ADITYA BIRLA CAPITAL
HEALTH INSURANCE

Activ Health - 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

Standard Definitions

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

2. **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.

3. **AYUSH Day care Center** - means 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:
   a. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   b. Having dedicated AYUSH therapy sections as required and / or has equipped operation theatre where surgical procedures are to be carried out;
   c. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

4. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization is approved.

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

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

7. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
   a. Internal Congenital Anomaly
      Congenital anomaly which is not in the visible and accessible parts of the body.
   b. External Congenital Anomaly
      Congenital anomaly which is in the visible and accessible parts of the body.

8. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without any associated increase in premium.

9. **Day Care Treatment** means medical treatment, and / or surgical procedure which is:
   i. undertaken under General or Local Anaesthesia in a hospital / day care centre in less than 24 hrs because of technological advancement, and
   ii. which would have otherwise required hospitalization of more than 24 hours.

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

10. **Day Care Centre** - means any institution established for day care treatment of illness and / or injuries or a medical setup with 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.

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

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

13. **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.

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

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

16. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

17. **Hospital** means any institution established for in- patient care and day care treatment of illness and / or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) 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;

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

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

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

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

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

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

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

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

24. **Maternity Expenses means**:
    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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time- bound exclusions and for all waiting periods.

42. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

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

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

II. Specific Definitions

45. **Age or Aged** means the completed age as on last birthday, and which means completed years as at the Policy Start date.

46. **Any Room** means any category room in a Hospital.

47. **Ambulance** means 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.

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

49. **Ayush Treatment** refers to the hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

50. **Contribution** is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured

51. **Country of Residence** means the country in which the Insured Person is currently residing and as specifed in the Insured Person's corresponding address as specified in the Policy Schedule which for the purpose of this Policy shall be India.

52. **Dependent Child** means a child (natural or legally adopted or step child), who is upto the Age of 25 years.

53. **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.

54. **Empanelled Service Providers** means 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.

55. **Family Floater Policy** means 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 (upto 3) (i.e. natural or legally adopted) between the age 3 months to 25 years.

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

57. **Individual Policy** means 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, mother, father, brother, sister, mother in-law, father in-law, grandfather, grandmother, grandson, granddaughter, son in-law, daughter in-law, brother in-law, sister in-law, nephew, niece.

58. **Insured Person** means 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.

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

60. **Major Illness** means any of the Illnesses, medical events or Surgical Procedures as specifically defind and listed under Section C.IV.(31) and C.V.(36) (International Coverage for Major Illnesses).

61. **Material facts** for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk

62. **Mental Illness** as per The Mental Health Act, 2017 means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence.

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 Benefit under this Policy

64. **Neurological Deficit** means symptoms of dysfunction in the nervous system that are present on clinical examination and are expected to last throughout the Insured Person's lifetime and include numbness, increased sensitivity, paralysis, and localized weakness.

65. **Nominee** means the person named in the Policy Schedule who is nominated to receive the Benefits in respect of an Insured Person under the Policy in accordance with the terms and conditions of the Policy, if the Insured Person is deceased when the Benefit becomes payable.

66. **Policy** means 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.

67. **Policy Period** means 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.

68. **Policy Year** means a period of 12 consecutive months commencing from the start date or any anniversary.

69. **Policy Schedule** means 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.

70. **Single Private A/C Room** means a basic (most economical of all accommodation) category of single room in a Hospital with air-conditioning facility where a single patient is accommodated and which has / does not have an attached toilet (lavatory and / or bath).

71. **Start Date of the Policy** means the inception date of the current Policy Period as specified in the Policy Schedule.

72. **Sum Insured** means:
    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.

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

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

75. **We / Our / Us** means Aditya Birla Health Insurance Co. Limited.

76. **You / Your / Policyholder** means the person named in the Policy Schedule as the policyholder and who has concluded this Policy with Us.

77. **A Standard Definitions of Critical Illness**

1. Cancer of Specified Severity

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

II. The following are excluded-
    i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
    ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
    iii. Malignant melanoma that has not caused invasion beyond the epidermis;
    iv. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
    v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
    vi. Chronic lymphocytic leukaemia less than RAI stage 3
    vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
    viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Myocardial Infarction

(First Heart Attack of specific severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. Open Chest CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive key hole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:

i. Angioplasty and / or any other intra-arterial procedures

4. Open Heart Replacement Or Repair Of Heart Valves

I. The actual undergoing of open-heart valve Surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy / valvuloplasty are excluded.

5. Kidney Failure Requiring Regular Dialysis

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

6. Stroke Resulting in Permanent Symptoms

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

II. The following are excluded:

i. Transient ischemic attacks (TIA)
ii. Traumatic Injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

7. Major Organ / Bone Marrow Transplant

I. The actual undergoing of a transplant of:

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

II. The following are excluded:

i. Other stem-cell transplants
ii. Where only islets of langerhans are transplanted

8. Permanent Paralysis of Limbs

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

9. Multiple Sclerosis with Persisting Symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. Investigations including typical MRI findings, which unequivocally confirm the diagnosis to be multiple sclerosis and

ii. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Neurological damage due to SLE is excluded.

10. Coma of Specified Severity

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. No response to external stimuli continuously for at least 96 hours;

ii. Life support measures are necessary to sustain life; and

iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

11. Motor Neuron Disease with Permanent Symptoms

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

12. Third Degree Burns

I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

13. Deafness

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

14. Loss of Speech

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

15. End Stage Liver Failure

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy.

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

16. End Stage Lung Failure

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and

ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

iii. Arterial blood gas analysis with partial oxygen pressures of 55mmHg or less (PaO2 <55 mm Hg); and

iv. Dyspnea at rest.

76. **B Specific Definitions of Critical Illness**

17. Aplastic Anemia

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

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

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

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

Temporary or reversible Aplastic Anaemia is excluded.
In this condition, the bone marrow fails to produce sufficient blood cells or clotting agents.

18. Bacterial Meningitis

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

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

19. Fulminant Hepatitis

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

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

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

20. Muscular Dystrophy

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

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

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

77. **Definitions related to the specific Optional Cover(s) at Section V**:

(i) Complications of Altruistic Surrogacy Pregnancy and post-partum Delivery; and

(ii) Complications of oocyte retrieval:

a) Appropriate Authority means the appropriate authority appointed under Section 35 of the Surrogacy (Regulation) Act 2021.

b) Altruistic Surrogacy means the surrogacy in which no charges, expenses, fees, remuneration or monetary incentive of whatever nature, except the medical expenses and such other prescribed expenses incurred on surrogate mother and the insurance coverage for the surrogate mother, are given to the surrogate mother or her dependents or her representative;

c) Assisted Reproductive Technology Bank means an organisation which shall be responsible for collection of gametes, storage of gametes and embryos and supply of gametes to the assisted reproductive technology clinics or their patients;

d) Assisted Reproductive Technology Clinic means any premises equipped with requisite facilities and medical practitioners registered with the National Medical Commission for carrying out the procedures related to the assisted reproductive technology;

e) Commissioning Couple means an infertile married couple who approach an assisted reproductive technology clinic or assisted reproductive technology bank for obtaining the services authorised of the said clinic or bank;

f) Gestational Surrogacy means a practice whereby a surrogate mother carries a child for the intending couple through implantation of embryo in her womb and the child is not genetically related to the surrogate mother;

g) Gynaecologist means either a medical post-graduate in Gynaecology and obstetrics and should have record of performing 50 ovum pickup procedures and at least three years of working experience in an ART clinic under supervision of a trained ART specialist or a medical post-graduate in gynaecology and obstetrics with super specialist Doctorate of Medicine / Fellowship in reproductive medicine with experience not less than three years of working in an Assisted Reproductive Technology clinic;

h) Implantation means the attachment and subsequent penetration by the zona-free blastocyst, which starts five to seven days following fertilization;

i) Intending Couple means a couple who have a medical indication necessitating gestational surrogacy and who intend to become parents through surrogacy;

j) Intending Woman means an Indian woman who is a widow or divorcee between the age of 35 to 45 years and who intends to avail the surrogacy;

k) Oocyte means naturally ovulating oocyte in the female genetic tract;

l) Oocyte Donor: Is a woman who donates her eggs to another woman, who might not be able to conceive by herself naturally.

m) Oocyte Retrieval: Is a procedure in order to remove Oocytes from the ovary of a woman, to enable fertilization.

n) Surrogacy means a practice whereby one woman bears and give birth to a child for an intending couple with the intention of handing over such child to the intending couple after the birth;

o) Surrogacy Clinic means surrogacy clinic, centre or laboratory, conducting assisted reproductive technology services, in-vitro fertilisation services, genetic counselling centre, genetic laboratory, Assisted Reproductive Technology Banks conducting surrogacy procedure or any clinical establishment, by whatsoever name called, conducting surrogacy procedures in any form;

p) Surrogacy Procedures means all gynaecological, obstetrical or medical procedures, techniques, tests, practices or services involving handling of human gametes and human embryo in surrogacy;

q) Surrogate Mother means a woman who agrees to bear a child (who is genetically related to the intending couple or intending woman) through surrogacy from the implantation of embryo in her womb and fulfils the conditions as provided in sub-clause (b) of clause (iii) of section 4 of the Surrogacy (Regulation) Act 2021;

Section C. BENEFITS COVERED UNDER THE POLICY

Section I: Basic Covers:

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

Benefits under this Section C.I are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and / or the sub-limit and / or Co-payment as may be applicable for each Benefit under Section 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, Injury or conditions described in the Benefits below if it is contracted or sustained by an Insured Person during the Policy Period.

All claims must be made in accordance with the procedure set out in Section F.1. Claims paid under this Section will impact the Sum Insured and eligibility for Cumulative Bonus.

(1) In-patient Hospitalization:

What is covered

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

(i) Reasonable and Customary Charges for Room Rent for accommodation in Hospital room and other boarding charges up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy;

(ii) ICU Charges;

(iii) Operation theatre expenses;

(iv) Medical Practitioner's fees, including fees of surgeon, consultants, physicians, specialists and anaesthetists treating the Insured Person;

(v) Qualified Nurses charges;

(vi) Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;

(vii) Investigative tests or diagnostic procedures directly related to the Injury / Illness for which the Insured Person is Hospitalized;

(viii) Anaesthesia, blood, oxygen and blood transfusion charges; Cost of Pacemaker, Diagnostic materials and X rays, Dialysis, Chemotherapy, radiotherapy;

(ix) Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Conditions:

(i) The Hospitalization of the Insured Person is medically necessary and follows the written advice of a Medical Practitioner.

(ii) If the Insured Person is admitted in a room category / limit that is higher than the one that is specified in the Policy Schedule / Product Benefit Table of this Policy, then the Insured Person shall bear a rateable proportion of the Room Rent (and the total Associated Medical Expenses, including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category to the Room Rent actually incurred.

- For the purpose of this Benefit "Associated Medical Expenses" shall include the applicable nursing charges, operation theatre charges, fees of Medical Practitioner including surgeon / anaesthetist / specialist within the same Hospital where the Insured Person has been admitted.
  "Associated Medical Expenses" does not include cost of pharmacy and consumables, cost of implants and medical devices and cost of diagnostics.
- Proportionate deductions are not applicable for ICU charges.
- Such proportionate deductions, if any, will not be applied in respect of the Hospitals which do not follow differential billing, or for those Associated Medical Expenses in respect of which differential billing is not adopted based on the room category.

Sub-limits

For Platinum - Essential Plan, treatment-wise sub-limits will apply as below, these limits are applicable per Policy Year.

Sr.No	Disease Category	Zone I	Zone II	Zone III
1.	Cataract (including cost of lens) per eye	Rs 40,000	Rs 30,000	Rs 20,000
2.	Angioplasty (including cost of stent)	Rs 3,00,000	Rs 2,50,000	Rs 2,00,000
3.	Knee replacement (including revision Surgery)	Rs 3,00,000	Rs 2,50,000	Rs 2,00,000
4.	Hip replacement (including revision Surgery)	Rs 3,00,000	Rs 2,50,000	Rs 2,00,000
5.	Cholecystectomy (open or lap)	Rs 60,000	Rs 45,000	Rs 35,000
6.	Lap / open / vaginal hysterectomy (with / without Salpigo-oophorectomy)	Rs 60,000	Rs 45,000	Rs 35,000

(2) Pre – hospitalization Medical Expenses:

What is covered

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

Conditions

(i) We have accepted a claim for In-patient Hospitalization under Section C.I.(1) or Day Care Treatment under Section C.I.(4) or Domiciliary Hospitalization under Section C.I.(5) or Ayush Treatment under Section C.I.(10) for the same Illness / Injury;

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

(3) Post – hospitalisation Medical Expenses:

What is covered

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

Conditions

(i) We have accepted a claim for In-patient Hospitalization under Section C.I.(1) or Day Care Treatment under Section C.I.(4) or Domiciliary Hospitalization under Section C.I.(5) or Ayush Treatment under Section C.I.(10) for the same Illness / Injury;

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

(4) Day Care Treatment:

What is covered

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

Conditions

(i) The Day Care Treatment is Medically Necessary Treatment and follows the written advice of a Medical Practitioner;

(ii) The Medical Expenses are incurred, including for any procedure which requires a period of specialized observation or care after completion of the procedure undertaken by an Insured Person as Day Care Treatment.

What is not covered

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

(**5**) **Domiciliary Hospitalisation**:

What is covered

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

Conditions

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

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

(iii) If a claim is accepted under this Benefit, then We shall pay Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses under Section C.I.(2) and Section C.I.(3) respectively for the same Illness /Injury.

What is not covered

We shall not be liable to pay for any claim made under this Benefit in connection with:

(i) Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;

(ii) Arthritis, gout and rheumatism;

(iii) Chronic nephritis and nephritic syndrome;

(iv) Diarrhea and all type of dysenteries, including gastroenteritis;

(v) Diabetes mellitus and insipidus;

(vi) Epilepsy;
(vii) Hypertension;
(viii) Psychiatric or psychosomatic disorders of all kinds;
(ix) Pyrexia of unknown origin.

