Assessment. It is a dynamic screening tool based on series of lifestyle and health based questions to assess Your lifestyle habits and health history to determine your current Health Status. Provided that:

You opt to complete the Health Risk Assessment(HRA) at the time of buying the Policy.

(Note: If Your HRA outcome is good as defined below which is determined by the screening Tool)

- (i) You will eligible for 10% discount on premium if opted at the time of buying the policy

HRA Outcome	Description
Good Risk	No risk or History of any disease compared to peers in the same age and gender group
Moderate/High Risk	Moderate to High risk or Positive history of any disease compared to peers in the same age and gender group

- (ii) Once you completed the HRA, you will receive a report which contains a health score based on the assessment of your current health.
- (iii) Discount applicable only on first policy year.
- (iv) Discount is applied on the Premium of the Individual Insured Person who is eligible for HRA discount
- (v) In case of Family Floater risk of each Adult insured will be evaluated and average discount need to be calculated.

Family size	Weightage
Self and Spouse	1:1
Self, Spouse and Dependent Children	1:1:0

Please refer Annexure B for Illustration on HRA Parameters.

**Section IV: Optional Covers**

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

Benefits under this Section C.IV are subject to the terms, conditions and exclusions of this Policy. The sub-limit for each Benefit is specified against that Benefit in the Policy Schedule /Product Benefit Table of this Policy. Payment of the Benefit shall be subject to the availability of the applicable sub-limit for that Benefit.

All claims under this Section C.IV must be made in accordance with the procedure set out in Section F.1 Wherever a claim qualifies under more than one Benefit in Section C.IV, We shall pay for all such eligible covers opted and in force.

**(s) Super NCB**

**What is covered**

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

## Conditions

- (i) "Super NCB" is an extension to the Benefit mentioned in Section C.II.(I) (No Claim Bonus) and therefore all the conditions and provisions stated under Section C.II.(I) shall also be valid and applicable in relation to for this Section. IV.(s).
- (ii) At the time of Renewal of this Policy, if the Policyholder chooses not to renew this optional cover, then the Super NCB under the expiring Policy shall be forfeited.
- (iii) The Binge Refill & accumulated No Claim Bonus shall not be considered while calculating the Super NCB.

## (t) Travel Protect

We shall pay fixed benefits amount specified in the Policy Schedule/ Product Benefit Table of this policy only once in a policy year irrespective of the claim amount, where the Insured Person travels by a common Carrier within the territory of India. The cover under this benefit shall cease for that policy year post claim settlement under this benefit.

Definition applicable to this section

Common Carrier Shall means any commercial public airline operating under license issued by the Appropriate authority for transportation of passengers.

Period of Insurance shall mean a period within the Policy Period which commences when the Insured Person crosses the City of Residence and expires automatically on the earliest of:

- a) the Insured Person returning to the City of residence OR
- b) the expiry of the period specified in the Policy Schedule / Product benefit Table of this Policy from the commencement of the Period of Insurance; OR
- c) the Policy Period End Date.

Place of Origin Shall mean the starting point/ place from where the Insured Person's trip is scheduled to be undertaken through a Common Carrier by which he leaves the City of Residence.

This optional cover will be applied on individual basis for Individual Policies, Multi Individual & Family Floater policy.

### **t.a Total Loss of Checked-in Baggage Benefit**

#### **What is covered**

We shall pay the fixed benefit amount specified in the Policy Schedule/ Product Benefit Table of this Policy against this Optional Benefit in the event of total and complete loss of the Insured Person's Checked- in baggage whilst the Insured Person was travelling within India by a common Carrier provided that:

- (i) Coverage under this Optional Benefit shall commence only after the Checked-in Baggage is in the custody of the Common Carrier and a receipt is obtained by the Insured Person.
- (ii) Coverage under this Optional Benefit is only available for 24 hours after the common carrier reaching the Place of Destination specified in the Insured Person's valid ticket and shall terminate automatically thereafter.

#### **What is not covered**

Any claim in respect of any Insured Person for, arising due to any of the following shall not be admissible under this Optional Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

- (i) Any loss arising from any delay, detention, confiscation by customs officials or other public authorities;
- (ii) Any loss due to damage to the Checked-In Baggage;
- (iii) Valuables
- (iv) Any item that the Common Carrier's policy or rules specifies should not have been carried.

For this Optional Benefit only:

Valuables shall mean and include photographic, audio, video, painting, cash, computer and any other electronic equipment, telecommunications, telescopes, binoculars, antiques, watches, jewellery and gems, furs and articles made of precious stones and metals.

### **t.b Delay of Checked-in Baggage**

#### **What is covered**

We shall pay the fixed benefit amount specified in the Policy Schedule/Product Benefit Table of this Policy against this Optional Benefit if the delivery of the Insured Person's Checked-In baggage which has been entrusted with the Common Carrier is delayed by a period equal to or exceeding the first six hours as specified in the policy schedule/product benefit Table of this Policy, from the Insured Person's arrival at the Place of Destination specified on his/her valid ticket during the Policy Period of Insurance.

#### **What is not covered**

Any claim in respect of any Insured Person for, arising due to any of the following shall not be admissible under this Optional Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

- (i) Any delay which does not exceed the time period specified in the Policy Schedule/Product benefit Table of this Policy for this Optional Benefit;
- (ii) Detention or confiscation of the Check-in baggage by the Common Carrier or customs or any government or other agencies;
- (iii) Any delay attributable to damage to the Checked-In Baggage warranting an examined delivery by the Common Carrier;

### **t.c Trip Cancellation & Interruption**

#### **A. Trip Cancellation:**

##### **What is covered**

If the Insured Person's outward trip as a fare paying passenger from the City of Residence to a Place of Destination on a Common Carrier is unavoidably cancelled before the commencement of the Period of Insurance solely and directly due to one of the reasons below, then We shall pay the benefit amount specified in the Policy Schedule/ Product Benefit Table of this Policy.

