Activ Secure - Policy Terms and Conditions

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 receipt of premium in full and accepted by Us in respect of the Insured Persons and the terms, conditions and exclusions as specified in the Policy Schedule / the Product Benefit Table of this Policy.

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

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

I. Personal Accident Cover

Section I.A: Basic Covers

Benefits under this Section I.A are subject to the terms, conditions and exclusions of this Policy. The Sum Insured and/or the sub-limit for each Benefit under Section I.A 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 I.A must be made in accordance with the procedure set out in Section VII.

I.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 including any P.A. Cumulative Bonus, as applicable.

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
a) Once a claim has been accepted and paid under this Benefit then cover under this Policy shall immediately and automatically cease in respect of that Insured Person.

I.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 including any P.A. Cumulative Bonus, 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

a) 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.
b) Once a claim has been accepted and paid under this Benefit then cover under Section I of this Policy shall immediately and automatically cease in respect of that Insured Person.

What is not covered

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.

I.3 Permanent Partial Disablement (PPD)

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 partial disablement of the Insured Person of the nature as specified in the table below within 365 days from the date of the Accident, then We shall pay the percentage of the Sum Insured as specified in the Policy Schedule / the Product Benefit Table including any P.A. Cumulative Bonus, as applicable, and as specified in the table below:

S.No	Table of Benefits	Percentage of the Sum Insured payable
Type of Permanent Partial Disablement		
1	Hearing of both ears	75%
2	An arm at the shoulder joint	70%
3	A leg above mid-thigh	70%
4	An arm above the elbow joint	65%
5	An arm beneath the elbow joint	60%
6	A leg up to mid-thigh	60%
7	A hand at the wrist	55%
8	A leg up to beneath the knee	50%
9	An eye	50%
10	A leg up to mid-calf	45%
11	A foot at the ankle	40%
12	Hearing of one ear	30%
13	A thumb	20%
14	An index finger	10%
15	Sense of smell	10%
16	Sense of taste	5%
17	Any other finger	5%
18	A large toe	5%
19	Any other toe	2%

Conditions

a) In case the Insured Person suffers a loss not mentioned in the table above, then an external medical advisor shall determine the degree of disablement and the amount payable, if any.
b) 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 at the expiry of the 365 days that there is no reasonable medical hope of improvement.
c) If a claim in respect of a whole member (any organ, organ system or a limb) also encompasses some or all of its parts, Our liability to make payment under this Benefit shall be limited to the member only and not for any of its parts or constituents.

What is not covered

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

I.4 Education Benefit

What is covered
If We have accepted a claim under Section I.1 or under Section I.2, then in addition to the amount payable under that Section, We shall pay a lump sum amount as specified in the Policy Schedule /the Product Benefit Table towards the education of the surviving Dependent Children.

Conditions
a) The maximum amount payable under this Section shall not exceed the amount as specified in the Policy Schedule/ the Product Benefit Table irrespective of the number of Dependent Children.
b) This Benefit shall be payable subject to the Dependent Child being up to 25 years of Age as on the date of occurrence of the event giving rise to the claim under Section I.1 or Section I.2 and irrespective of whether the child is an Insured Person under this Policy.
c) The Dependent Child shall not have any independent source of income and must be pursuing an educational course as a full time student at an accredited educational institute.

I.5 Emergency Road Ambulance Cover

What is covered
If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period that requires Hospitalization of the Insured Person as an In-patient, then in addition to the amount payable under Section I.1 or I.2 or I.3 if any, We shall reimburse the costs incurred to transfer the Insured Person from the site of the Accident to the nearest Hospital by road Ambulance immediately following the Accident up to the limits as specified in the Policy Schedule / the Product Benefit Table.
In addition to the above, coverage under this Benefit shall also be provided under the below circumstances:
(I) If 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; or
(ii)If 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.

Condition
a) The treating Medical Practitioner certifies in writing that the transportation of the Insured Person by Ambulance was medically necessary.
b) The Ambulance/ healthcare service provider is registered

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

I.6 Funeral Expenses

What is covered
If We have accepted a claim under Accidental Death Cover in accordance with Section I.1, then in addition to the amount payable under that Section, We shall pay a lump sum amount equal to the amount as specified in the Policy Schedule /the Product Benefit Table towards funeral, cremation or burial expenses of that Insured Person.

I.7 Repatriation of Remains

What is covered
If We have accepted a claim under Accidental Death Cover in accordance with Section I.1, then in addition to the amount payable under that Section, We shall pay a lump sum amount as specified in the Policy Schedule /the Product Benefit Table towards transportation of mortal remains from the place of death to the residence of the Insured Person or to a cremation/ burial ground.

I.8 Orphan Benefit

What is covered
If We have accepted a claim under Accidental Death Cover in accordance with Sections I.1 for the Insured Person and that Insured Person's spouse (who may or may not be an Insured Person under this Policy) is also deceased on or before the date of the Accident which caused the death of the Insured Person and as a consequence, their Dependent Child becomes an orphan, then in addition to the amount payable under that Section, We shall pay a lump sum amount equal to the amount as specified in the Policy Schedule / the Product Benefit Table.