(6) Road Ambulance Cover:

What is covered

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

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

(i) It is medically necessary to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital.
(ii) It is medically necessary to transfer the Insured Person to another Hospital during the course of Hospitalization due to lack of super speciality treatment in the existing Hospital.

Conditions

(i) The Ambulance / healthcare service provider is duly registered;
(ii) We have accepted a claim for In-patient Hospitalization under Section C.I.(1) above for the same Illness / Injury;

What is not covered

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

(7) Organ Donor Expenses:

What is covered

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

Conditions

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

What is not covered

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

(8) Reload of Sum Insured:

What is covered

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

Conditions

(i) A claim shall be admissible under this Benefit only if the claim is admissible under In-patient Hospitalization under Section C.I.(1) or Day Care Treatment under Section C.I.(4).

(ii) The reload of Sum Insured shall not apply to the first claim in the Policy Year.

(iii) The reload of Sum Insured shall be available only for subsequent claims and not in relation to any Illness / Injury (including its complications) for which a claim has been admitted for the Insured Person during that Policy Year.

(iv) The reload of Sum Insured shall be available only for Section C.I.(1) Inpatient Hospitalisation and Section C.I.(4) Day care treatment.

(v) The reloaded Sum Insured shall not be considered while calculating the Cumulative Bonus.

(vi) In case of an Individual Policy, reload of the Sum Insured is available to each Insured Person and can be utilised by Insured Persons who are covered under the Policy.

(vii) In case of a Family Floater Policy, the reload of Sum Insured shall be available on a floater basis for all Insured Persons in the family that are covered under the Policy.

(viii) If the reload of Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

(9) Super Reload:

What is covered

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

Conditions

(i) A claim shall be admissible under this Benefit only if the claim is admissible under In-patient Hospitalization under Section C.I.(1) or Day Care Treatment under Section C.I.(4) or Section C.I.(10) (AYUSH Cover) or Section C.I.(5) (Domiciliary Hospitalization) or Section C.I.(14) (Modern Treatment Methods and Advancement in Technologies) or Section C.I.(7) (Organ Donor Expenses) or Section C.I.(13) (Home Treatment) arising in that Policy Year for any or all Insured Person(s).

(ii) The Super Reload of Sum Insured shall apply to the first claim in the Policy Year.

(iii) The Super Reload of Sum Insured shall be available for all subsequent claims also and to any Illness / Injury (including its complications) for which a claim has been admitted for the Insured Person during that Policy Year.

(iv) Our total, maximum liability under a single claim under this Benefit shall not be more than the base Sum Insured.

(v) The Super Reloaded Sum Insured shall not be considered while calculating the Cumulative Bonus.

(vi) In case of an Individual Policy, Super Reload of the Sum Insured is available to each Insured Person and can be utilised by Insured Persons who are covered under the Policy.

(vii) In case of a Family Floater Policy, the Super Reload of Sum Insured shall be available on a floater basis for all Insured Persons in the family that are covered under the Policy.

(viii) If the Super Reload of Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

(10) Ayush Cover:

What is covered

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

Conditions

(i) Treatment taken is within India; and

(ii) Exclusion mentioned in Section D.II.27 does not apply to this Benefit

(11) Mental Illness Hospitalization:

What is covered

We shall cover the Medical Expenses incurred by the Insured Person upto the limit specified in the Policy Schedule / Product Benefit Table of this Policy, towards Hospitalization of the Insured Person under Section C.I.(1) (In- patient Hospitalization) specifically for any Mental Illnesses.

Pre-hospitalization Medical Expenses incurred, immediately preceding the Insured Person's admission to the Hospital and Post-hospitalization Medical Expenses incurred immediately following the Insured Person's discharge, within the Policy Period will also be indemnified under this Benefit in accordance with as per Section C.I.(2) (Pre-hospitalization Medical Expenses) and Section C.I.(3) (Post-hospitalization Medical Expenses) respectively.

What is not covered:

(i) Any condition which is not clinically significant or is related to anxiety, bereavement, relationship or academic problems, acculturation difficulties or work pressure.

(ii) Treatment related to intentional self-inflicted Injury or attempted suicide by any means.

(12) Obesity Treatment:

What is Covered

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

(i) The Insured Person undergoing the Surgery is of minimum Age of 18 years.

(ii) Surgery to be conducted is upon the advice of the Medical Practitioner / Bariatric Surgeon

(iii) The Surgery / Surgical Procedure conducted should be supported by clinical protocols.

(iv) The Medical Practitioner / Bariatric Surgeon confirms in writing that the Insured Person's Body Mass Index (BMI) is;

  I. greater than or equal to 40 or

  II. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

    i. Obesity-related cardiomyopathy

    ii. Coronary heart disease

    iii. Severe sleep apnea

    iv. uncontrolled type2 diabetes

Conditions

(i) A claim under this Benefit is acceptable only if it is towards any of the below procedures:

  a. Gastric Bypass- The Roux-en-Y Gastric Bypass, Biliopancreatic Diversion with or without Duodenal Switch (BPD / DS) Gastric Bypass

  b. Sleeve Gastrectomy

  c. Laparoscopic Gastric Banding

(ii) Written confirmation from Medical Practitioner / Bariatric Surgeon is provided to Us that the Bariatric Surgery is not for a specific correctable cause for treating obesity. Example: Endocrine disorder.

(iii) A prior approval should be taken from Us before the Bariatric Surgery is performed.

What is not Covered

(i) Bariatric Surgery for cosmetic / aesthetic reasons.

(ii) For treating drug-Induced obesity, for Severe Untreated Hormonal Imbalance, Psychiatric and Eating Disorders-Induced obesity.

(13) Home Treatment:

What is covered

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

Conditions

(i) Requisite pre-authorisation is obtained from Us for the said Illness / Injury.

(ii) OPD Treatment is not covered under this Benefit.

(iii) The same Illness is payable as per the conditions specified in Section C.I.(1).

(iv) Insured Person may avail a treatment in a network Hospital under Section C.I.(1) in case that Pre-Authorisation is not received by the Insured Person(s) from Us, as per the terms and conditions of Section C.I.(1).

(v) The amount, frequency and time period of the home treatment services should be reasonable and supported in agreement by the treating Medical Practitioner and the Insured Person availing the service.

(vi) The maximum number of days, of covered services per Insured Person, for each Policy Year, covered under this Benefit shall not exceed 15 days.

(vii) The condition of the Insured Person must be expected to improve in a reasonable and generally predictable period of time.

(viii) Treatment under this Benefit will be provided under the supervision of a Medical Practitioner to safely and effectively administer the home treatment plan, in accordance with the condition of the Insured Person.

(ix) We do not assume any liability towards, and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner and / or Network Provider / Empanelled Service Provider or in any service under this Benefit or for any consequences of actions taken or not taken in reliance thereon.

(x) The exclusion no. 52 as specified in Annexure I – Non Medical Expenses are waived off to the extent of this Benefit(s) as specified in this Section C.I.(13).

(xi) We do not assume any liability towards any additional or incidental charges / expenses, including but not limited to any charges towards breakage, damage, deposit for equipment, and equipment transportation. All such charges / expenses shall be borne by the Insured Person.

(xii) The foregoing home treatment services are provided through Network Provider / Empanelled Service Provider in select cities for select treatment procedures only. Please contact Us or refer to Our website for updated list of treatment procedures and cities where home treatment service is provided.

(14) Modern Treatment Methods and Advancement in Technologies:

What is covered

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

(i) Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

(ii) Balloon Sinuplasty

(iii) Deep Brain stimulation

(iv) Oral chemotherapy

(v) Immunotherapy- Monoclonal Antibody to be given as injection

(vi) Intra vitreal injections

(vii) Robotic surgeries

(viii) Stereotactic radio surgeries

(ix) Bronchial Thermoplasty

(x) Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

(xi) IONM - (Intra Operative Neuro Monitoring)

(xii) Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

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

What is covered

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

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

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

Conditions

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

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

What is not covered

We will not provide services in the following instances:

(i) Travel undertaken specifically for securing medical treatment.

(ii) Injuries resulting from participation in acts of war or insurrection.

(iii) Commission of an unlawful act(s).

(iv) Attempt at suicide.

(v) Incidents involving the use of drugs unless prescribed by a Medical Practitioner.

(vi) Transfer of the Insured Person from one medical facility to another medical facility of similar capabilities which provides a similar level of care.

(vii) Pandemic / Epidemic

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

(i) Without medical authorization.

(ii) With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness which can be treated by local Medical Practitioner and do not prevent the Insured Person from continuing his / her trip or returning home.

(iii) With a pregnancy beyond the end of the 28th week and will not evacuate or repatriate a child born while the Insured Person was traveling beyond the 28th week.

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

What is covered

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

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

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

Conditions

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

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

What is not covered

We will not provide services in the following instances:

(i) Travel undertaken specifically for securing medical treatment.

(ii) Injuries resulting from participation in acts of war or insurrection.

(iii) Commission of an unlawful act(s).

(iv) Attempt at suicide.

(v) Incidents involving the use of drugs unless prescribed by a Medical Practitioner.

(vi) Transfer of the Insured Person from one medical facility to another medical facility of similar capabilities which provides a similar level of care.

(vii) Trips exceeding 90 days from residential address without prior notification to Us.

(viii) Pandemic / Epidemic

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

(i) Without medical authorization.

(ii) With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness which can be treated by local Medical Practitioner and do not prevent the Insured Person from continuing his / her trip or returning home.

(iii) With a pregnancy beyond the end of the 28th week and will not evacuate or repatriate a child born while the Insured Person was traveling beyond the 28th week.

(17) OPD Cover:

What is covered

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

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

Conditions

(i) This Benefit shall be available on an individual basis to each eligible Insured Person up to the limit specified in the Policy Schedule for both Individual and Family Floater Policies.

(ii) The limit for OPD Expenses for each Insured Person(s) covered under this Policy shall remain the same in case of a Family Floater Policy.

(18) Post-hospitalization Physiotherapy cover:

What is covered

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

Conditions

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

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

(19) Premium Waiver:

What is covered:

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

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

Conditions:

(i) This Benefit is available once in the lifetime in the Policy regardless of the number of years the Policy has served with Us.

(ii) This Benefit is applicable for all the Insured Person Aged 18 years and above

(iii) The symptoms of the Critical Illness first occur or manifest itself during the Policy Period and after completion of 90 days from the inception of the First Policy with Us.

(iv) For Platinum Premiere Plan, waiver of premium for 1 year shall be excluding the premium for International Coverage for Major Illnesses, Critical Illness Cover and Personal Accident Cover (AD, PTD)

(v) For Platinum Enhanced Plan, waiver of premium for 1 year shall be excluding the premium of Optional Covers – International Coverage for Major Illnesses, Critical Illness Cover and Personal Accident Cover (AD, PTD), if opted.

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

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

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

(21) Mandatory Co-payment

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

Conditions

i. For persons who have opted for a 'Waiver of Mandatory Co-payment' this Co-payment will not apply.

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

Section II: Additional Benefits

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

Benefits under this Section 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 Cumulative Bonus.

(22) Cumulative Bonus:

What is covered

We shall apply a Cumulative Bonus in the form of No Claim Bonus at such rates as specified in the Policy Schedule / Product Benefit Table of this Policy on the Sum Insured of the expiring Policy as specified for Section 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 Cumulative Bonus shall not exceed 100% of the Sum Insured on the Renewed Policy as specified in the Policy Schedule / Product Benefit Table of this Policy.

Conditions

(i) If the Policy is a Family Floater Policy, then Cumulative Bonus will accrue only if no claims have been made in respect of the Insured Person(s) in the expiring Policy Year. Cumulative Bonus which is accrued during the claim free Policy Year will only be available to those Insured Person(s) who were insured in such claim free Policy Year and continue to be Insured Person(s) in the subsequent Policy Year.

(ii) Cumulative Bonus shall not be accumulated in excess of the percentage applicable under the Plan in force for the Insured Person as stated in the Policy Schedule.

(iii) Cumulative Bonus will not be added if the Policy is not Renewed with Us by the end of the Grace Period.

(iv) If the Policy Period is two or three years, any Cumulative Bonus that has accrued for the first / second Policy Year will be credited at the end of the first / second Policy Year as the case may be and will be available for any claims made in the subsequent Policy Year.

(v) The accumulated Cumulative Bonus can be utilised for Benefits covered under Section C.I.(1) (In-patient Hospitalization),C.I.(2) (Pre-hospitalization Medical Expenses),C.I.(3) (Post-hospitalization Medical Expenses),C.I.(4) (Day Care Treatment),C.I.(5) (Domiciliary Hospitalization),C.I.(6) (Road Ambulance Cover)

(vi) The accumulated Cumulative Bonus can be utilised only when Sum Insured have been completely exhausted.

(vii) The Cumulative Bonus shall not enhance or be deemed to enhance any condition of this Policy or limits as prescribed in the Policy Schedule and Product Benefit Table of this Policy.

(viii) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater Policy basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest accrued amongst all the Insured Persons.

(ix) If the Insured Persons in the expiring Policy are covered on a Family Floater Policy basis and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater Policies / Individual Policies then the Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.

(x) If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be reduced in the same proportion to the Sum Insured.

(xi) If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.

(xii) The Cumulative Bonus is provisional and is subject to revision if a claim is made in respect of the expiring Policy Year, which is notified after the acceptance of Renewal premium. Such awarded Cumulative Bonus shall be withdrawn only in respect of the expiring year in which the claim was admitted.

(xiii) In case of Family Floater Policies, Dependent Children attaining Age 25 years at the time of Renewal will be moved out of the Family Floater Policy into an Individual Policy. However, all continuity benefits for such Insured Person on the Policy will remain intact. Cumulative Bonus earned on the Policy will stay with the Insured Person(s) covered under the original Policy.