- (i) Earthquake, storm, flood, inundation, cyclone or tempest provided that the peril takes Place prior to the commencement of the Period of Insurance at or in the vicinity of the Place of Origin of the Trip, the ultimate scheduled Place of Destination or any intermediate place which is involved in or related to the proposed journey;
- (ii) Terrorism provided that the peril takes place prior to the commencement of the Period of Insurance at or in the vicinity of the Place of Origin of the trip, the ultimate scheduled Place of Destination or any intermediate place which is involved in or related to the proposed Trip
- (iii) The Insured Person's Immediate Family Member dies or is Hospitalized in an Emergency Due to an unforeseen Illness or Injury for at least 2 consecutive days provided that such Illness or Injury shall be diagnosed not earlier than 10 consecutive days from the scheduled commencement of the Trip;

- (iv) The Insured Person is Hospitalized in an Emergency due to an unforeseen Illness or Injury (in case this Optional Benefit is applicable to the Insured Person along with Section C.1(a)) and such Hospitalization commences within 10 days from the scheduled commencement of the trip and continues for at least 2 consecutive days and the treating Medical Practitioner certifies in writing that the insured person is not fit to undertake Travel.

#### **B. Trip Interruption:**

##### **What is covered**

If the Insured Person's stay is unavoidably curtailed after the commencement of the Period of Insurance solely and directly due to one of the reasons below, then We shall pay the benefit amount specified in the Policy Schedule/ Product Benefit Table of this policy.

- (i) Earthquake, storm, flood, inundation, cyclone or tempest provided that the peril takes place within the Period of Insurance at or in the vicinity of the Place of Origin of the trip, the ultimate scheduled Place of Destination or any intermediate place which is involved in or related to the proposed trip.
- (ii) Terrorism provided that the peril takes place within the Period of Insurance at or in the vicinity of the Place of Origin of the trip the ultimate scheduled Place of Destination or any intermediate place which is involved in or related to the proposed Trip;
- (iii) The Insured Person's Immediate Family Member dies or is Hospitalized in an Emergency due to an unforeseen Illness or Injury and such Hospitalization continues for at least 5 consecutive days;

##### **What is not covered**

Any claim in respect of any Insured Person for, arising due to any of the following shall not be admissible under this Optional Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

- (i) Negligence or fault of the travel agent
- (ii) Any advance intimation given to the Insured Person of a possible delay of the Common Carrier by the way of sources such as travel advisories issued by competent /Government authority(s) etc in a public domain that might result in the cancellation or curtailment of the trip

#### **t.d Trip Delay**

##### **What is covered**

If the departure of a Common Carrier in which the Insured Person is scheduled to travel on a valid ticket during the Period of Insurance is delayed from city of residence from the schedule departure time for more than the number of consecutive and completed hours/minutes as specified in the Policy Schedule/Product Benefit Table from the later the declared time of departure or expected time of departure due solely and directly to any one of the following:

- (i) Earthquake, flood, rains, storm, cyclone or tempest; or
- (ii) Terrorism
- (iii) Delay of a scheduled Common Carrier caused by inclement weather.
- (iv) Delay due to a sudden strike or any other action by employees of the Common Carrier.
- (v) Delay caused by equipment failure of the Common Carrier.
- (vi) Delay caused by operational problem at the Common Carrier end (like crew / staff scheduling issues etc).
- (vii) Cancellation or rescheduling of flights done at the instance of the Common Carrier that causes delay

We shall pay the benefit amount specified in the Policy Schedule/ Product Benefit Table against this Optional Benefit provided that We or the Assistance Service Provider is given written notice of the delay immediately and in any event within 30 days of the commencement of the delay and immediate alternative arrangements are made by the Insured Person for progressing the trip as scheduled

##### **What is not covered**

Any Claim in respect of any Insured Person for, arising due to any of the following shall not be admissible under this Optional Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

- (i) Any contingencies other than those specifically named above;
- (ii) The Common Carrier is taken out of service on the instructions of the Civil Aviation Authority or any similar authority;
- (iii) Delay caused by strike or industrial action if already notified at the time the Insured Person booked his/her ticket or paid or committed to other travel and accommodation expenses.
- (iv) The failure to arrive for the Common Carrier's departure in sufficient time to complete all departure formalities in accordance with the Common Carrier's published time schedule.
- (vi) Rescheduling of the flight by the flight operator minimum 10 hours prior to the original departure date & time of the booked Common Carrier is not covered.

#### **t.e Missed Flight Connection**

##### **What is covered**

If the Insured Person misses the connecting flight during the Period of Insurance solely and directly due to the delayed arrival of the Common Carrier in which the Insured Person was traveling on a valid ticket, We pay the benefit amount specified in the Policy Schedule/ Product Benefit Table of this Policy for the costs incurred by the Insured Person to continue the journey to the Scheduled Place of Destination provided that the time gap between the scheduled arrival of the Common Carrier and the connecting flight is more than the number of consecutive hours specified in the Policy Schedule/ Product Benefit Table of this Policy.

##### **What is not covered**

Any claim in respect of any Insured Person for, arising due to any of the following shall not be admissible under this Optional Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

- (i) Missing of the flight is the result of any deviation from the originally scheduled route at the instance of the Insured Person for any reason whatsoever;
- (ii) Any advance intimation given to the Insured Person of a possible delay of the Common Carrier by the way of sources such as travel advisories issued by competent /Government authority(s) etc in a public domain that might lead to missing of the connecting flight;

#### **(u) Premium Waiver**

##### **What is covered**

If an Insured Person is diagnosed for the first time during the policy year with any of the below listed Critical Illnesses OR suffers an Injury due to an Accident resulting in the Permanent Total Disablement of the Insured Person which is of the nature specified in the table below within 365 days from the date of the Accident which occurred during the Policy Period, then the premium will be waived off for 1 Policy year.