Conditions
a) The maximum amount payable under this Section shall not exceed the amount as specified in the Policy Schedule/ the Product Benefit Table irrespective of the number of Dependent Children and whether the child is an Insured Person under this Policy or not.
b) This Benefit shall be payable subject to the Dependent Child being up to 25 years of Age as on the date of occurrence of the event and provided that the Dependent Child does not have any independent source of income.
c) Any claim towards Orphan Benefit for Children where the Dependent Child is less than 18 years of Age, shall be payable to the legal guardian of the Dependent Child.

I.9 Modification Benefit (Residence and vehicle)

What is covered
If We have accepted a claim for Permanent Total Disablement under Section I.2 or Permanent Partial Disablement under Section I.3, then in addition to the amount payable under that Section, We shall reimburse maximum up to the amount as specified in the Policy Schedule / the Product Benefit Table towards the costs incurred for suitable improvements carried out in the Insured Person's residence and/or vehicle following the Insured Person's disablement.
Expenses covered under this Section shall include expenses for necessary modification to:
a) make the residence accessible and habitable for the disabled Insured Person;
b) one motor vehicle owned or leased by the Insured Person to make such vehicle accessible to or driveable by the Insured Person.

Conditions
a) The modification must be carried out in India only by an individual experienced in carrying out such modifications and such modifications must be certified by a Medical Practitioner as "necessary".
b) The modification must be directly required as a result of the Injury caused by an Accident for which We have accepted a claim under Section I.2 or I.3.

I.10 Compassionate visit

What is covered
If We have accepted a claim under Section I.1 or under Section I.2, then in addition to any amount payable under that Section, We shall reimburse the amount which shall be lower of return economy class air ticket or up to the amount as specified in the Policy Schedule /the Product Benefit Table for an Immediate Relative of the Insured Person to travel to the place of Hospitalization of the Insured Person.

Conditions
a) Such travel by the Immediate Relative should be by the most direct route.
b) Such travel may be undertaken using any mode of legally allowed transport.
c) The Insured Person is Hospitalized at a distance of at least 100 kilometre from his place of residence. For the purpose of this Benefit, "Immediate Relative" means the Insured Person's spouse, children (including step- children, adopted children and ward), brother, sister, parents, parents-in-law, brother-in-law or sister-in-law, and any legal guardian.

I. 11 P.A Cumulative Bonus

What is covered
If the Insured Person has not made any claim under Section I.1 and Section I.2 and Section I.3 in a Policy Year, then We shall apply a P.A. Cumulative Bonus of 5% on the Sum Insured as specified for Section I.1 in the Policy Schedule for that Insured Person. The maximum P.A. Cumulative Bonus shall not exceed 50% of the Sum Insured as specified for Section I.1 in the Policy Schedule for that Insured Person. This accrued P.A. Cumulative Bonus shall be available for any claim under Section I.1, I.2 and I.3 of this Policy.
If a P.A. Cumulative Bonus is applied and a claim is made, then at the time of Renewal, the accrued P.A. Cumulative Bonus shall be reduced by 5% of the Sum Insured as specified for Section I.1 in the Policy Schedule for that Insured Person.

Conditions
a) P.A. Cumulative Bonus shall not accrue if the Policy is not Renewed with Us by the end of the Grace Period.
b) If the Policy Period is for either two years or for three years, then any P.A. Cumulative Bonus that has accrued for the first Policy Year or the second Policy Year as the case may be shall be credited at the end of the first Policy Year or the second Policy Year as the case may be and shall be available for any claims made in the subsequent Policy Year.
c) If the Sum Insured under the Policy has been increased at the time of Renewal, then the P.A. Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
d) The P.A. Cumulative Bonus is subject to revision in case a claim is being reported under the expiring Policy Year.

What is not covered
This Benefit is not applicable to an Insured Person whose Sum Insured specified for Section I.1 in the Policy Schedule is more than Rs. 10 Crores.

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

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

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

I.12 Temporary Total Disablement (TTD)

What is covered
If the Insured Person suffers an Injury solely and directly due to an Accident occurring during the Policy Period that disables the Insured Person from engaging in any employment or occupation on a temporary basis, then We shall pay the weekly amount as specified in the Policy Schedule /the Product Benefit Table for the duration that the temporary total disablement continues.

Conditions
a) The temporary total disablement is certified by a treating doctor.
b) We shall not be liable to make payment for more than the number of weeks as specified in the Policy Schedule in respect of any one Injury calculated from the date of commencement of the temporary total disablement.
c) This Benefit shall not be paid in excess of the Insured Person's base weekly income at the time of accident excluding overtime, bonuses, tips, commissions, or any other compensation.
d) This Benefit is payable provided that if the Insured Person is disabled for a part of the week, then only a proportionate part of the weekly benefit shall be payable.
e) This Benefit shall be payable at the completion of the duration of temporary total disablement. In case the temporary total disablement continues for a period of more than 30 days then We shall make payment of the amount due at the end of every calendar month provided the person continues to suffer from the temporary total disablement at the end of such period.
f) This cover shall not be Renewed after the Insured Person has attained 70 years of Age.