(xiv) In the event of a claim impacting the eligibility of a Cumulative Bonus, the accumulated Cumulative Bonus shall be reduced by the percentage of Sum Insured as accumulated in the previous Policy Year and as mentioned in Policy Schedule / Product Benefit Table of this Policy.

(23) Dental Consultation & Investigations:

What is covered:

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

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

Conditions

(i) The services listed in this Benefit shall be arranged by Us only on a cashless basis at Our Network Providers and / or Empanelled Service Providers.

(ii) Requisite pre-authorisation shall be obtained from Us / Our Network Providers and / or Empanelled Service Provider for the services listed in this Benefit.

(iii) Appointments to avail the services listed in this Benefit, may be scheduled by calling at Our toll free call centre number specified in the Policy Schedule.

(iv) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider and / or Empanelled Service Providers in relation to the services availed under this Benefit.

(v) The foregoing services are provided through Network Provider / Empanelled Service Provider in select cities for select treatment procedures only. Please contact Us or refer to Our website for updated list of cities where these services are provided.

(vi) All three services listed under this section Dental Consultation and Investigation, shall be availed on a single appointment scheduled by Us.

(24) Health Check-up Program:

What is covered

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

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

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

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

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

Reference:

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

BMI - Body Mass Index,

CBC - Complete Blood Count,

ESR – Erythrocyte Sedimentation Rate,

ECG – Electrocardiogram,

TMT - Treadmill Test,

SGPT - Serum Glutamic Pyruvic Transaminase,

SGOT - Serum Glutamic Oxaloacetic Transaminase,

GGT - Gamma-Glutamyl Transferase,

LDL – Low Density Lipoprotein,

HDL – High Density Lipoprotein,

VLDL – Very Low Density Lipoprotein,

Hba1c - Glycated 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 (such as Diagnostic centres);

(ii) The Network Provider / Empanelled Service Provider shall be assigned by us post receiving customer's request to avail this Benefit;

(iii) The Insured Person will be eligible to avail a health check-up every Policy Year.

(iv) For calculation of Healthy Heart Score™, tests under Health Assessment™ namely - MER (including BP, BMI, HWR and smoking status), Blood Sugar, Total Cholesterol will have to be carried out at one go (together) and at least once every Policy Year.

(v) Apart from the tests under Health Assessment™ mentioned under point iv) Insured Persons shall be entitled to avail the tests under the Health Check-up Program in one instance or at separate times during the Policy Year provided that the same test cannot be repeated during the same Policy Year.

(vi) If the Insured Person who has a covered chronic condition, has already undergone tests under Chronic Management Program within three months from date of availing this Benefit, then those specific tests shall not be permitted to be repeated under the Health Check-up Program in the same Policy Year.

(vii) Section D.II.25, is not applicable in respect of coverage under this Benefit.

(viii) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider in relation to the health check-up.

(25) Second E-Opinion for Major Illness:

What is covered

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

(i) The Insured Person on diagnosis of Major Illness should share the following for the e-opinion:

a) First consultation paper

b) Final Diagnosis paper

c) Treating doctor certification on final diagnosis

d) All investigation reports supporting documents

e) Consent Form to collect documents from various source

f) Any other relevant documents to ascertain eligibility of claim

(ii) On the basis of the Insured Person's reported medical condition, We / Our Empanelled Service Provider will identify Medical Practitioners from Our network.

(iii) The Insured Person may choose one of the Medical Practitioners out of the 3 choices given by Us / Our Empanelled Service Provider.

(iv) Medical Reports and all other information pertaining to the Insured Person is shared with the chosen Medical Practitioner.

(v) After receipt of all Medical information, a detailed e- opinion from the selected Medical Practitioner would be delivered to the Insured Person as soon as it is available.

Conditions:

(i) It is agreed and understood that the Second E- Opinion will be based only on the information and documentation provided to Us, which will be shared with the Our empanelled Medical Practitioners and is subject to the conditions specified below:

(ii) It is agreed and understood that the Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained, it is the Insured Person's sole and absolute discretion to follow the suggestion for any advice related to his / her health.

(iii) Appointments to avail of this Additional Benefit may be availed through Our Website or Our mobile application or through calling Our call centre on the toll free number specified in the Policy Schedule.

(iv) Under this Additional Benefit, We are only providing the Insured Person with access to an e-opinion and such e-opinion shall not be deemed to substitute the Insured Person's physical visit or consultation to an independent Medical Practitioner.

(v) The e-opinion provided is not valid for any medico legal purposes.

(vi) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner / Our Empanelled Service Provider.

(vii) This benefit is available on Cashless Facility basis only.

(26) Recovery Benefit

What is covered

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

Conditions

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

Section III: Value Added Benefits

The Benefits listed below are in-built value added benefits and shall be available to all Insured Persons in accordance with the applicable Plan as specified in the Policy Schedule. Benefits under this Section 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 Cumulative Bonus.

(27) Chronic Management Program (OPD):

What is covered

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

(i) Medical Practitioner's consultations;

(ii) Diagnostic test;

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

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

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

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

(i) **Asthma** is a Chronic condition that affects the airways (bronchi) of the lungs, causing them to constrict (become narrow) when exposed to certain triggers which results in the symptoms of wheezing, coughing, tight chest and shortness of breath.

(ii) **Hypertension** is the term used to describe a persistent elevated blood pressure, commonly referred to as high blood pressure, and if this chronic disease is not treated appropriately, is a major risk factor for heart disease, stroke, kidney disease and even eye diseases.

(iii) **Hyperlipidaemia** is a chronic disease that refers to an elevated level of lipids (fats), including cholesterol and triglycerides, in the blood and if not treated appropriately, it is a major risk factor for increased risks of heart disease, heart attacks, strokes and other incidents of disease.

(iv) **Diabetes mellitus** is a chronic, progressive disease in which impaired insulin production leads to high blood glucose (sugar) levels, and without good self-management and proper treatment, the increased glucose (sugar) in the blood affects and damages every organ in the body, which causes serious health consequences

Eligibility to avail benefit under the Chronic Management Program

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

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

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

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

Chronic offering in case an Insured Person suffers from a combination of chronic conditions:
If the Insured Person is suffering from more than one of above Chronic conditions at the inception of the Policy, then the Insured Person will be charged as per applicable premium grid depending on the number of Chronic conditions such Insured Person is suffering from.

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

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

Conditions

(i) In order to avail Cashless Facilities benefits under this Program, the Insured Person is required to carry the health identification card issued by Us along with valid identity proof.

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

(iii) Commencement of Chronic Management Program, in case of any new Chronic condition covered under the Policy suffered by the Insured Person(s), shall be effective only at the subsequent Policy Anniversary, only if the Policy has been Renewed continuously with Us without any break.

(28) Health Assessment™:

What is covered

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

Conditions

(i) If the Insured Person who has undergone tests under Health Check-up Program / Comprehensive Health Check-up with Dental Investigation, then those specific tests shall not be permitted to be repeated under the Health AssessmentTM in the same Policy Year.

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

(29) HealthReturns™:

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

How to Earn HealthReturns™

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

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

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

(ii) Undergo a Health Assessment™

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

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

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

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

Conditions

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

Step 2 – Comply with Chronic Management program

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

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

(i) Active Dayz™ encourages and recognises all types of exercise / fitness activities by making use of activity tracking apps, devices and visits to the Fitness centre or yoga centres to track and record the activities members engage in.

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

(1) Completing a Fitness centre or yoga centre activity for a minimum of 30 minutes at Our panel of Fitness or yoga centre, OR;

(2) Recording 10,000 steps or more in a day for all Insured Persons Aged less than 60 years and 7,500 steps or more for all Insured Persons Aged 60 years above (tracked through Our mobile application or a wearable device linked to the Policy number) OR;

(3) Burning 300 calories or more in one exercise session per day OR;

(4) participation in a recognized marathon / walkathon / cyclothon or a similar activity which offers a completion certificate with timing

(iii) In order to make it easier for the Insured Person to earn HealthReturns™, We provide two fitness assessments per Policy Year. These fitness assessments will measure the Insured Person's cardiovascular endurance, flexibility, strength, height to weight ratio and Body fat percentage. The Insured Person will receive fitness assessment results based on his / her measurements.

(iv) The fitness assessment results will be valid for six months and the best of the fitness assessment result and number of Active Dayz™ will be used in a given month to calculate HealthReturns™.

'Active Dayz' can be earned by undertaking any one of the four activities under point (ii) or 'Fitness Assessment' under point (iii). The Insured Person shall earn HealthReturns™ based on the Healthy Heart Score™, the fitness assessment result and the number of Active Dayz™ recorded. HealthReturns™ is accrued on a monthly basis according to the following grid.

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

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

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

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

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

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

The sum total earning under this benefit shall not exceed:

a. In case of Platinum Essential Plan – 50 % of the premium excluding premium for optional benefit(s).
b. In case of Platinum Enhanced Plan – 100% of the premium excluding premium for optional benefit(s).
c. In case of Platinum Premiere Plan – 100% of the premium excluding premium for International Coverage for Major Illnesses, Personal Accident Cover (AD, PTD), Critical Illness Cover.

How it works for an Individual Policy

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

How it works for a Family Floater Policy

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

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

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

Earned HealthReturns™ can be utilized by any covered Insured person under a Policy.

How can one spend HealthReturns™:

Funds under HealthReturns™ may be utilized towards the following expenses:

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

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

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

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

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

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

(30) Expert Health Coach:

1) Health Coach:

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

2) Nutrition Coach:

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

3) Mental Health Coaching:

Insured Person(s), are eligible for activ mind assessment followed by support. We shall support the Insured Person(s) for the following

1. Guidance on knowing Your Mental Health status

The Insured Person will be guided to take an online mental health assessment tool.

The result of this assessment will be given on a scale of 'healthy' to 'extremely severe' risk for anxiety, depression and stress.

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

2. Guidance on Improving Your Mental Health (Available only for Platinum – Enhanced and Platinum Premiere plan)

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

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

3. Tele / online Support

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

4) Tele consultation with Homeopathy Doctor (Available only for Platinum Enhanced and Platinum Premiere plan)

Upon the Insured Person's request, We shall also provide access to a homeopathy Medical Practitioner(s) for consultation via tele-medicine, followed up with a prescription as may be applicable.

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

(i) These coaches shall be available over a telephonic discussion as a call back service / feasible mode of communication. The request for call back may be placed through Digital self-servicing mediums of mobile app / website.

(ii) It is agreed and understood that Our coaches are not providing and shall not be deemed to be providing any medical advice. They shall only provide a suggestion for the Insured Person's consideration and it is the Insured Person's sole and absolute choice to follow the suggestion for any health related advice.

(iii) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this Benefit.

(iv) Mental health coaching services will render general support for issues concerning stress, anxiety and depression. This will not include support for clinically established mental health conditions like bipolar disorder, schizophrenia, dementia, Alzheimer's disease and / or any other pre diagnosed condition. Our support includes grief / bereavement counselling, support on mental health issues arising from rape / gender based violence, HIV, parenting and inter personal relationships. We do not offer any medical or legal / financial advice, in any manner whatsoever.

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

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

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

(31) International Coverage for Major Illnesses:

Benefits under this Section C.IV.(31) are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and / or the sub-limit for each Benefit under Section is specified against that Benefit in the Policy Schedule / Product Benefit Table of this Policy. Payment of the Benefit shall be subject to the availability of the Sum Insured and the applicable sub-limit for that Benefit. Our maximum, total and cumulative liability in respect of an Insured Person for any and all claims arising under a Benefit during the Policy Period for that Insured Person shall not exceed the Sum Insured / sub-limit specified against the applicable Benefit in the Policy Schedule / Product Benefit Table. We will indemnify the Reasonable and Customary Charges incurred towards medical treatment taken by the Insured Person during the Policy Period for an Illness, Injury or conditions described in the Benefits below if it is contracted or sustained by an Insured Person during the Policy Period. This Policy covers only treatment which is planned and scheduled in advance and taken outside India and does not cover any Emergencies occurring or Emergency Care required while the Insured Person is overseas or in India.

All claims paid under this Section will impact the Sum Insured available under the Policy, and must be made in accordance with the procedure set out in Section F.1. Coverage under section (16) International Emergency Assistance Services (including Air Ambulance) is not applicable for this Section C.IV.(31)

(31). (a) In-patient Hospitalization (outside India):

What is covered

We will cover the Medical Expenses incurred towards the Insured Person for one or more of the following arising out of an Insured Person's Inpatient Care outside India during the Policy Period caused solely and directly due to a Major Illness that occurs or manifests itself during the Policy Period:

(i) Reasonable and Customary Charges incurred towards the Room Rent of a Hospital room and other boarding charges, up to the sub-limits as specified in the Policy Schedule / Product Benefit Table of this Policy;
(ii) ICU Charges;
(iii) Operation theatre expenses;
(iv) Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
(v) Qualified Nurses charges;
(vi) Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
(vii) Investigative tests or diagnostic procedures directly related to the Major Illness for which the Insured Person is Hospitalized;
(viii) Anaesthesia, blood, oxygen and blood transfusion charges;
(ix) Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.
(x) Medication applied as per the medical prescription issued by the treating Medical Practitioner while the Insured Person is Hospitalized for treatment of a Major Illness.
(xi) Medication prescribed for post-operative treatment is covered for up to 30 days from the date the Insured Person has completed the stage of the treatment received out of India and only when this medication is purchased prior to the Insured Person returning to India.