**List & Definition of Critical Illnesses as applicable:** The symptoms of the Critical Illness first diagnosed or manifest itself during the Policy Period and after completion of 90 days from the inception of the First Policy with Us.

Critical Illnesses	Definition
1 Cancer of Specified Severity:	<p>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.</p> <p>II. The following are excluded-</p> <ul style="list-style-type: none"> <li>i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.</li> <li>ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;</li> <li>iii. Malignant melanoma that has not caused invasion beyond the epidermis;</li> <li>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 T2NOMO</li> <li>v. All Thyroid cancers histologically classified as T1NOMO (TNM Classification) or below;</li> <li>vi. Chronic lymphocytic leukaemia less than RAI stage 3</li> <li>vii. Non-invasive papillary cancer of the bladder histologically described as TaNOMO or of a lesser classification,</li> <li>viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1NOMO (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;</li> <li>ix. All tumours in the presence of HIV infection.</li> </ul>
2 Myocardial Infarction (First Heart Attack of specific severity)	<p>I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:</p> <ul style="list-style-type: none"> <li>i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)</li> <li>ii. New characteristic electrocardiogram changes</li> <li>iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.</li> </ul> <p>The following are excluded:</p> <ul style="list-style-type: none"> <li>i. Other acute Coronary Syndromes</li> <li>ii. Any type of angina pectoris</li> <li>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.</li> </ul>
3 Open Chest CABG	<p>I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive key hole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.</p> <p>II. The following are excluded:</p> <ul style="list-style-type: none"> <li>i. Angioplasty and/or any other intra-arterial procedures</li> </ul>
4 Open Heart Replacement Or Repair of Heart Valves	<p>I. The actual undergoing of open-heart valve Surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.</p>
5 Kidney Failure Requiring Regular Dialysis	<p>I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.</p>
6 Stroke Resulting In Permanent Symptoms	<p>I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.</p> <p>II. The following are excluded:</p> <ul style="list-style-type: none"> <li>i. Transient ischemic attacks (TIA)</li> <li>ii. Traumatic Injury of the brain</li> <li>iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.</li> </ul>

7 Major Organ / Bone Marrow Transplant	<p>I. The actual undergoing of a transplant of:</p> <ul style="list-style-type: none"> <li>i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or</li> <li>ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.</li> </ul> <p>II. The following are excluded:</p> <ul style="list-style-type: none"> <li>i. Other stem-cell transplants</li> <li>ii. Where only islets of langerhans are transplanted</li> </ul>
8 Permanent Paralysis of Limbs	<p>I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.</p>
9 Multiple Sclerosis With Persisting Symptoms	<p>I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:</p> <ul style="list-style-type: none"> <li>i. investigations including typical MRI findings, which unequivocally confirm the diagnosis to be multiple sclerosis and</li> <li>ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.</li> </ul> <p>II. Other causes of neurological damage such as SLE and HIV are excluded.</p>
10 Coma of Specified Severity	<p>I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:</p> <ul style="list-style-type: none"> <li>i. no response to external stimuli continuously for at least 96 hours;</li> <li>ii. life support measures are necessary to sustain life; and</li> <li>iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.</li> </ul> <p>II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.</p>
11 Motor Neuron Disease With Permanent Symptoms	<p>I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.</p>
12 Third Degree Burns	<p>I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.</p>
13 Deafness	<p>I. Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.</p>
14 Loss of Speech	<p>I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by and Ear, Nose, Throat (ENT) specialist.</p> <p>II. All psychiatric related causes are excluded.</p>
15 Aplastic Anemia	<p>Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:</p> <ul style="list-style-type: none"> <li>a. Blood product transfusion;</li> <li>b. Marrow stimulating agents;</li> <li>c. Immunosuppressive agents; or</li> <li>d. Bone marrow transplantation.</li> </ul> <p>The diagnosis must be confirmed by a haematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following:</p> <ul style="list-style-type: none"> <li>a. Absolute neutrophil count of 500/mm<sup>3</sup> or less</li> <li>b. Platelets count less than 20,000/mm<sup>3</sup> or less</li> <li>c. Absolute Reticulocyte count of 20,000/mm<sup>3</sup> or less</li> </ul> <p>Temporary or reversible Aplastic Anaemia is excluded. In this condition, the bone marrow fails to produce sufficient blood cells or clotting agents.</p>

16 End Stage Liver Failure	<p>I. Permanent and irreversible failure of liver function that has resulted in all three of the following:</p> <ol style="list-style-type: none"> <li>i. Permanent jaundice; and</li> <li>ii. Ascites; and</li> <li>iii. Hepatic encephalopathy.</li> </ol> <p>II. Liver failure secondary to drug or alcohol abuse is excluded.</p>
17 End Stage Lung Failure	<p>I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:</p> <ol style="list-style-type: none"> <li>i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and</li> <li>ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and</li> <li>iii. Arterial blood gas analysis with partial oxygen pressures of 55mmHg or less (PaO2 &lt;55 mm Hg); and</li> <li>iv. Dyspnea at rest.</li> </ol>
18 Bacterial Meningitis	<p>Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal chord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks resulting in permanent inability to perform three or more Activities for Loss of Independent Living.</p> <p>This diagnosis must be confirmed by:</p> <ol style="list-style-type: none"> <li>a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and</li> <li>b. A consultant neurologist certifying the diagnosis of bacterial meningitis.</li> </ol> <p>Bacterial Meningitis in the presence of HIV infection is excluded.</p>
19 Fulminant Hepatitis	<p>A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:</p> <ol style="list-style-type: none"> <li>a. Rapid decreasing of liver size;</li> <li>b. Necrosis involving entire lobules, leaving only a collapsed reticular framework;</li> <li>c. Rapid deterioration of liver function tests;</li> <li>d. Deepening jaundice; and</li> <li>e. Hepatic encephalopathy.</li> </ol> <p>Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.</p>
20 Muscular Dystrophy	<p>A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist acceptable to Us, with confirmation of at least 3 of the following 4 conditions:</p> <ol style="list-style-type: none"> <li>a. Family history of muscular dystrophy;</li> <li>b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;</li> <li>c. Characteristic electromyogram; or</li> <li>d. Clinical suspicion confirmed by muscle biopsy.</li> </ol> <p>The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months.</p>

<b>Type of Permanent Total Disablement</b>
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.