Conditions

(i) The Hospitalization is towards Medically Necessary Treatment, and follows the written advice of a Medical Practitioner.
(ii) For the purpose of this Benefit, the treatment should be taken in a registered Hospital or clinic as per law, rules and / or regulations applicable to the country where the treatment is taken, and which is a listed Network Provider / Empanelled Service Provider. For the list of Network Providers, You may please visit Our / Our Empanelled Service Provider's website or contact Us at Our call centre on the toll free number specified in the Policy Schedule.
(iii) Any payment shall be made only on a Cashless Facility basis.
(iv) Requisite pre-authorisation shall be obtained from Us / Our Empanelled Service Provider for the said Illness /Injury in accordance with the Claims Procedure set out in SectionF.1

(v) The symptoms of the Major Illness first occur or manifest itself during the Policy Period and after completion of the initial waiting period of 30 days, subject to applicability of any waiting periods specified in the Policy Schedule.

(vi) The rate of exchange as published by the Reserve Bank of India (RBI) as on the date of payment to the Hospital shall be used for conversion of amounts not settled in Indian rupee into Indian rupees for calculation of claim payments under this Benefit. If the RBI rates are not published on the date of the Insured Person's discharge from the Hospital, the exchange rate next published by the RBI shall be considered for conversion of any amounts not settled in Indian rupee.

(vii) The Medical Expenses are incurred outside India.

(viii) Exclusion no.D.II.48 is not applicable in respect of this Benefit.

(ix) Exclusion no.D.II.54 (Treatment taken outside India) is not applicable in respect of this Benefit.

(x) No Pre-hospitalization Medical Expenses are covered under this Benefit.

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

Sr.No	Major Illnesses	Definition
01.	Cancer Treatment	I. We will be covering Primary Treatment of a malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer including but not limited to leukemia, lymphoma and sarcoma (except cutaneous lymphoma). II. Any In-situ Cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues. III. Any pre-cancerous change in the cells that are cytologically or histologically classified as high grade dysplasia or severe dysplasia
02.	Coronary Artery By-Pass surgery	I. We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. II. The following are excluded: Angioplasty and / or any other intra-arterial procedures
03.	Heart Valve Replacement	I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. II. The following are excluded: Catheter based techniques including but not limited to, balloon valvotomy / valvuloplasty are excluded.
04.	Major Organ Transplantation	I. We will be covering the actual undergoing of a transplant of one of the following human organs: lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ. The undergoing of a transplant has to be confirmed by a specialist medical practitioner. II.The following are excluded: a) Any transplant when the need for a transplant arises as a consequence of alcoholic liver disease. b) Any transplant when the transplant is conducted as a self-transplant. c) Any transplant when the Insured is a donor for a third-party. d) Any transplants from a dead donor. e) Any organ transplant that involves Stem Cells treatment. f) Where only islets of langerhans are transplanted g) The transplant made possible by the purchase of donor organs. h) Any disease which has been caused by an organ transplant save where the disease in question is qualified as a major illnesses covered under the product.

05.	Bone Marrow Transplant	We will be covering Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured originating from: a. the Insured (Autologous bone marrow transplant); or b. from a living compatible donor (allogeneic bone marrow transplant).
06.	Neurosurgery	We will be covering any I. Surgical intervention of the brain or any other intracranial structures; II. Surgical Treatment of benign solid tumours located in the spinal cord.
07.	Pulmonary artery graft surgery	I. We will be covering the undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.
08.	Aorta Graft Surgery	I. We will be covering the actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches. II. The following are excluded: a. Surgery performed using only minimally invasive or intra-arterial techniques. b. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.
09.	Coronary Artery By-Pass surgery post occurrence of Myocardial Infraction	I. We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures, post the occurrence of myocardial infraction. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. II. The following are excluded: Angioplasty and / or any other intra-arterial procedures
10.	Surgical treatment for Stroke	I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced. II.We will be covering surgical treatment of Stroke limited to; a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy b. Stenting of Intra cranial blood vessels, needed for the treatment of Stroke III. The following are excluded: a. Transient ischemic attacks (TIA) b. Traumatic injury of the brain c. Vascular disease affecting only the eye or optic nerve or vestibularfunctions. I. We will be covering surgical treatment of Benign solid brain tumour limited to; a. Surgical Removal of solid brain tumour through Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy b. Embolization of Intra cranial blood vessels, needed for the treatment of solid brain Tumour

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

16.	Surgery for Pheochromocytoma	I. We will be covering the actual undergoing of surgery to remove the tumour II. Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines and the Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who is an endocrinologist.

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

What is covered

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

Conditions

(i) We have accepted a claim for In-patient Hospitalization under Section C.IV.(31).(a) for the same Major Illness;

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

(iii) Treatment taken inside India is not applicable.

(31). (c) Organ Donor Expenses:

What is covered

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

Conditions

(i) The organ donation conforms to the Transplantation of Human Organs Act 1994 as amended from time to time;

(ii) The Insured Person is the recipient of the organ so donated by the organ donor.

(iii) The Insured Person has been advised to undergo an organ transplant based on the Medical Advice of the treating Medical Practitioner;

What is not covered

(i) Pre-hospitalization Medical Expenses or Post-Hospitalization Medical Expenses of the organ donor.

(ii) Any costs incurred towards donor screening expenses.

(iii) Any other Medical Expenses or treatment incurred by the organ donor incidental to the harvesting from the organ donor.

(iv) Costs directly or indirectly associated with the acquisition of the donor's organ.

(v) Transplant of any organ / tissue where the transplant is experimental or investigational.

(vi) Expenses related to organ transportation or preservation.

(vii) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

(31). (d) Travel Expenses:

What is covered

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

(i) Transportation from the Insured Person's place of residence to the designated airport.

(ii) One-time economy class air fare by direct route to the city of treatment and onwards transportation to the designated place of accommodation in the city of treatment or the Hospital.

(iii) Transportation from the airport to the Hospital or place of accommodation in the city of treatment.

(iv) Transportation from the place of accommodation in the city of treatment or the Hospital to the nearest airport in the city of treatment.

(v) One-time economy class air fare by direct route to the city of the Insured Person's permanent address, and onwards transportation to his / her place of residence.

Conditions:

(i) We shall be liable to pay an amount only up to the costs of direct route economy class fare (business class, air ambulance or medical stretcher may be provided subject to availability in the international carrier, but only for the Insured Person under written advice of the attending Medical Practitioner due to the severity of his / her medical conditions) as available on the date of the journey;

(ii) The costs for the accompanying attendant's and / or living donor's airfare shall be indemnified by Us only if the treating Medical Practitioner has certified in writing that an accompanying attendant and / or living donor must accompany the Insured Person.

(iii) Treatment taken inside India is not applicable in respect of this Benefit.

(iv) Exclusion no.D.II.54 (Treatment taken outside India) is not applicable in respect of this Benefit.

(v) We / Our Empanelled Service Provider will provide an onward travel date based on the agreement reached with the treating Medical Practitioner and Hospital.

(vi) We / Our Empanelled Service Provider will arrange the onward travel subject to a ready to fly certificate from the attending Medical Practitioner in the Insured Person's Country of Residence.

(vii) We / Our Empanelled Service Provider will arrange the return travel based on the completion of the Medically Necessary Treatment and the agreement with the treating Medical Practitioner that the Insured Person is fit to travel.

(viii) In the event that the Insured Person changes the dates of travel from those booked and communicated by Us / Our Empanelled Service Provider, You will be liable to compensate Us for all the associated costs of organizing and providing new arrangements, unless the changes are proven to be necessary from a medical standpoint and Our prior approval is obtained in writing.

(ix) This Benefit is available on Cashless Facility basis only, unless a prior approval in writing has been taken from Us before making such travel booking.

Documents to be submitted for any Claim under this Benefit

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

(i) A certificate from the Medical Practitioner specifying the period of Hospitalization.

(ii) Discharge summary of the Hospital furnishing details including the date of admission and date of discharge.

(iii) Original bill and receipt from the carrier indicating the amount paid for the travel.

(iv) Payment receipt of any change in the travel booking with the documentation, if Cashless Facility for the same is not provided.

(v) Pre Authorization form and Claim form duly filed and signed by the Insured Person for Cashless Facility.

(31).(e) Accommodation Expenses:

What is covered

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

Conditions:

(i) We / Our Empanelled Service Provider will arrange the accommodation booking dates based on the approved treatment schedule. These dates will be communicated to the Insured Person to allow for sufficient time for the Insured Person to make all the necessary personal arrangements.

(ii) We / Our Empanelled Service Provider will arrange a checking-out date for the place of accommodation based on the completion of the treatment and the agreement with the treating Medical Practitioner that the Insured Person is fit to travel.

(iii) In the event that the Insured Person changes the dates of travel from those booked and communicated by Us / Our Empanelled Service Provider, You will be liable to compensate Us for all the associated costs of organizing and providing new accommodation arrangements, unless the changes are proven to be necessary from a medical standpoint and Our prior approval is obtained in writing.

(iv) The accommodation arrangements exclude any expenses towards breakfast, meals and incidental costs (not limited to minibar, laundry, personal expenses) at the place of accommodation, and any upgrades to the room.

(v) This Benefit is available on Cashless Facility basis only, unless a prior approval in writing has been taken from Us before making such accommodation booking.

Documents to be submitted for any Claim under this Benefit

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

(i) A certificate from the Medical Practitioner specifying the period of Hospitalization.

(ii) Discharge summary of the Hospital furnishing details including the date of admission and date of discharge.

(iii) Original bill and receipt or letter obtained from the hotel indicating the amount paid for the accommodation.

(iv) Payment receipt of extension of hotel booking with the documentation, if Cashless Facility for the same is not provided.

(v) Pre Authorization form and Claim form duly filed and signed by the Insured Person for Cashless Facility.

(31).(f) Repatriation of mortal remains:

What is covered

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

Conditions

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

Documents to be submitted for any Claim under this Benefit:

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

(i) Copy of the death certificate providing details of the place, date, time, and the circumstances and cause of death;

(ii) Copy of the post-mortem report / certificate;

(iii) Documentary proof for expenses incurred towards disposal of the mortal remains;

(iv) In case of transportation of the body of the deceased to the city of his / her permanent address in the Country of Residence, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the transportation of the mortal remains of the deceased.

(v) Copy of Embalming certificate.

(31).(g) International Second E-opinion for Major Illnesses:

What is covered

If an Insured Person is diagnosed with any listed Major Illnesses as specified under SectionC.IV.(31) during the Policy Period, the Insured Person may at his / her sole discretion choose to avail an e-opinion from Our panel of internationally available Medical Practitioners, provided that.

(i) The Insured Person on diagnosis of Major Illness should share the following for the e-opinion:
   - (a) First consultation paper
   - (b) Final Diagnosis paper
   - (c) Treating doctor certification on final diagnosis
   - (d) All investigation reports supporting documents
   - (e) Consent Form to collect documents from various source
   - (f) Any other relevant documents to ascertain eligibility of claim

(ii) On the basis of the Insured Person's reported medical condition, We / Our Empaneled Service Provider will identify Medical Practitioners from Our network.

(iii) The Insured Person may choose one of the Medical Practitioners out of the 3 choices given by Us / Our Empaneled Service Provider.

(iv) Medical reports and all other information pertaining to the Insured Person is shared with the chosen Medical Practitioner.

(v) After receipt of all medical information, a detailed e- opinion from the selected Medical Practitioner would be delivered to the Insured Person as soon as it is available.

Conditions:

It is agreed and understood that the Second E- Opinion will be based only on the information and documentation provided to Us, which will be shared with the Our empanelled Medical Practitioners and is subject to the conditions specified below:

(i) It is agreed and understood that the Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained, it is the Insured Person's sole and absolute discretion to follow the suggestion for any advice related to his / her health.

(ii) Appointments to avail of this Additional Benefit may be availed through Our Website or Our mobile application or through calling Our call centre on the toll free number specified in the Policy Schedule.

(iii) Under this Additional Benefit, We are only providing the Insured Person with access to an e-opinion and such e-opinion shall not be deemed to substitute the Insured Person's physical visit or consultation to an independent Medical Practitioner.

(iv) The e-opinion provided under this Additional Benefit shall be limited to the covered listed Major Illnesses under C.IV.(31).(a) and not be valid for any medico legal purposes.

(v) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner / Our Empanelled Service Provider.

(vi) This benefit is available on Cashless Facility basis only.

(31).(h) Visa Documentation Guidance:

What is covered

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

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

Conditions

(i) We do not assume any liability towards any loss or damage arising out of or in relation to any rejection of visa by the foreign country

(ii) We do not assume any liability towards any actual or alleged errors in the information provided by us, including any consequence of the Insured Person's actions taken or not taken in reliance thereon.

(iii) Under this Additional Benefit, We are only providing the Insured Person with information concerning visa documentation and this shall not be construed to be a provision of visa or facilitation of the visa process itself, on Our part.

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

Benefits under this Section (32) are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and / or the sub-limit for each Benefit under Section (32) is specified against that Benefit in the Policy Schedule / the Product Benefit Table. Payment of the Benefit shall be subject to the availability of the Sum Insured / applicable sub-limit for that Benefit.

All claims under Section must be made in accordance with the procedure set out in Section F.1.

1. Accidental Death Cover (AD):

What is covered

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

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

Condition

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

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

What is covered

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

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

Conditions

(i) For the purpose of this Benefit:

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

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

What is not covered

(iii) Loss caused directly or indirectly due to the following shall not be covered:

a. due to infections (except pyogenic infections which occur through an Accidental cut or wound) or any other kind of disease; or
b. any Surgical Procedure except as may be necessary solely as a result of the Injury.

(33) Critical Illness Cover:

What is covered

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

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

Conditions

(i) Our total, cumulative, maximum liability during the lifetime of the Insured Person is upto 100% of the Sum Insured.

(ii) Once a claim for a listed condition is admissible in respect of an Insured Person, no further Renewals shall be allowed for that Insured Person under this Benefit.

Survival Period:

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

Section V: Optional Covers

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

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

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

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

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

(34) Personal Accident Cover (AD, PTD):

Benefits under this Section (34) are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and / or the sub-limit for each Benefit under Section (34) is specified against that Benefit in the Policy Schedule / the Product Benefit Table. Payment of the Benefit shall be subject to the availability of the Sum Insured / applicable sub-limit for that Benefit.

All claims under Section must be made in accordance with the procedure set out in Section F.1.

1.Accidental Death Cover (AD):

What is covered

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

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

Condition

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

2. Permanent Total Disablement (PTD):

What is covered

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

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

Conditions

(i) For the purpose of this Benefit:

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

In this benefit, Loss means the physical separation of a body part, or the total loss of functional use of a body part or organ provided this has continued for at least 365 days from the onset of such disablement and provided further that We are satisfied based on a written confirmation by a Medical Practitioner at the expiry of the 365 days that there is no reasonable medical hope of improvement.

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

What is not covered

(i) Loss caused directly or indirectly due to the following shall not be covered:

a. due to infections (except pyogenic infections which occur through an Accidental cut or wound) or any other kind of disease; or

b. any Surgical Procedure except as may be necessary solely as a result of the Injury.

(35) Critical Illness Cover:

What is covered

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

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

Conditions

(i) Our total, cumulative, maximum liability during the lifetime of the Insured Person is upto 100% of the Sum Insured.

(ii) Once a claim for a listed condition is admissible in respect of an Insured Person, no further Renewals shall be allowed for that Insured Person under this Benefit.

Survival Period:

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

(36) International Coverage for Major Illnesses:

Benefits under this Section C.V.(36) are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and / or the sub-limit for each Benefit under Section is specified against that Benefit in the Policy Schedule / Product Benefit Table of this Policy. Payment of the Benefit shall be subject to the availability of the Sum Insured and the applicable sub-limit for that Benefit. Our maximum, total and cumulative liability in respect of an Insured Person for any and all claims arising under a Benefit during the Policy Period for that Insured Person shall not exceed the Sum Insured / sub-limit specified against the applicable Benefit in the Policy Schedule / Product Benefit Table.

We will indemnify the Reasonable and Customary Charges incurred towards medical treatment taken by the Insured Person during the Policy Period for an Illness, Injury or conditions described in the Benefits below if it is contracted or sustained by an Insured Person during the Policy Period. This Policy covers only treatment which is planned and scheduled in advance and taken outside India and does not cover any Emergencies occurring or Emergency Care required while the Insured Person is overseas or in India.
All claims paid under this Section will impact the Sum Insured available under the Policy, and must be made in accordance with the procedure set out in Section F.1. Coverage under section (16) International Emergency Assistance Services (including Air Ambulance) is not applicable for this Section. C.V.(36)

(36). (a) In-patient Hospitalization (outside India):

What is covered

We will cover the Medical Expenses incurred towards the Insured Person for one or more of the following arising out of an Insured Person's Inpatient Care outside India during the Policy Period caused solely and directly due to a Major Illness that occurs or manifests itself during the Policy Period:

(i) Reasonable and Customary Charges incurred towards the Room Rent of a Hospital room and other boarding charges, up to the sub-limits as specified in the Policy Schedule / Product Benefit Table of this Policy;
(ii) ICU Charges;
(iii) Operation theatre expenses;
(iv) Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
(v) Qualified Nurses charges;
(vi) Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
(vii) Investigative tests or diagnostic procedures directly related to the Major Illness for which the Insured Person is Hospitalized;
(viii) Anaesthesia, blood, oxygen and blood transfusion charges;
(ix) Surgical appliances and allowable prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.
(x) Medication applied as per the medical prescription issued by the treating Medical Practitioner while the Insured Person is Hospitalized for treatment of a Major Illness.
(xi) Medication prescribed for post-operative treatment is covered for up to 30 days from the date the Insured Person has completed the stage of the treatment received out of India and only when this medication is purchased prior to the Insured Person returning to India.

Conditions

(i) The Hospitalization is towards Medically Necessary Treatment, and follows the written advice of a Medical Practitioner.
(ii) For the purpose of this Benefit, the treatment should be taken in a registered Hospital or clinic as per law, rules and / or regulations applicable to the country where the treatment is taken, and which is a listed Network Provider / Empanelled Service Provider. For the list of Network Providers, You may please visit Our / Our Empanelled Service Provider's website or contact Us at Our call centre on the toll free number specified in the Policy Schedule.
(iii) Any payment shall be made only on a Cashless Facility basis.
(iv) Requisite pre-authorisation shall be obtained from Us / Our Empanelled Service Provider for the said Illness / Injury in accordance with the Claims Procedure set out in Section F.1.
(v) The symptoms of the Major Illness first occur or manifest itself during the Policy Period and after completion of the initial waiting period of 30 days, subject to applicability of any waiting periods specified in the Policy Schedule.
(vi) The rate of exchange as published by the Reserve Bank of India (RBI) as on the date of payment to the Hospital shall be used for conversion of amounts not settled in Indian rupee into Indian rupees for calculation of claim payments under this Benefit. If the RBI rates are not published on the date of the Insured Person's discharge from the Hospital, the exchange rate next published by the RBI shall be considered for conversion of any amounts not settled in Indian rupee.
(vii) The Medical Expenses are incurred outside India.
(viii) Exclusion no. D.II .48 is not applicable in respect of this Benefit.
(ix) Exclusion no. D.II.54 (Treatment taken outside India) is not applicable in respect of this Benefit.
(x) No Pre-hospitalization Medical Expenses are covered under this Benefit.

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

Sl no	Major Illnesses	Definition
01.	Cancer Treatment	I. We will be covering Primary Treatment of a malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer including but not limited to leukemia, lymphoma and sarcoma (except cutaneous lymphoma). II. Any In-situ Cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues. III. Any pre-cancerous change in the cells that are cytologically or histologically classified as high grade dysplasia or severe dysplasia
02.	Coronary Artery By-Pass surgery	I. We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. II. The following are excluded: Angioplasty and / or any other intra-arterial procedures
03.	Heart Valve Replacement	I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. II. The following are excluded: Catheter based techniques including but not limited to, balloon valvotomy / valvuloplasty are excluded.
04.	Major Organ Transplantation	I. We will be covering the actual undergoing of a transplant of one of the following human organs: lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ. The undergoing of a transplant has to be confirmed by a specialist medical practitioner. II.The following are excluded: a) Any transplant when the need for a transplant arises as a consequence of alcoholic liver disease. b) Any transplant when the transplant is conducted as a self-transplant. c) Any transplant when the Insured is a donor for a third-party. d) Any transplants from a dead donor. e) Any organ transplant that involves Stem Cells treatment. f) Where only islets of langerhans are transplanted g) The transplant made possible by the purchase of donor organs. h) Any disease which has been caused by an organ transplant save where the disease in question is qualified as a major illnesses covered under the product.
05.	Bone Marrow Transplant	We will be covering Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured originating from: a. the Insured (Autologous bone marrow transplant); or b. from a living compatible donor (allogeneic bone marrow transplant).

06.	Neurosurgery	We will be covering any I. Surgical intervention of the brain or any other intracranial structures; II. Surgical Treatment of benign solid tumours located in the spinal cord.
07.	Pulmonary artery graft surgery	I. We will be covering the undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.
08.	Aorta Graft Surgery	I. We will be covering the actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches. II. The following are excluded: a. Surgery performed using only minimally invasive or intra-arterial techniques. b. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.
09.	Coronary Artery By-Pass surgery post occurrence of Myocardial Infraction	I. We will be covering the actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures, post the occurrence of myocardial infraction. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. II. The following are excluded: Angioplasty and / or any other intra-arterial procedures
10.	Surgical treatment for Stroke	I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced. II.We will be covering surgical treatment of Stroke limited to; a. Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy b. Stenting of Intra cranial blood vessels, needed for the treatment of Stroke III. The following are excluded: a. Transient ischemic attacks (TIA) b. Traumatic injury of the brain c. Vascular disease affecting only the eye or optic nerve or vestibular functions.
11.	Surgical treatment for benign Brain tumour	I. We will be covering surgical treatment of Benign solid brain tumour limited to; a. Surgical Removal of solid brain tumour through Intra cranial surgery by the route of Burr Hole Procedure or Craniotomy b. Embolization of Intra cranial blood vessels, needed for the treatment of solid brain Tumour II. Benign solid brain tumour is defined as a life threatening, non-cancerous tumour in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI.

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

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

What is covered

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

Conditions

(i) We have accepted a claim for In-patient Hospitalization under SectionC.V.(36).(a) for the same Major Illness;

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

(iii) Treatment taken inside India is not applicable.

(36). (c) Organ Donor Expenses:

What is covered

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

Conditions

(i) The organ donation conforms to the Transplantation of Human Organs Act 1994 as amended from time to time;

(ii) The Insured Person is the recipient of the organ so donated by the organ donor.

(iii) The Insured Person has been advised to undergo an organ transplant based on the Medical Advice of the treating Medical Practitioner;

What is not covered

(i) Pre-hospitalization Medical Expenses or Post-Hospitalization Medical Expenses of the organ donor.

(ii) Any costs incurred towards donor screening expenses.

(iii) Any other Medical Expenses or treatment incurred by the organ donor incidental to the harvesting from the organ donor.

(iv) Costs directly or indirectly associated with the acquisition of the donor's organ.

(v) Transplant of any organ / tissue where the transplant is experimental or investigational.

(vi) Expenses related to organ transportation or preservation.

(vii) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

(36). (d) Travel Expenses:

What is covered

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

(i) Transportation from the Insured Person's place of residence to the designated airport.

(ii) One-time economy class air fare by direct route to the city of treatment and onwards transportation to the designated place of accommodation in the city of treatment or the Hospital.

(iii) Transportation from the airport to the Hospital or place of accommodation in the city of treatment.

(iv) Transportation from the place of accommodation in the city of treatment or the Hospital to the nearest airport in the city of treatment.

(v) One-time economy class air fare by direct route to the city of the Insured Person's permanent address, and onwards transportation to his / her place of residence.

Conditions:

(i) We shall be liable to pay an amount only up to the costs of direct route economy class fare (business class, air ambulance or medical stretcher may be provided subject to availability in the international carrier, but only for the Insured Person under written advice of the attending Medical Practitioner due to the severity of his / her medical conditions) as available on the date of the journey;

(ii) The costs for the accompanying attendant's and / or living donor's airfare shall be indemnified by Us only if the /or living donor must accompany the Insured Person.

(iii) Treatment taken inside India is not applicable in respect of this Benefit.

(iv) Exclusion no.D.II.54 (Treatment taken outside India) is not applicable in respect of this Benefit.

(v) We / Our Empanelled Service Provider will provide an onward travel date based on the agreement reached with the treating Medical Practitioner and Hospital.

(vi) We / Our Empanelled Service Provider will arrange the onward travel subject to a ready to fly certificate from the attending Medical Practitioner in the Insured Person's Country of Residence.

(vii) We / Our Empanelled Service Provider will arrange the return travel based on the completion of the Medically Necessary Treatment and the agreement with the treating Medical Practitioner that the Insured Person is fit to travel.

(viii) In the event that the Insured Person changes the dates of travel from those booked and communicated by Us / Our Empanelled Service Provider, You will be liable to compensate Us for all the associated costs of organizing and providing new arrangements, unless the changes are proven to be necessary from a medical standpoint and Our prior approval is obtained in writing.

(ix) This Benefit is available on Cashless Facility basis only, unless a prior approval in writing has been taken from Us before making such travel booking.

Documents to be submitted for any Claim under this Benefit

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

(i) A certificate from the Medical Practitioner specifying the period of Hospitalization.

(ii) Discharge summary of the Hospital furnishing details including the date of admission and date of discharge.

(iii) Original bill and receipt from the carrier indicating the amount paid for the travel.

(iv) Payment receipt of any change in the travel booking with the documentation, if Cashless Facility for the same is not provided.

(v) Pre Authorization form and Claim form duly filed and signed by the Insured Person for Cashless Facility.

(36).(e) Accommodation Expenses:

What is covered

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

Conditions:

(i) We / Our Empanelled Service Provider will arrange the accommodation booking dates based on the approved treatment schedule. These dates will be communicated to the Insured Person to allow for sufficient time for the Insured Person to make all the necessary personal arrangements.

(ii) We / Our Empanelled Service Provider will arrange a checking-out date for the place of accommodation based on the completion of the treatment and the agreement with the treating Medical Practitioner that the Insured Person is fit to travel.

(iii) In the event that the Insured Person changes the dates of travel from those booked and communicated by Us / Our Empanelled Service Provider, You will be liable to compensate Us for all the associated costs of organizing and providing new accommodation arrangements, unless the changes are proven to be necessary from a medical standpoint and Our prior approval is obtained in writing.

(iv) The accommodation arrangements will include bookings for a double room or twin bed room in a three or four-star hotel or accommodation category. (The choice of accommodation will always be subject to availability and the proximity to the Hospital or treating Medical Practitioner.)

(v) The accommodation arrangements exclude any expenses towards breakfast, meals and incidental costs (not limited to minibar, laundry, personal expenses) at the place of accommodation, and any upgrades to the room.

(vi) This Benefit is available on Cashless Facility basis only, unless a prior approval in writing has been taken from Us before making such accommodation booking.

Documents to be submitted for any Claim under this Benefit

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

(i) A certificate from the Medical Practitioner specifying the period of Hospitalization.

(ii) Discharge summary of the Hospital furnishing details including the date of admission and date of discharge.

(iii) Original bill and receipt or letter obtained from the hotel indicating the amount paid for the accommodation.

(iv) Payment receipt of extension of hotel booking with the documentation, if Cashless Facility for the same is not provided.

(v) Pre Authorization form and Claim form duly filed and signed by the Insured Person for Cashless Facility.

(36).(f) Repatriation of mortal remains:

What is covered

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

Conditions

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

Documents to be submitted for any Claim under this Benefit:

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

(i) Copy of the death certificate providing details of the place, date, time, and the circumstances and cause of death;

(ii) Copy of the post-mortem report / certificate;

(iii) Documentary proof for expenses incurred towards disposal of the mortal remains;

(iv) In case of transportation of the body of the deceased to the city of his / her permanent address in the Country of Residence, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the transportation of the mortal remains of the deceased.