- (i) This Benefit is available once in the lifetime of the Policy, regardless of the number of years the Policy has served with Us.
- (ii) Waiver of premium for 1 year shall be excluding with respect to the premium payable towards optional covers opted, if any
- (iii) In case of Individual/multi individual Policy, each individual Insured Person can opt this optional covers as per their requirements. In case of Family Floater Policy, once selected, the optional covers shall apply to all Insured Persons without any individual selection.
- (iv) This optional cover can be opted only at inception of the Policy.  
Not applicable for Renewal/Portability & Migration cases.

(v) **EMI Protection**

**What is covered**

We shall pay equated monthly instalment due under existing loan account as specified in the Policy Schedule / Product Benefit Table of this Policy where the insured is hospitalized due to any illness/injury in excess of 6 consecutive days during the Policy Period while the policy is in force and provided that claim under In-patient Hospitalization under Section C.I.(a) or Day Care Treatment under Section C.I.(c) or Section C.I.(i) AYUSH Cover or Section C.I. (f) (a) Domiciliary Hospitalization or (f) (b) Home Treatment is admitted by Us. The benefit amount will be paid as a lump sum amount post the insured Person discharge from the hospital.

This Benefit is available once in the lifetime in the Policy regardless of the number of years the Policy has served with Us. This optional cover will be applied on individual basis for Individual, Multi Individual & Family Floater policy.

**What is not covered**

Any penalty or arrears which may have accumulated due to delayed or missed EMI's prior to the date of hospitalisation.

(w) **Non-Medical Expense waiver**

**What is covered**

We shall cover cost of Non-Medical Items, listed under Annexure I of this Policy, which are necessarily incurred towards Hospitalization of the Insured Person, arising out of Illness or Injury contracted or sustained during the Policy Period. The Benefit is available subject to claim being admissible under the In-patient Hospitalization Benefit (C.I. a) and/ or Day Care Treatment (C.I.C) Benefit under the Policy and provided that the expenses on Non-Medical Items pertain to the same Illness/injury admitted by Us. The total, cumulative and maximum claim pay out under this Benefit shall be limited to applicable policy Sum Insured specified in the Policy Schedule/Product Benefit table of the Base Policy.

(x) **Reduction in Maternity Waiting Period**

**What is covered**

We will provide for a waiver of waiting period for Maternity Expenses (Section C.I.k) from 36 months to 24 months from the date of inception of first Policy with Us. New Born Baby Expense, Vaccination Expense & Stem Cell Preservation will follow reduction in waiting period under Maternity Expenses Cover. All other terms, conditions and exclusions under Maternity Expenses Cover (Section C.I.K) shall continue to apply.

This optional cover can be opted only at inception of the Policy. This Benefit will not be available at Renewal stage and/or Portability & Migration cases.

(y) **OPD Expenses**

**What is covered**

We shall cover the Medical Expenses incurred by the Insured Person during the Policy Period towards outpatient consultation as specified in the Policy Schedule/Product Benefit Table of the Policy in relation to any illness/ injury diagnosed during the Policy Period. These services can be availed via Our application or through toll free number of Empanelled Service Provider specified in the Policy Schedule on cashless basis in selected cities.

This cover includes:

- (a) Physical Outpatient consultations given by a Medical Practitioner or AYUSH Medical Practitioner during the Policy Year.
- (b) Teleconsultation given by a Medical Practitioner or AYUSH Medical Practitioner for any telephonic/ virtual consultations and recommendations.

For the purpose of this Benefit, telephonic/virtual consultation shall mean consultation provided by a Medical Practitioner through various mode of communication like audio, video, online portal, chat or mobile application.

**Conditions:**

Benefits under this Section shall be available on an individual basis to each eligible Insured Person up to the limit specified in the Policy Schedule for an Individual Policy and Family Floater Policies.

Any claim under this Benefit shall not impact the Opted Sum Insured, No Claim Bonus & Super No Claim Bonus (if opted).

**Section D: PERMANENT EXCLUSION**

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

**I. Standard Exclusions**

**1. Pre-Existing Diseases (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 months as specified in the Policy Schedule / Product Benefit Table of this Policy of continuous coverage after the date of inception of the first policy with Insurer.
- 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 months as specified in the Policy Schedule / Product Benefit Table of this Policy for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