(v) Copy of Embalming certificate.

(36).(g) International Second E-opinion for Major Illness:

What is covered

If an Insured Person is diagnosed with any listed Major Illnesses as specified under Section C. V.(36) during the Policy Period, the Insured Person may at his / her sole discretion choose to avail an e-opinion from Our panel of internationally available Medical Practitioners, provided that.

(i) The Insured Person on diagnosis of Major Illness should share the following for the e-opinion:
   - (a) First consultation paper
   - (b) Final Diagnosis paper
   - (c) Treating doctor certification on final diagnosis
   - (d) All investigation reports supporting documents
   - (e) Consent Form to collect documents from various source
   - (f) Any other relevant documents to ascertain eligibility of claim

(ii) On the basis of the Insured Person's reported medical condition, We / Our Empaneled Service Provider will identify Medical Practitioners from Our network.

(iii) The Insured Person may choose one of the Medical Practitioners out of the 3 choices given by Us / Our Empaneled Service Provider.

(iv) Medical reports and all other information pertaining to the Insured Person is shared with the chosen Medical Practitioner.

(v) After receipt of all medical information, a detailed e- opinion from the selected Medical Practitioner would be delivered to the Insured Person as soon as it is available.

Conditions:

It is agreed and understood that the Second E- Opinion will be based only on the information and documentation provided to Us, which will be shared with the Our empanelled Medical Practitioners and is subject to the conditions specified below:

(i) It is agreed and understood that the Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained, it is the Insured Person's sole and absolute discretion to follow the suggestion for any advice related to his / her health.

(ii) Appointments to avail of this Additional Benefit may be availed through Our Website or Our mobile application or through calling Our call centre on the toll free number specified in the Policy Schedule.

(iii) Under this Additional Benefit, We are only providing the Insured Person with access to an e-opinion and such e-opinion shall not be deemed to substitute the Insured Person's physical visit or consultation to an independent Medical Practitioner.

(iv) The e-opinion provided under this Additional Benefit shall be limited to the covered listed Major Illnesses under C.V.(36).(a) and not be valid for any medico legal purposes.

(v) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner / Our Empanelled Service Provider.

(vi) This benefit is available on Cashless Facility basis only.

(36).(h) Visa Documentation Guidance:

What is covered

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

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

Conditions

(i) We do not assume any liability towards any loss or damage arising out of or in relation to any rejection of visa by the foreign country

(ii) We do not assume any liability towards any actual or alleged errors in the information provided by us, including any consequence of the Insured Person's actions taken or not taken in reliance thereon.

(iii) Under this Additional Benefit, We are only providing the Insured Person with information concerning visa documentation and this shall not be construed to be a provision of visa or facilitation of the visa process itself, on Our part.

(37) Preferred Provider Network (PPN) Discount:

What is covered

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

Conditions

(i) If the Insured Person takes In-patient Hospitalization Treatment as applicable under section C.I.(1) in a Hospital other than those listed as "Preferred Provider Network", then the Policyholder / Insured Person shall bear a Co-Payment of 10% on each and every claim arising in such regard, which will be in addition to any other Co-Payment applicable under the Policy.

(ii) The updated list of Hospitals listed as "Preferred Provider Network" can be referred to on Our website.

(iii) PPN discount in Premier plan is not applicable for below benefits:

a. Personal Accident

b. Critical Illness

c. International Coverage for Major Illnesses"

(iv) PPN discount is not applicable on optional covers for below plans:

a. Platinum Enhanced

b. Gold Enhanced"

(v) Under Platinum Essential Plan, PPN discount Optional Cover is applicable on 'Waiver of Mandatory Co-payment' when opted. For other optional covers under this plan, PPN discount is not applicable.

(38) Waiver of Mandatory Co-payment

What is covered

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

(39) **Maternity Expenses**

i. Maternity Expenses:

What is covered

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

Coverage under this Benefit shall include:

(i) Medical Expenses for a delivery of a child (including caesarean section) or lawful medical termination of pregnancy

(ii) Pre or post natal Maternity Expenses;

(iii) Any claim under this benefit shall not impact the Opted Sum Insured or Cumulative Bonus.

Conditions

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

What is not covered

(i) Medical expenses for ectopic pregnancy. However, these expenses will be covered under In-patient Treatment under Section C.I.(1);.

(ii) Any Pre-hospitalization Medical Expenses or Post – hospitalization Medical Expenses under Section C.I.(2) and C.I.(3), above will not be covered under this Benefit,

(iii) Any Reloaded Sum Insured will not be available for coverage under this Benefit.

Note: Section D.I .18, is not applicable if this Benefit is in force.

ii. New Born Baby Expenses

What is covered

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

(i) This would include in-patient hospitalisation expenses incurred on the New Born Baby while the Insured Person is Hospitalised as an in-patient for delivery.

(ii) Charges incurred on the New Born Baby during and post birth up to 90 days from the date of delivery, within the limits of Maternity Expenses.

(iii) A New Born Baby beyond 90 days can be covered under the Policy by way of an endorsement or at the next Renewal whichever is earlier, on payment of requisite premium.

Conditions

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

iii. Vaccination Expenses

What is covered

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

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

i. Coverage will be subject to claims admitted under Maternity Expenses cover and will be up to the limits of Maternity Sum Insured.

ii. Vaccination expenses will be covered only if the Insured Person whose maternity claim has been accepted by Us continues to Renew the Policy with Us during the period. Reimbursement claims for vaccination expenses can be submitted quarterly in a Policy Year.

iii. Section D.II.31 is not applicable if this Benefit is in force.

iv. Benefits under this Section shall be available separately and on an individual basis to each eligible Insured Person up to the limits specified in the Policy Schedule for an Individual Policy and shall be available on a floater basis for all eligible Insured Persons up to the limits specified in the Policy Schedule for Family Floater Policies.

Note:

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

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

iv. Stem cell preservation

What is covered

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

Conditions

i. The harvesting and storage of the stem cells of the New Born Baby is carried out as a preventive measure against possible future Illnesses.

ii. The stem cells of the New Born Baby are preserved in an India based Stem Cell Bank only.

iii. The payment under this Benefit is subject to a valid claim being accepted by Us under Maternity Expenses under section C.V.(39).(i).

iv. The coverage under this Benefit will be over and above the Maternity Expenses limit and up to the limits specified in the Policy Schedule and Product Benefit Table.

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

(40) OPD Expenses

What is covered

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

We will cover the following expenses:

(i) Outpatient consultations by a general Medical Practitioner / specialist Medical Practitioner where for every consultation, We will cover up to a maximum of 10% of the limit specified in the Product Benefit Table and Policy Schedule for OPD Expenses.

(ii) Out-patient diagnostic tests and / or medicines purchased from a pharmacy as prescribed by a general Medical Practitioner / specialist Medical Practitioner in writing up to a maximum of 50% of the limit specified in the Product Benefit Table and Policy Schedule for OPD Expenses.

(iii) Outpatient diagnostic procedures in case of road traffic Accident as prescribed by a General Medical Practitioner / Specialist Medical Practitioner in writing to a maximum of Rs.10,000 over and above the OPD Limit as specified in the Product Benefit Table and Policy Schedule.

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

If in a Policy Year an Insured Person does not utilize the complete limit under OPD Expenses, then the unutilized amount will be carried forward to the subsequent Policy Year, if the Policy has been Renewed with Us continuously without any break and shall be available for utilization within 12 months of such carry forward only. However, such carry forward is not applicable for unutilized limit for Road Traffic Accident Diagnostic as specified in the Product Benefit Table and Policy Schedule

OPD Bonus on Unutilized OPD Expenses

We will add a OPD Bonus of 5% to the unutilized OPD Expenses at the end of the Policy Year, if OPD Expenses have not been utilized completely by the Insured Person in the expiring Policy Year, provided that:

(i) This OPD Bonus will apply even if claims under other Benefits have been made under the Policy;

(ii) This OPD Bonus will be calculated based on the unutilised OPD Expenses, irrespective of any change in the Sum Insured or OPD Expenses opted in.

(iii) This OPD Bonus on the unutilized OPD Expenses limit shall not apply in case the Policy is not renewed within the Grace Period.

(iv) This OPD Bonus is not applicable on unutilized limit for Road Traffic Accident Diagnostic

Unutilized OPD Expenses along with earned OPD Bonus shall be carried forward to the subsequent Policy Year, if the Policy has been Renewed with Us continuously without any break and shall be available for utilization within 12 months of such carry forward only. Unutilized OPD Expenses along with earned OPD Bonus shall not be carried forward, if the Policy has not been Renewed with Us continuously without any break.

Permanent exclusions and waiting periods do not apply in respect of this Benefit.

Conditions

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

(41) Hospital Cash Benefit

What is covered

We will pay the Hospital Cash Benefit specified in the Policy Schedule, for each continuous and completed period of 24 hours of Hospitalisation, during the Policy Period for treatment of an Illness or Injury.

This Benefit shall be payable for a maximum limit of 30 days in a Policy Year and 10 days for each claim.

Conditions

(i) A deductible of 24 hours shall apply under this Benefit, thus the benefits shall become payable only after the completion of the first 24

(ii) Benefits under this Section shall be available on an individual basis to each eligible Insured Person up to the limits specified in thePolicy Schedule irrespective of the type of Policy.

(iii) Claim under this Benefit shall be payable only if in-patient claim has been settled by Us under this Policy under Section C.I.(1).

42) (1) Complications of Altruistic Surrogacy Pregnancy and Post-partum Deliver

(42) (2) Complications of oocyte retrieval

a) What is covered

In-patient Hospitalisation Medical Expenses:

We shall cover the one or more of the following Medical Expenses, up to the Sum Insured, in respect of the Surrogate Mother or the Oocyte donor, as specified in the Policy Schedule towards:

1) Complications arising within a period of 36 months, which directly arise out of pregnancy during Surrogacy and post-partum delivery for the Surrogate Mother, following an Altruistic Surrogacy; or
2) Complications arising due to Oocyte retrieval with respect to the Oocyte donor:

The following Medical Expenses are covered:

i. Reasonable and Customary Charges for Room Rent for accommodation in Hospital room and other boarding charges up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy;
ii. ICU Charges;
iii. Operation theatre expenses;
iv. Medical Practitioner's fees, including fees of surgeon, consultants, physicians, specialists and anaesthetists treating the Insured Person;
v. Qualified Nurses charges;
vi. Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
vii. Investigative tests or diagnostic procedures directly related to the surrogacy or oocyte retrieval procedure and incurred in relation to such Surrogate Mother or the Oocyte donor only, as applicable;
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.

Provided further that,

i. The treatment is undergone in a registered Surrogacy Clinic or Assisted Reproductive Technology Clinic (as applicable), under the supervision of a registered Medical Practitioner as per the applicable law;
ii. The surrogacy / ART procedures and treatment are carried out in accordance with the Surrogacy (Regulation) Act 2021 and the Surrogacy (Regulation) Rules 2022, and the Assisted Reproductive Technology Act 2021 and Assisted Reproductive Technology (Regulation) Rules 2022, as may be applicable.
iii. Maximum liability of the Company under all such claims for the entire Policy Period, shall be Sum Insured opted and specified against this Benefit in the Policy Schedule.

b) What is not covered

1. Medical Expenses incurred towards

i. Delivery expenses (Normal Delivery or caesarean section) of the Surrogate Mother;
ii. New Born baby through Surrogacy to the Surrogate Mother;
iii. Complication of pregnancy to the Surrogate Mother, which is other than "Altruistic Surrogacy" and / or for the second Surrogacy of the Surrogate Mother and / or if the Surrogate Mother donates her own gametes;
iv. Miscarriage (including miscarriage due to accident) except in case of life threatening medical condition to the Surrogate Mother, during the policy period of the Surrogate Mother;
v. Complications arising due to Oocyte retrieval, if the Oocyte Donor is donating for second time;
vi. Treatment of any pre-existing conditions / disease of the Insured including its complications;
vii. Treatment taken on OPD basis;
viii. Pre and Post Hospitalisation of the Insured Person;
ix. Surrogacy related Consultations, Diagnostic or Pharmacy;
x. Surrogacy Treatment Procedure cost (Injection, tests, Ultra sound, Embryo transfer, Ovum pickup);
xi. Surrogacy consultations with fertility specialist and others;

2. **Complications of pregnancy resulting from**:
   i. The Surrogacy procedure conducted in a clinic which is not registered as per the provisions of The Surrogacy (Regulation) Act 2021;
   ii. Surrogacy which is for commercial purposes;
   iii. Surrogacy which is for producing children for sale, prostitution or any other form of exploitation.

3. Any claim arising due to non-compliance of the provisions stated in the respective Surrogacy law ie, the Surrogacy (Regulation) Act 2021 / Rules, 2022, the Assisted Reproductive Technology Act, 2021 / Rules 2022 and any subsequent amendments to the applicable law;

4. Any Illness or Injury other than complications arising out of pregnancy and post-partum delivery for the Surrogate Mother or complications arising out of oocyte retrieval for the Oocyte Donor.

c) Conditions:

1. Either Option 42 (1) or 42 (2) may be selected under this Optional Cover, and will be available only as specified in the Policy Schedule;

2. This Optional Cover is applicable only for any 1 surrogacy or oocyte retrieval procedure, as applicable, and incurred in relation to only 1 Surrogate Mother or Oocyte donor. The Optional Cover shall expire upon the expiry of the respective Policy Period and is not renewable after its expiry;

d) Waiting period and Exclusions:

The Waiting Periods specified under the Policy shall not be applicable for this Optional Cover;

e) Renewability:

This Optional Cover is applicable only for any 1 surrogacy or oocyte retrieval procedure, as applicable, and incurred in relation to only 1 Surrogate Mother or Oocyte donor. The Optional Cover shall expire upon the expiry of the respective Policy Period and is not renewable after its expiry;

No cancellation shall be applicable by the Policyholder where Optional Cover 42 (1). Complications of Altruistic Surrogacy Pregnancy and Post-partum Delive_ OR 42 (2) Complications of oocyte retrieval has been opted

Section D. Exclusions

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

1. **I. Standard Exclusions:Pre-Existing Diseases (Code- Excl01)**

   (Not applicable for Section C.IV.32 and Section C.V.34 – Personal Accident Cover (AD, PTD)

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

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

   (Not applicable for Section C.IV.32 and Section C.V.34 - (Personal Accident Cover (AD, PTD), Section C.IV.33 and Section C.V.35 (Critical Illness cover)

   a) Expenses related to the treatment of the listed Conditions, surgeries / treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with Us. This exclusion shall not be applicable for claims arising due to an accident.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If any of the specified disease / procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases / procedures:

	Body System	**Illness**	**Treatment / Surgery**
1.	Eye	Cataract	Cataract Surgery
		Glaucoma	Glaucoma Surgery
		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 / Spermatocoele	Medical & Surgical treatment
7.	Skin	Skin tumour (unless malignant)	Medical & Surgical treatment
		All skin diseases	
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

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.

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

(Not applicable for Section C.IV.32 and Section C.V.34 - (Personal Accident) Section C.IV.33 and Section C.V.35 (Critical Illness cover)

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

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 IV of this policy and as disclosed in website (www.adityabirlahealth.com/healthinsurance) / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
12. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code- Excl12).
13. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code- Excl13)
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 dioptres.
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. **Initial waiting period (Applicable for Section C.IV.32 and Section C.V.34 (Personal Accident Cover – AD.PTD) and Section C.IV.33 and Section C.V.35 (Critical Illness cover)**
    (i) For Section C.IV.32 and Section C.V.34 - Personal Accident, no initial waiting period applicable.
    (ii) For Section C.IV.33 and Section C.V.35 - Critical Illness Cover, We shall not be liable to make any payment in respect of any Critical Illness whose signs or symptoms first occur within 90 days from the Start Date of cover.

20. **Chronic Management Program Waiting Period**
    (i) Where the Insured Person has under gone a Health AssessmentTM and the results of the Health AssessmentTM indicate that the Insured Person is suffering from a chronic condition, then a Waiting Period of 24 months shall be applicable from the Start Date of the Policy Policy in respect of the Insured Person for Chronic Management Program.

However, Hospitalization related to these conditions will be covered after a Waiting Period as specified in section D.I.3.

(ii) If the results of the Health AssessmentTM indicate that the Insured Person does not have any of the aforementioned conditions, then the Insured Person will be entitled to avail the benefits under Chronic Management Program, if the Insured Person develops any such conditions later in life, without any applicability of the Waiting Period. However, Hospitalization related to these conditions will be covered after a Waiting Period as specified in section D.I.3.

(iii) Where the Insured Person has undergone a pre-Policy medical examination and is found to be suffering from a covered chronic condition under the policy, Chronic Management Program shall be available from day 1 for such condition(s). However, Hospitalization related to these conditions will be covered after a Waiting Period of 30 days.

21. Maternity Waiting Period

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

22. Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, uprising, revolution, insurrection, military or usurped acts, nuclear weapons / materials, chemical and biological weapons, ionizing radiation, contamination by radioactive material or radiation of any kind, nuclear fuel, nuclear waste.
23. Willful or deliberate exposure to danger, intentional self Injury, participation or involvement in naval, military or air force operation.
24. Any Illness /Injury / Accident due to abuse of intoxicants, smoking cessation programs and the treatment of nicotine addiction, unless prescribed by a Medical Practitioner
25. All routine examinations and preventive health check-ups.
26. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment);
27. Non allopathic treatment
28. Conditions for which treatment could have been done on an outpatient basis without any Hospitalization
29. Experimental, investigational or devices and pharmacological regimens.
30. Convalescence, cure, sanatorium treatment, private duty nursing, long-term nursing care or custodial care
31. Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing.
32. 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.
33. Hearing aids, spectacles or contact lenses including optometric therapy, multifocal lens
34. Treatment for alopecia, baldness, wigs, or toupees, and all treatment related to the same.
35. Medical supplies including elastic stockings, diabetic test strips, and similar products
36. Any expenses incurred on prosthesis, corrective devices external durable medical equipment of any kind, like wheelchairs crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident. Cost of artificial limbs, crutches or any other external appliance and / or device used for diagnosis or treatment.
37. Parkinson and Alzheimer's disease, General debility or exhaustion ("rundown condition"), sleep-apnea, stress.
38. External Congenital Anamolies or diseases or defects.
39. Stem cell therapy (except Hematopoietic stem cells for bone marrow transplant for haematological conditions) or related Surgery, or growth hormone therapy.
40. Venereal disease and sexually transmitted disease or Illness including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
41. Expenses for organ donor screening, or save as and to the extent provided for in the treatment of the donor (including Surgery to remove organs from a donor in the case of transplant Surgery).
42. Admission for Organ Transplant but not compliant under the Transplantation of Human Organs Act, 1994 (amended)
43. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.

44. Dentures and artificial teeth, Dental Treatment and Surgery of any kind, unless requiring Hospitalization due to an Accident.
45. Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose
46. 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,.
47. Expenses which are medically not necessary such as items of personal comfort and convenience including but not limited to television (if specifically charged), charges for access to telephone and telephone calls (if specifically charged), food stuffs (save for patient's diet), cosmetics, hygiene articles, body care products and bath additives, barber expenses, beauty service, guest service as well as similar incidental services and supplies, vitamins and tonics unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim
48. Treatment taken from a person not falling within the scope of definition of Medical Practitioner with any state medical council / medical council of India
49. Treatment charges or fees charged by any Medical Practitioner acting outside the scope of license or registration granted to him by any medical council.
50. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, except if pre-approved by Us.
51. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.
52. Administrative Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing, including MRD charges (medical records department charges).
53. Non-Medical Expenses including but not limited to RMO charges, surcharges, night charges, service charges levied by the Hospital under any head and as specified in the Annexure I for Non- Medical Expenses
54. Treatment taken outside India except for the Benefit C.IV.(31) and C.V.(36)
55. Use of Radio Frequency (RF) probe for ablation or other procedure unless specifically approved by Us in writing in advance.
56. In respect of the existing diseases, disclosed by the Insured Person and mentioned in the Policy Schedule (based on Insured Person's consent), Policyholder is not entitled to get the coverage for specified ICD codes.

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

1) Any treatment taken inside India.

57. Exclusions specific to Section C.IV.(32) & Section C.V.(34) (Personal Accident Cover), if opted

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

1. Any Pre- Existing Disease or Injury or disability arising out of a Pre- Existing Disease or any complication arising therefrom.
2. Any payment in case of more than one claim under the Policy during any one Policy Period by which Our total, cumulative and maximum liability in that period would exceed the Sum Insured.
3. Suicide or attempted suicide, intentional self-inflicted Injury, acts of self-destruction whether the Insured Person is medically sane or insane.
4. Mental Illness or sickness or disease including a psychiatric condition, mental disorders of or disturbances of consciousness, strokes, fits or convulsions which affect the entire body and pathological disturbances caused by mental reaction to the same.
5. Certification by a Medical Practitioner who shares the same residence as the Insured Person or who is a member of the Insured Person's family.

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

58. Exclusions - Specific to Critical Illness Cover Section C.IV.(33) and Section C.V.(35), if opted.

We shall not be liable to make any payment under Critical Illness Cover Section of this Policy towards a covered Critical Illness, directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following or as specified in the Policy Schedule:

1. Any Illness, sickness or disease other than those specified as Critical Illnesses under this Policy.
2. Any condition directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) and its variants or mutants,
3. Any condition directly or indirectly caused by or associated with sexually transmitted disease, including Genital Warts, Syphilus, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis
4. Any Illness / Injury / Accident due to the abuse of intoxicant.
5. Narcotics used by the Insured Person unless taken as prescribed by a Medical Practitioner.
6. Any condition directly or indirectly caused due to intentional self-Injury, suicide or attempted suicide; whether the Insured Person is medically sane or insane.

7. Any condition directly or indirectly caused by or arising from or attributable to a foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
8. Any condition caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.
9. Working in underground mines, tunneling or involving electrical installations with high tension supply, or as jockeys or circus personnel.
10. External Congenital Anamolies or diseases or defects
11. Any Critical Illness based on certification / diagnosis / treatment from persons not registered as Medical Practitioners, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for or is not Medically Necessary Treatment or any kind of self-medication and its complications.
12. In the event of the death of the Insured Person within the stipulated survival period as set out above.
13. Hormone replacement therapy.
14. 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
15. 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.
16. 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.
17. 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.
18. 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
19. 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.

Section E General Terms & Clauses

I. Standard General Terms & 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 in below grid

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

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

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 Policy**:

   The Policy shall automatically terminate on the death of all Insured Persons , including any Surrogate Mother or the Oocyte donor, if applicable

   b. **Family Policy**:

   The Policy shall automatically terminate in the event of the death of all the Insured Persons , including any Surrogate Mother or the Oocyte donor, if applicable

   c. **Refund**:

   A refund in accordance with the grid above shall be payable if there is an automatic cancellation of the Policy provided that no claim has been filed under the Policy by or on behalf of any Insured Person.

3. **Cancellation by Us**:

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

4. **Treatment of HealthReturns™ on Cancellation**:

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

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 atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.
For Detailed Guidelines on migration, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987&flag=1]

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 portability, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_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 cumulative 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 to 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, 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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

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

15. Redressal of Grievance

In case of a grievance, the Insured Person / Policyholder can contact Us with the details through:
Our website: https://www.adityabirlacapital.com/healthinsurance/faqs
Toll Free : 1800 270 7000
Email: care.healthinsurance@adityabirlacapital.com
Courier: Aditya Birla Health Insurance Co. Limited
Unit no 1101 & 1104 11th floor, Unit no 1501 & 1502 15th floor, G Corp Tech Park, Kasarwadavali, Ghodbunder Road, Thane West - 400601

In case you are not satisfied with the resolution you may write to Head Customer Care : carehead.healthinsurance@adityabirlacapital.com

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

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://bimabharosa.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)

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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) You shall disclose to Us in writing of any chronic condition acquired by any Insured Person at the time of seeking Renewal of this Policy or during the Policy tenure, irrespective of any claim arising or made. If an Insured Person is found to be suffering from a covered chronic condition post any waiting period (if applicable), then We shall manage such conditions under Chronic Management Program as per the terms and conditions laid out under Section C.III.(27).

(viii) Alterations like increase / decrease in Sum Insured or Change in Plan / Product, addition / deletion of Insured Persons (except due to child Birth / Marriage or Death) will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the Proposal Form before the expiry of the Policy. We reserve Our right to carry out underwriting in relation to acceptance of request for changes on Renewal. The terms and conditions of the existing Policy will not be altered.

(ix) Any enhanced Sum Insured during any Policy Renewals will not be available for an Illness, disease, Injury already contracted under the preceding Policy Periods. All waiting periods as mentioned below shall apply afresh for this enhanced limit from the effective date of such enhancement.

(x) Wherever the Sum Insured is reduced on any Policy Renewals, the waiting periods as mentioned in the Policy Schedule shall be waived only up to the lowest Sum Insured as applicable to the relevant waiting periods of the Plan in force.

(xi) Where an Insured Person is added to this Policy, either by way of endorsement, all waitingperiods under Section D.I.1, D.I.2 and D.I.3 will be applicable considering such Policy Year as the first year of Policy with Us with respect to the Insured Person.

(xii) Applicable No Claim Bonus shall be accrued on each Renewal as per eligibility under the plan in force.

(xiii) 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. Zone Classification:

Zone I: Mumbai and suburbs, Navi Mumbai and suburbs, Thane and suburbs, New Delhi, Delhi NCR, Gurgaon, Noida, Faridabad, Ghaziabad, Gautam Buddha Nagar, Bangalore and suburbs, Surat and suburbs

Zone II: Ahmedabad, Vadodara, Kolkata, Pune, Hyderabad, Chennai, Chandigarh, Mohali, Panchkula

Zone III: Rest of India

Identification of Zone will be based on the city of the proposed Insured Persons.

(a) Persons paying Zone I premium can avail treatment all over India without any Co-payment.

(b) Persons paying Zone II premium

i. Can avail treatment in Zone II and Zone III without any Co-payment (provided treatment is taken within eligible room category as specified in the Policy Schedule).

ii. Availing treatment in Zone I will have to bear 10% of each and every claim (provided treatment is taken within eligible room category as specified in the Policy Schedule).

(c) Person paying Zone III premium

i. Can avail treatment in Zone III, without any Co-payment

ii. Availing treatment in Zone II will have to bear 15% of each and every claim (provided treatment is taken within eligible room category as specified in the Policy Schedule).

iii. Availing treatment in Zone I will have to bear 25% of each and every claim (provided treatment is taken within eligible room category as specified in the Policy Schedule).

Note:

- Individual Policy: Your zone is based on the city mentioned in the Proposal form.
- In case of Family Floater Policy, a single Zone shall be applicable to all members covered under the Policy.
  You also have an option of selecting another Zone from the applicable Zone of any of the Insured Persons in the Policy.
- Option to select a Zone higher than that of the actual Zone is available on payment of relevant premium at the time of buying the Policy or at the time of Renewal.
- Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalisation due to an Accident.

23. 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.

24. Endorsements

The Policy will 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 inception or Renewal Start Date.

(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*

(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 / Aadhaar / 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 (New Born Baby or 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 birth certificate / 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.

25. 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.

26. 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.

27. 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.

28. 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.

29. Territorial Jurisdiction

All benefits are available in India only (except C.IV.(31) and V.(36)), and all claims shall be payable in India in Indian Rupees only.

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) The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payments that are brought about or contributed to as a consequence of or failure to follow such directions, advice or guidance.

(3) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.