**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:

	<b>Body System</b>	<b>Illness</b>	<b>Treatment/ Surgery</b>
1	Eye	Cataract	Cataract Surgery
		Glaucoma	Glaucoma Surgery
		Refractive Error Correction	Correction Surgery
2	Ear Nose Throat	Sinusitis	Medical & Surgical Treatment
		Rhinitis	Medical & Surgical Treatment
		Tonsillitis & Adenitis	Medical & Surgical Treatment
		Tympanitis & Non Traumatic Perforation	Medical & Surgical Treatment
		Deviated Nasal Septum	Medical & Surgical Treatment
		Otitis Media	Medical & Surgical Treatment
		Adenoiditis	Medical & Surgical Treatment
		Mastoiditis	Medical & Surgical Treatment
		Cholesteatoma	Medical & Surgical Treatment
3	Gynecology	All Cysts, Mass, Swelling, Lump, Granulomas, Polyps, Fibroids & Benign Tumour of the female genito urinary system	Medical & Surgical Treatment
		Polycystic Ovarian Disease	Medical & Surgical Treatment
		Uterine Prolapse	Medical & Surgical Treatment
		Fibroids (Fibromyoma)	Medical & Surgical Treatment
		Breast lumps (excluding Malignant)	Medical & Surgical Treatment
		Dysfunctional Uterine Bleeding (DUB)	Medical & Surgical Treatment
		Endometriosis	Medical & Surgical Treatment
		Menorrhagia	Medical & Surgical Treatment
		Pelvic Inflammatory Disease	Medical & Surgical Treatment
4	Orthopedic / Rheumatological	Gout	Medical & Surgical Treatment
		Rheumatism, Rheumatoid Arthritis	Medical & Surgical Treatment
		Non infective arthritis	Medical & Surgical Treatment
		Osteoarthritis	Medical & Surgical Treatment
		Osteoporosis	Medical & Surgical Treatment
		Prolapse of the intervertebral disc	Medical & Surgical Treatment
		Spondilosis, Spondioarthritis, Spondylopathies	Medical & Surgical Treatment
		Ankylosing Spondilitis / Spondylopathies	Medical & Surgical Treatment
		Psoriatic Arthritis / Arthropathy	Medical & Surgical Treatment
		Internal Derangement of Knee / Ligament or Tendon or Meniscus Tear	Medical & Surgical Treatment
		Joint Replacement Surgery	Medical & Surgical Treatment
		Non Specific Arthritis	Medical & Surgical Treatment
5	Gastroenterology (Alimentary Canal and related Organs)	Stone in Gall Bladder, Bile duct & other parts of Biliary System	Medical & Surgical Treatment
		Cholecystitis	Surgical Treatment
		Pancreatitis	Surgical Treatment
		Fissure, Fistula in ano, hemorrhoids (piles), Pilonidal Sinus, Ano-rectal & Perianal Abscess	Medical & Surgical Treatment
		Rectal Prolapse	Medical & Surgical Treatment
		Gastric or Duodenal Erosions or Ulcers + Gastritis & Duodenitis & Colitis	Medical & Surgical Treatment
		Gastro Esophageal Reflux Disease (GERD)	Medical & Surgical Treatment
		Cirrhosis	Medical & Surgical Treatment
		Chronic Appendicitis	Surgical Treatment
		Appendicular lump, Appendicular abscess	Medical & Surgical Treatment
6	Urogenital (Urinary and Reproductive system)	Stones in Urinary system (Stone in the Kidney, Ureter, Urinary Bladder)	Medical & Surgical Treatment
		Benign Hypertrophy / Enlargement of Prostate (BHP / BEP)	Medical & Surgical Treatment
		Hernia, Hydrocele,	Medical & Surgical Treatment
		Varicocoele / Spermatocele	Medical & Surgical Treatment

7	Skin	Skin tumour (unless malignant)	Medical & Surgical Treatment
		All skin diseases	Medical & Surgical Treatment
8	General Surgery	Any swelling, tumour, cyst, nodule, ulcer, polyp Mass , Swelling, Lump, Granulomas, Benign Tumour anywhere in the body (unless malignant)	Medical & Surgical Treatment
		Varicose veins, Varicose ulcers	Medical & Surgical Treatment
		Internal Congenital Anomaly or internal congenital diseases	Medical & Surgical Treatment

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

**Specified disease / procedure waiting period: (Code- Excl02)**

- g) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with Us. This exclusion shall not be applicable for claims arising due to an accident.
- h) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- i) 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.
- j) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- k) 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.
- l) List of specific diseases/procedures:
  - 1. Genetic Disorders

**3. 30-day waiting period (Code- Excl03)**

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

**4. 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.

**5. 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.

**6. 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

**7. 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.

**8. 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.

**9. 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.

**10. 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.

**11. 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 III of this policy and as disclosed in website ([www.adityabirlahealth.com/healthinsurance](http://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.

12. **Treatment for, Alcoholism, drug or substance abuse or any addictive condition** and consequences thereof. (Code- Excl12)
  13. **Treatments received in health 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)
  14. **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)
  15. **Refractive Error:(Code- Excl15)** - Expenses related to the treatment for correction of eye sight due to refractive error less than 7 .5 dioptries.
  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. **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
  18. **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.
- II. Specific Exclusions**
19. **Circumstantial Exclusion**
    - a. 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 defence, rebellion, uprising, revolution, insurrection, military participation or involvement in naval, military or air force operation
    - b. Usurped acts, nuclear weapons / materials, chemical and biological weapons, ionizing radiation, contamination by radioactive material or radiation of any kind, nuclear fuel, nuclear waste.
    - c. The Insured Person's direct participation in terrorist acts;
  20. **Behavioural Exclusions**
    - a. Suicide or attempted suicide, wilfully self-inflicted injury;
    - b. Illegal act of the Insured Persons
    - c. Any treatment for injury resulting from the consumption of alcohol or any intoxicating substance, its intake or abuse thereof
    - d. the use of drugs (other than drugs taken under treatment prescribed and directed by a Medical Practitioner but not for the treatment of drug addiction);
  21. **Medical Exclusions**
    - a. All routine examinations and preventive health check-ups
    - b. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment);
    - c. Conditions for which treatment could have been done on an outpatient basis without any Hospitalization
    - d. Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing
    - e. 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.
    - f. External Congenital Anomalies or diseases or defects.
    - g. Stem cell therapy except Hematopoietic stem cells for bone marrow transplant for haematological conditions) or Surgery, or growth hormone therapy or Hormone Replacement Therapy.
  22. **Prosthesis and Devices**
    - a. Hearing aids, spectacles or contact lenses including optometric therapy, multifocal lens
    - b. Wigs, or toupees, and related expenses.
    - c. Any expenses incurred on prosthesis, corrective devices external durable medical equipments, wheelchairs crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.), devices used for ambulatory monitoring of blood pressure, blood sugar, glucometers, nebulizers and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Cost of artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment. Sleep-apnea and other sleep disorders.
  23. **Non-Medical expenses**  
As mentioned under Annexure (I) List II, III & IV will be excluded unless forms a part of In-patient hospitalization.
  24. **Specific treatment Exclusion**  
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, Use of Radio Frequency (RF) probe for ablation.
  25. **Activities and Profession Exclusions**
    - a. 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.
    - b. Treatment charges or fees charged by any Medical Practitioner acting outside the scope of license or registration granted to him by any medical council.
    - c. 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.
  26. **Geographical Exclusion**  
Treatment taken outside India

**I. Standard General Terms and Clauses****1. Disclosure of Information**

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policyholder.

**2. Condition Precedent to Admission of Liability**

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

**3. 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.

**4. 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.

**5. 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.

**6. Cancellation****1. Cancellation by You**

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

Provided that in case there is a request for Refund where claim has been made only under Health Assessment™ (Section C.III.o) and / Health Check-up Program (Section C.II.m) we shall process the refund in accordance with the grid below provided and after deduction of the charges for the claims made under the Sections referred hereinabove.

In force Period-Up to	Refund		
	1 Year	2 Year	3 Year
1 Month	75.00%	85.00%	90.00%
3 months	50.00%	75.00%	85.00%
6 months	25.00%	60.00%	75.00%
12 months	NIL	50.00%	60.00%
15 months		30.00%	50.00%
18 months		20.00%	35.00%
24 months		NIL	30.00%
30 months	15.00%		
30+ months	NIL		

**2. Automatic Cancellation:**

- a. Individual & Family Policy: The Policy shall automatically terminate on the death of all Insured Persons.
- b. Refund: A refund in accordance with the grid above shall be payable if there is an automatic cancellation of the Policy provided that no claim has been filed under the Policy by or on behalf of any Insured Person.



### 3. Cancellation by Us:

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

### 4. Treatment of HealthReturns™ on Cancellation

All coverage, benefits, earning on HealthReturns™, shall automatically lapse upon cancellation of the Policy. However, any unclaimed and accrued HealthReturns™ (from previous Policy Year/month) shall be available for a claim over the next 12 month period from the date of cancellation/termination.

### 7. 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 at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link

[https://www.irdai.gov.in/ADMINCMS/cms/fmGuidelines\\_Layout.aspx?page=PageNo3987&flag=1](https://www.irdai.gov.in/ADMINCMS/cms/fmGuidelines_Layout.aspx?page=PageNo3987&flag=1)

### 8. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on migration, kindly refer the link

[https://www.irdai.gov.in/ADMINCMS/cms/fmGuidelines\\_Layout.aspx?page=PageNo3987&flag=1](https://www.irdai.gov.in/ADMINCMS/cms/fmGuidelines_Layout.aspx?page=PageNo3987&flag=1)

### 9. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

- i. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- v. No loading shall apply on renewals based on individual claims experience

### 10. 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 No claim bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

### 11. 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 and deductibles as per the terms and conditions of the Policy.

### 12. 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.

### 13. 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.

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

## 15. Redressal of Grievance

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

Our website: [www.adityabirlahealth.com/healthinsurance](http://www.adityabirlahealth.com/healthinsurance)

Toll Free : 1800 270 7000

Email: [care.healthinsurance@adityabirlacapital.com](mailto:care.healthinsurance@adityabirlacapital.com)

Courier: Aditya Birla Health Insurance Co. Limited 9th Floor, Tower 1, One World 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>

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 III.

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

## 16. 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.

## 17. 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)

## II. Specific Terms and Clauses

### 18. Material Change

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

### 19. Alterations in the Policy

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

### 20. 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.

### 21. Other Renewal Terms

- (i) We shall not be liable for any claim arising out of an Ailment suffered or Hospitalization commencing or Disease/Illness/Condition contracted during the period between the expiry of previous Policy and date of inception of subsequent Policy and such Disease/Illness/Condition shall be treated as a Pre-Existing Disease.
- (ii) Any unutilised funds under HealthReturns™ (from the previous Policy year/ month) will be available for claims during the Grace Period.
- (iii) You shall not be able to earn HealthReturns™ during the Grace Period.
- (iv) In case the Policy is not renewed before the end of the Grace Period, any unutilized funds under HealthReturns™ shall be available for a claim as up to a period of 3 months from the date of expiry of the Policy.
- (v) If the Insured Persons in the expiring Policy are covered in an Individual Policy, and such expiring Policy has been Renewed with Us on a Family Floater Policy basis then the accumulated amount under HealthReturns™ that will be carried forward in such Renewed Policy shall be the total of all the Insured Persons moving out and shall be maintained on an Individual Policy basis.
- (vi) If the Insured Persons in the expiring Policy are in a Family Floater Policy and such Insured Persons renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater Policy/ Individual Policies then the accumulated amount under HealthReturns™ shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
- (vii) Alterations like increase/ decrease in Sum Insured or Change in Plan/Product, addition/deletion of Insured Persons (except due to child Birth/Marriage or Death) will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the Proposal Form before the expiry of the Policy. We reserve Our right to carry out underwriting in relation to acceptance of request for changes on Renewal. The Terms and Conditions of the existing Policy will not be altered.
- (viii) Any enhanced Sum Insured during any Policy Renewals will not be available for an Illness, disease, Injury already contracted under the preceding Policy Periods. All waiting periods as mentioned below shall apply afresh for this enhanced limit from the effective date of such enhancement.
- (ix) Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned in the Policy Schedule shall be waived only up to the lowest Sum Insured as applicable to the relevant waiting periods of the Plan in force.

- (x) Where an Insured Person is added to this Policy, either by way of endorsement, all waiting periods under Section D.I.1, D.I.2, D.I.3 will be applicable considering such Policy Year as the first year of Policy with Us with respect to the Insured Person.
- (xi) Applicable No Claim Bonus shall be accrued on each Renewal as per eligibility under the plan in force.
- (xii) In case of Family Floater Policies, children attaining 25 years at the time of Renewal will be moved out of the floater into an individual cover. However, all continuity benefits for such Insured Person on the Policy will remain intact. No Claim Bonus earned on the Policy will stay with the Insured Persons(s) covered under the original Policy.