(4) We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

I. Claims Procedure for Benefits other than Personal Accident, Critical Illness and International Coverage for Major Illnesses

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

a. For Availing Cashless Facility :

(i) Cashless Facilities can be availed only at Our Network Providers. The complete list of Network Providers is available on Our website and at Our branches and can also be obtained by contacting Us over the telephone.

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

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

(i) We must be contacted to pre-authorise Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Each request for pre-authorisation must be accompanied with all the following details:

(1) The health card We have issued to the Insured Person supported with the Insured Person's KYC documents.
(2) The Policy Number;
(3) Name of the Policyholder;
(4) Name and address of Insured Person in respect of whom the request is being made;
(5) Nature of the Illness / Injury and the treatment / Surgery required;
(6) Name and address of the attending Medical Practitioner;
(7) Hospital where treatment / Surgery is proposed to be taken;
(8) Proposed date of admission.

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

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

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

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

(i) We must be contacted to pre-authorise Cashless Facility within 24 hours of the Insured Person's Hospitalization if the Insured Person has been Hospitalized in an Emergency. Each request for pre-authorisation must be accompanied with all the following details:

(1) The health card We have issued to the Insured Person supported with the Insured Person's KYC documents.

(2) The Policy Number;
(3) Name of the Policyholder;
(4) Name and address of Insured Person in respect of whom the request is being made;
(5) Nature of the Illness / Injury and the treatment / Surgery required;
(6) Name and address of the attending Medical Practitioner;
(7) Hospital where treatment / Surgery is proposed to be taken;
(8) Proposed date of admission.

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

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

(iv) Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, Hospital and locations, match with the details of the actual treatment received. For Hospitalization where Cashless Facility is pre-authorised by Us, We will make the payment of the amounts assessed to be due directly to the Network Provider.

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

d. For Reimbursement Claims :

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

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

e. 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 authorised, 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 & Final Payment Receipt

(7) Original Invoice with Payment receipt & implant Stickers for all Implants used during Surgeries i.e. Lens Sticker & Invoice in Cataract Surgery, Stent Invoice & Sticker in Angioplasty Surgery.

(8) All previous consultation papers indicating history & treatment details for current ailment

(9) All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription & invoice / bill with receipt from diagnostic centre

(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 & Copy Death Certificate (in Death Claims Only)

(13) Pre & Post-Operative Imaging reports – for Accident Cases Only

(14) Copy of Indoor case papers with nursing sheet detailing medical history of the patient, treatment details, & patient's progress (if available)

(15) Treating Medical Practitioner letter stating:

a) Presenting complaints with duration & past history

b) Medical history of Co-morbidities e.g. Hypertension, Heart ailment etc.

c) Treatment detail with name of drugs & route of administration

(16) Treating Medical Practitioner letter stating – for Accident Cases Only

a) Details of Accident / trauma

b) whether patient was under the influence of alcohol or any intoxicating substance during incident / Accident

(17) KYC documents in accordance with the provisions of the regulations, circulars and guidelines issued by the IRDAI with respect to KYC from time to time.

(18) As per terms of IRDAI Circular ref: IRDA/SDD/GDL/CIR/020/02/2013 dated 08.02.2013, KYC shall be performed for the claims cases where the payment to the claimant is above Rs. 1 lakh or such revised limit as may be prescribed by the Authority from time to time in this regard.

Additional documents in case of below covers

In case of Multiple Policy claims:

(1) Photocopy of entire claim document duly attested by previous Insurer or TPA

(2) Original payment receipts for expenses not claimed/settled by previous insurer

(3) Discharge voucher / settlement letter by previous insurer

OPD Cover :

(i) Doctor Consultation

(1) Duly filled claim form

(2) Original prescription from treating general Medical Practitioner / specialist Medical Practitioner

(3) Original invoice and payment receipt

(ii) Diagnostics

(1) Duly filled claim form

(2) Original investigation report(s)

(3) Original invoice and payment receipt

(4) Medical Practitioner's advice for such investigation / diagnostic test

(5) Copy of Police Report in case of Road Traffic Accident

(iii) Pharmacy

(1) Duly filled claim form

(2) Original invoice and payment receipt

(3) Copy of prescription from treating Medical Practitioner

Road Ambulance Cover :

(1) Photocopy of discharge card

(2) Original Ambulance invoice & paid receipt

Dental Benefit / Post-hospitalization Physiotherapy cover :

(1) Duly filled & signed claim form

(2) Original Prescription from treating Medical Practitioner

(3) Original Invoice for Physiotherapy treatment and payment receipt

(4) Original Invoice for Dental and payment receipt

(5) Positive Investigation report for Dental & Physiotherapy treatment benefit

Hospital Cash Benefit & Recovery Benefit :

(1) Photocopy of all the Hospitalization documents:-Discharge card, indoor case papers will be sought depending upon the requirement to ascertain the genuineness of claim

(2) Any other document as per the check list for Hospitalization / In patient claims in order to ascertain the genuineness of claim

Vaccination Cover:

(1) Duly filled & signed claim form

(2) Original Prescription from treating Medical Practitioner

(3) Original Invoice for Vaccination and payment receipt

Stem cell preservation benefit:

(1) Copy of stem cell banking receipt

(2) Procedure note / confirmation of successful preservation of stem cells

II. Claim Procedure for Personal Accident, Critical Illness Benefit / Premium Waiver Benefit

a. Intimation of Claim

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

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

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

1. The Policy number;
2. Name of the Policyholder;
3. Name and address of the Insured Person in respect of whom the request is being made

b. Claim Documents:

The claims documents as specified in below sections for various covers must be provided to Us within 30 days of occurrence of the event giving rise to a claim under the Policy at Your own / Insured Person's expenses

Where there is a delay in intimation of claim and / or submission of claim documents is proved to be genuine and for reasons beyond the control of the claimant, We may condone such delay and process the claim. We reserve the right to decline such requests for claim process where there is no merit behind such delay.

1. Personal Accident Cover

Documents required for all Benefits under Personal Accident Cover

(1) Claim Form (in original) duly completed and signed as prescribed by Us

(2) Photo ID and Age proof of Insured Person / Nominee (if Insured Person is not alive)

(3) Claim intimation or claim reference number (if any)

(4) Attested copy of medico legal certificate copy / first information report copy / Panchnama (spot / inquest)

(5) Copies of consultation letters detailing the treatment taken immediately after Accident

(6) Radiological investigation reports like X ray, CT scan, MRI etc with films supporting the diagnosis of Injury

(7) Cancelled cheque for NEFT

Additional documents required for Specific Benefits

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

Accidental Death Cover (AD)

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

Permanent Total Disablement (PTD)

(1) Attested copy of disability certificate issued by civil surgeon of district Hospital mentioning the type and percentage of disability.
(2) Original photograph of the Insured Person reflecting the disablement or injured part for which the claim is made
(3) Leave records with seal and signature of authorized signatory of the organization (if employed)
(4) Salary slips for last 3 months with seal and signature of authorized signatory of the organization (if employed)
(5) Last 3 years financial years income tax return for self-employed persons
(6) Copies of medical documents towards treatment taken during disability period, including discharge summary of the Hospital
(7) 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)

2. Critical Illness Cover / Premium Waiver Benefit

(1) Claim Form (in original) duly completed and signed as prescribed by Us
(2) Photo ID and Age proof of Insured Person / Nominee (if Insured Person is not alive)
(3) Copy of the claim intimation, if any
(4) Final Hospital bill
(5) Hospital discharge summary / day care summary / transfer summary
(6) Operation theatre notes
(7) Investigation reports (Including CT scan / MRI /USG / Histopathology or Biopsy report)
(8) Doctor's prescriptions
(9) Cancelled cheque for NEFT
(10) Others

Additional documents for submission of claims under Critical Illness Cover

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

(1) Medical certificate confirming the diagnosis of Critical Illness
(2) Certificate from attending Medical Practitioner confirming that the claim does not relate to any Pre-Existing Disease or any Illness or Injury which was diagnosed within the first 90 days of the Inception Date
(3) Photocopy of discharge certificate / card from the Hospital, if any
(4) Photocopy of investigation test reports confirming the diagnosis
(5) Photocopy of first consultation letter and subsequent prescriptions

(6) Photocopy of indoor case papers if applicable (if available)

(7) Specific documents (if any) listed under the respective Critical Illness

(8) In the cases where Critical Illness arises due to an Accident, FIR copy or medico legal certificate shall be required wherever conducted.

We may call for any additional documents / information as required based on the circumstances of the claim.

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 Our website.

III. Claims Procedure for - International Coverage for Major Illnesses

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

a. For Availing Cashless Facility

i. Cashless Facility can be availed only at Our Network Providers / Empaneled Service Providers.

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

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

i. We / Our Empanelled Service Provider must be contacted to pre-authorise Cashless Facility for planned treatment at the earliest possible prior to the proposed treatment. Each request for pre-authorisation must be accompanied with all the following details:

1) The health card issued by Us to the Insured Person, along with the Insured Person's KYC documents.
2) The Policy Number;
3) Name of the Policyholder;
4) Name and address of Insured Person in respect of whom the request is being made;
5) Nature of the Illness / Injury and the treatment / Surgery required;
6) Name and address of the attending Medical Practitioner;
7) The Insured Person on diagnosis of Major Illness should share the following for e-opinion
   (i) First consultation paper from treating medical practitioner in India
   (ii) Final Diagnosis paper
   (iii) Treating doctor certification on final diagnosis
   (iv) All investigation reports supporting documents
   (v) Consent Form to collect documents from various source
   (vi) Any other relevant documents to ascertain eligibility of claim
8) On the basis of the Insured Person's medical condition, We / Our Empaneled Service Provider will identify 3 Hospitals from Our network.
9) The Insured Person may choose one of the Hospitals / treatment centres out of the 3 choices given by Us / Our Empaneled Service Provider.
10) Medical Reports and all other information is shared with the chosen Hospital / clinic.
11) After the receipt of all medical information, a detailed Medical Opinion from the selected Hospital / treatment centre would be delivered to You at the earliest.
12) Insured Person must notify Us of the willingness to take the treatment abroad and the country of choice.
13) On receipt of the Insured Person's confirmation of his / her decision to receive treatment abroad at the selected country for treatment, We / Our Empaneled Service Provider will identify 3 Hospitals from our Network.
14) You may choose one of the Hospitals / treatment centres out of the 3 Choices given by Us / Our Empaneled Service Provider or You may choose from a fourth option from Our / Empaneled Service Provider's network Hospitals.
15) We will organize the necessary logistical, travel, accommodation and medical arrangements for the correct admission of the Insured Person and will issue a Preliminary Medical Certificate valid only for that Hospital.

(16) We will provide coverage only in the indicated Hospital in the Preliminary Medical Certificate. Any expense incurred in a different Hospital from the one specified in the Preliminary Medical Certificate will not be covered.

17) Any expense incurred before the issuance of the Preliminary Medical Certificate will not be covered.

18) The list of recommended Hospitals and the Preliminary Medical Certificate are issued on the basis of the medical condition of the Insured Person at the time of issue of Preliminary Medical Certificate. Since the health condition of the Insured Person may change over time, both documents will have a validity of three months.

19) In the event that the Insured Person does not select a Hospital from the list of recommended Hospital or does not initiate treatment within 3 months of issuance of Preliminary Medical Certificate within 3 months of issue, We on the request of customer shall reinitiate the process of Pre-Authorisation for planned treatment based on the health condition of the Insured Person at that time.

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

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

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

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

c. For Reimbursement Claims:

i. For all claims under benefit Post – hospitalization Medical Expenses and Repatriation of Mortal Remains of this Section C.IV.31 and C.V.36 for which pre-authorization under Cashless Facility has not been accepted or for which treatment has not been taken at a Network Provider, We shall be given written notice of the claim along with the following details within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier:

(1) The Policy Number;
(2) Name of the Policyholder;
(3) Name and address of the Insured Person in respect of whom the request is being made;
(4) Health Card, Photo ID, KYC documents
(5) Nature of Illness or Injury and the treatment / Surgery taken;
(6) Name and address of the attending Medical Practitioner;
(7) Hospital where treatment / Surgery was taken;
(8) Date of admission and date of discharge;
(9) Any other information that may be relevant to the Illness / Injury / Hospitalization

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

d. 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 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 authorised, We / Our Empanelled Service Provider will be provided these documents by the Network Provider / You (as the case may be) 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. invoice in 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) KYC documents in accordance with the provisions of the regulations, circulars and guidelines issued by the IRDAI with respect to KYC from time to time.
16) A valid ticket / proof of travel (such as Airline boarding pass) to the location the Insured Person is traveling as a bona fide passenger
17) As per terms of IRDAI Circular ref: IRDA/SDD/GDL/CIR/020/02/2013 dated 08.02.2013, KYC shall be performed for the claims cases where the payment to the claimant is above Rs. 1 lakh or such revised limit as may be prescribed by the Authority from time to time in this regard.

Additional documents in case of below covers

In case of Multiple Policy claims:

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

Ambulance expenses Photocopy of discharge card

1) Original Ambulance invoice & paid receipt

iii. For acceptance of claims in electronic mode, the documents shall be submitted in such form and manner as may be specified by Us.

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

- Health Assessment™
- HealthReturns™
- Health Check-up Program
- Expert Health Coach
- Domestic Emergency Assistance Services (including Air Ambulance)
- International Emergency Assistance Services (including Air Ambulance)
- Second E-Opinion on Major Illnesses
- Chronic Management Program
- Dental Consultation & Investigations

Notwithstanding the foregoing, We may call for any additional documents / information as required based on the circumstances of the claim.

IV. **Claims Assessment & Repudiation**

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

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

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

(c) Payment for reimbursement claims will be made to You. In the unfortunate event of Your death, We will pay the Nominee named in the Policy Schedule or Your legal heirs or legal representatives holding a valid succession certificate.

For details on the claims process or assistance during the process, You may contact the 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.