## 22. Records to be maintained

You or the Insured Person, as the case may be 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.

## 23. Endorsements

The Policy shall allow the following endorsements during the Policy Period. Any request for endorsement must be made by You in writing along with the mandatory documents. Any endorsement would be effective from the date of the request as received from You, or the date of receipt of premium, whichever is later except in the case of date of birth and gender correction in which the endorsement effective date will be the Policy Start Date or the date of Renewal.

### (i) Non-Financial Endorsements – which do not affect the premium.

- 1) Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)
- 2) Rectification in gender of the Proposer/ Insured Person (if this does not impact the premium) \*
- 3) Rectification in relationship of the Insured Person with the Proposer
- 4) Rectification of date of birth of the Insured Person (if this does not impact the premium) \*
- 5) Change in the correspondence address of the Proposer
- 6) Change/Updation in the contact details viz., Phone No., E-mail Id, alternate contact address of the Proposer etc.
- 7) Change in Nominee Details
- 8) Updation of PAN/passport/EIA/CKYC No.
- 9) Change in Height, weight, marital status (if this does not impact the premium) \*
- 10) Change in bank details
- 11) Change in educational qualification
- 12) Change in occupation
- 13) Change in Nationality
- 14) Others

\* These endorsements, if impact the premium, and if accepted, shall be effective from the Start Date of the Policy.

### (ii) Financial Endorsements – which result in alteration in premium.

- (1) Addition of Insured Person^ (newly wedded spouse)
- (2) Deletion of Insured Person on death or separation or Policyholder/Insured Person leaving India
- (3) Change in Age/date of birth\*
- (4) Change in Height, weight\*
- (5) Others

\* These endorsements, if impact the premium, and if accepted, shall be effective from the Start Date of the Policy.

^ The Policyholder should provide a fresh application in a proposal form along with marriage certificate as the case may be for addition of Insured person.

All endorsement requests may be assessed by Us and if required additional information/documents may be requested.

## 24. Grace Period

The Policy may be Renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the expiry date of the Policy and in no case later than the Grace Period of 30 days from the expiry date. We shall not be liable to pay for any claim arising out of an Illness/Injury/ Accident that occurred during the Grace Period. The provisions of Section 64VB of the Insurance Act 1938 shall be applicable. All policies Renewed within the Grace Period shall be eligible for continuity of cover. If the Policy is not Renewed within the Grace Period then We may agree to issue a fresh Policy subject to Our underwriting guidelines and no continuity of benefits shall be available from the expired Policy.

## 25. Communications & Notices

Any communication or notice or instruction under this Policy shall be in writing and will be sent to:

- (i) The Policyholder's, at the address/ E-mail ID as specified in the Policy Schedule/Proposal form or provided to Us by the Policyholder / Insured Person
- (ii) To Us, at the address specified in the Schedule.
- (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.

## 26. Electronic Transactions

The Policyholder and the Insured agree to adhere and comply with all such terms and conditions of electronic transactions as We may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of Us, for and in respect of the Policy or its terms, or Our other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with Our terms and conditions for such facilities, as may be prescribed from time to time.

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

## 27. 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.

## 28. Assignment

The Policy and the benefits under this Policy may be assigned in whole or in part.

## 29. Territorial Jurisdiction

All benefits are available in India only (except Section C. II.(P), and all claims shall be payable in India in Indian Rupees only.

## 30. Sequence of Sum Insured Utilisation

The utilisation of Sum Insured and limits thereof as applicable across various Benefits shall be as follows:

- (i) Sum Insured
- (ii) Accumulated No Claim Bonus
- (iii) Accumulated Super No Claim Bonus
- (iv) (Binge Refill) Refill of Sum Insured

In the aforesaid sequence of utilization of Sum Insured, in case insured person has utilized a specific limit or is not eligible for a specific limit, then may choose to utilize from the next available limit in the given sequence as may be applicable.

## 31. Premium through National Automated Clearing House (NACH)/ Standing Instruction (SI) provided that You may pay the premium through National Automated Clearing House (NACH)/ Standing Instruction (SI) provided that:

NACH/Standing Instruction Mandate form is completely filled & signed by You.

The Premium amount which would be auto debited & frequency of instalment is duly filled in the mandate form.

New Mandate Form is required to be filled in case of any change in the Policy Terms and Conditions whether or not leading to change in Premium.

You need to inform us at least 15 days prior to the due date of instalment premium if You wish to discontinue with the NACH/ Standing Instruction facility.

Non-payment of premium on due date as opted by You in the mandate form subject to an additional renewal/ revival period will lead to termination of the policy

## Section F: OTHER TERMS AND CONDITIONS

### 1. Claims Administration & Process

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

- (1) On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed.
- (2) 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.
- (3) 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.

### I. Claims Procedure

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

#### a. For Availing Cashless Facility

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

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

- (i) We must be contacted to pre-authorise Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Each request for pre-authorisation must be accompanied with all the following details:
  - (1) The health card issued by Us to the Insured Person, along with the Insured Person's KYC documents.
  - (2) The Policy Number;
  - (3) Name of the Policyholder;
  - (4) Name and address of Insured Person in respect of whom the request is being made;
  - (5) Nature of the Illness/Injury and the treatment/Surgery required;
  - (6) Name and address of the attending Medical Practitioner;
  - (7) Hospital where treatment/Surgery is proposed to be taken;
  - (8) Proposed date of admission.
- (ii) If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation in respect of that request.
- (iii) When we have obtained sufficient details to assess the request, We will issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.
- (iv) The Authorization letter shall be issued to the Network Provider within 24 hours of receiving the complete information.

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

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

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

**d. For Reimbursement Claims:**

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

**II. Claims Documentation:**

We shall be provided the following necessary information and documentation in respect of all Claims at Your/Insured Person's expense within 30 days of the Insured Person's discharge from Hospital:

- (i) Claims for Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses to be submitted to us within 30 days of the completion of the post Hospitalization treatment.
- (ii) For those claims for which the use of Cashless Facility has been authorized, we will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:
  - (1) Duly signed, stamped and completed Claim Form
  - (2) Photo ID & Age Proof
  - (3) Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents)
  - (4) Copy of the Network Provider's Registration Certificate / Copy of Form C in case of Hospitalization
  - (5) Original Discharge Card / Day Care Summary / Transfer Summary
  - (6) Original final Hospital Bill with all original deposit and final payment receipt
  - (7) Original invoice with payment receipt and implant stickers for all implants used during surgeries i.e. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery.
  - (8) All previous consultation papers indicating history and treatment details for current ailment
  - (9) All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription and invoice / bill with receipt from diagnostic center
  - (10) All original medicine / pharmacy bills along with Medical Practitioner's prescription
  - (11) MLC / FIR Copy – in Accidental cases only
  - (12) Copy of Death Summary and copy of Death Certificate (in death claims only)
  - (13) Pre and Post-Operative Imaging reports – in Accidental cases only
  - (14) Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress (if available).
  - (15) Original invoice for Vaccination and payment receipt
  - (16) KYC documents
  - (17) Additional Claim documents for Section C.I.(g) Road Ambulance
    - o Photocopy of discharge card
    - o Original Ambulance invoice & paid receipt
  - (18) Additional Claim documents for Section IV: Optional Covers (t) Travel Protect It is a Condition Precedent to Our liability under this Optional Benefit that the following necessary information and documentation shall be submitted to Us or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Optional Benefit

**t.a Total Loss of Checked-in Baggage Benefit**

- (i) Property irregularity report issued by the appropriate authority
- (ii) A valid ticket / proof of travel to the location the Insured Person is traveling as a bona fide passenger.
- (iii) Voucher of the Common Carrier for the compensation paid for the non-delivery/short delivery of the Checked-In Baggage; / short delivery of the Checked-In Baggage

**t.b Delay of Checked-in Baggage**

- (i) Property irregularity report issued by the appropriate authority stating the scheduled time of delivery and actual time of delivery of the Checked-In Baggage
- (ii) Copies of correspondence exchanged, if any, with the Common Carrier in connection with the delay in delivery of the Checked-In Baggage;
- (iii) A valid ticket / proof of travel to the location the Insured Person is traveling as a bona fide passenger
- (iv) Voucher of the Common Carrier for the delay in delivery of the Checked-In Baggage

**t.c Trip Cancellation & Interruption**

- (i) Confirmation in writing of cancellation of the journey from the Common Carrier detailing the circumstances of cancellation/interruption;
- (ii) Ticket / boarding pass issued by the Common Carrier indicating the cost of ticket of the journey indicating cancellation charges retained by the Common Carrier.

- (iii) A declaration from the Insured Person furnishing the circumstances that compelled him/her to cancel the journey;
- (iv) Medical evidence as may be required in case of the cancellation of the journey arising out of personal contingencies of the Insured Person or his/her Immediate Family Member;
- (v) Death certificate (if applicable).

**t.d Trip Delay**

- (i) Certificate from the Common Carrier confirming the delay and detailing the circumstances of delay.
- (ii) Copy ticket for the common carrier

**t.e Missed Flight Connection**

- (i) Confirmation from the Common Carrier of the delay as to the expected time of arrival and the actual time of arrival at Place of Destination;
- (ii) Copy of unused ticket for the missed common carrier
- (iii) Certificate from the Common Carrier of the missed common carrier that the fare for the part of the Journey covered by the missed flight is forfeited in full or in part together with the amount of forfeiture;
- (iv) Original used ticket obtained afresh towards the alternative common carrier for the part of the journey covered indicating the amount paid as fare.

**(19) Additional Claim documents for Section IV: Optional Covers (u) Premium Waiver**

**A. If an Insured Person is diagnosed for the first time with or for any of the listed (20) Critical Illnesses during the policy period, the following document need to be submitted if Premium waiver optional cover is opted.**

- (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
- (ix) Cancelled cheque for NEFT
- (x) Others

**B. If the insured person suffers an Injury due to an Accident resulting in the Permanent Total Disablement of the Insured Person which is of the nature specified within 365 days from the date of the Accident, then submit following document**

- (i) Attested copy of disability certificate issued by civil surgeon of district Hospital mentioning the type and percentage of disability.
- (ii) Original photograph of the Insured Person reflecting the disablement or injured part for which the claim is made
- (iii) Leave records with seal and signature of authorized signatory of the organization (if employed)
- (iv) Salary slips for last 3 months with seal and signature of authorized signatory of the organization (if employed)
- (v) Last 3 years financial years income tax return for self-employed persons
- (vi) Copies of medical documents towards treatment taken during disability period, including discharge summary of the Hospital
- (vii) 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) (if available)

**(20) Additional Claim documents for Section IV: Optional Covers (v) EMI Protection**

- (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) Claim intimation or claim reference number
- (iv) Current Outstanding Loan Certificate from financier, along with copies of documents submitted
- (v) Loan disbursement letter along with payment record till the date of Accident
- (vi) Repayment schedule showing the EMI details

**(21) In case of Multiple Policy claims:**

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

Note - For acceptance of claims in electronic mode, the documents shall be submitted in such form (Soft copy or Hard copy) and in manner as may be specified by Us.

For the following Claims, please notify the same at our call centre/website/e-mail

- Health Assessment™ Section C.III.(o)
- HealthReturns™ Section C.III.(p)
- Health Check-up Program Section C.II.(m)

**III. Claims Assessment & Repudiation:**

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