I.13 Accidental in-patient Hospitalization Cover

What is covered
If the Insured Person suffers an Injury solely and directly due to an Accident occurring during the Policy Period that requires Hospitalization of the Insured Person as an In-patient, then We shall cover the Medical Expenses incurred for such Hospitalization up to the limits as specified against this cover in the Policy Schedule / the Product Benefit Table for that Insured Person. We shall cover the following Medical Expenses:
- Room Rent and other boarding charges;
- ICU Charges;
- Operation theatre expenses;
- Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;

- Qualified Nurses' charges;
- Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
- Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized and conducted within the same Hospital where the Insured Person is admitted;
- Anaesthesia, blood, oxygen and blood transfusion charges;
- Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.

Day Care Treatment:
We will cover the Medical Expenses incurred on the Insured Person's Day Care Treatment on the recommendation of a Medical Practitioner following an Injury suffered by the Insured Person solely and directly due to an Accident occurring during the Policy Period up to the limits as specified under this Benefit in the Policy Schedule / the Product Benefit Table for that Insured Person.

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 on Our toll free number as specified in the Policy Schedule.

Conditions
(a) The Insured Person is Hospitalized in India.
(b)The Hospitalization is for Medically Necessary Treatment and is on the written advice of a Medical Practitioner.

What is not covered
a) Any Hospitalization for an existing disability from an Accident which has occurred prior to the Inception Date of this Policy.
b) Any Hospitalization for an Injury solely and directly due to an Accident where the treatment is undertaken by a family member in the form of self-medication or any other treatment that is not scientifically recognized.
c) Vaccination and inoculation of any kind unless forming part of Medically Necessary Treatment for Injury solely and directly due to an Accident and as prescribed by the Medical Practitioner.
d) Vitamins and tonics unless forming part of Medically Necessary Treatment for Injury solely and directly due to an Accident and as prescribed by the Medical Practitioner.
e) Aesthetic treatment, Cosmetic Surgery and plastic Surgery unless medically necessary and certified by the attending Medical Practitioner for reconstruction following an Accident.
f) Dental Treatment or Surgery of any kind unless medically necessary as a result of Injury to natural teeth as well as requiring Hospitalization due to an Accident.
g) Experimental, investigational or unproven treatment devices and pharmacological regimens.

I.14 Broken Bones Benefit

What is covered
If the Insured Person sustains broken bones of the nature as specified in the table below, solely and directly due to an Accident which occurs during the Policy Period, then We shall pay the percentage of the maximum limit as mentioned in the Policy Schedule /the Product Benefit Table for this cover. The percentage of limit as per the nature of the Injury are as specified in the table below.

Broken Bones resulting an Injury to	Percentage of the Broken Bone Cover limit payable
Vertebral body resulting in spinal cord damage	100%
Pelvis	100%
Skull (excluding nose and teeth)	30%
Chest (all ribs and breast bone)	50%
Shoulder (collar bone and shoulder blade)	30%
Arm	25%
Leg	25%
Vertebra – vertebral arch (excluding coccyx)	30%
Wrist (collies or similar Fractures)	10%
Ankle (Potts or similar Fracture)	10%
Coccyx	5%
Hand	3%
Finger	3%
Foot	3%
Toe	3%
Nasal bone	3%

For the purpose of this Benefit:
- Broken Bones means the breakage of one or more of bones of the Insured Person specified in the table above as evidenced by a Fracture but excluding any form of hair line Fracture.
- Pelvis means all pelvic bones which shall be treated as one bone. The sacrum shall be considered as part of the vertebral column.
- Skull means all skull and facial bones (excluding nasal bones and teeth) which shall be treated as one bone.

Conditions

a) If We have admitted a claim in accordance with this Benefit which results in 100% of the limit under this Benefit being paid, then cover under this Benefit shall immediately and automatically cease in respect of that Insured Person and shall not be available at the time of Renewal.
b) Our maximum liability under this Benefit is limited to the percentage of limit mentioned against this Benefit in the Policy Schedule /the Product Benefit Table, irrespective of the number of Fractures that an Insured Person sustains due to an Accident. If a claim in respect of any Fracture of a whole bone also encompasses some or all of its parts, Our liability to make payment shall be limited to the whole bone only and not for any of its parts.

What is not covered

a) Any Fracture which results due to any Illness or disease (including malignancy) or due to osteoporosis/ degeneration of bones shall not be payable under this Benefit.

I.15 Coma Benefit

What is covered

If the Insured Person suffers a coma solely and directly due to an Accident which occurs during the Policy Period, then We shall pay a lump sum amount equal to the limit as specified in the Policy Schedule / the Product Benefit Table in respect of that Insured Person.

Conditions

a) The condition of coma must be confirmed by a specialist Medical Practitioner in writing which includes:
   (i) no response to external stimuli continuously for at least 96 hours; and
   (ii) life support measures are necessary to sustain life.
b) If We have admitted a claim in accordance with this Benefit, then cover under this Benefit shall immediately and automatically cease in respect of that Insured Person and shall not be available at the time of Renewal.

What is not covered

a) We shall not pay for coma which results from alcohol/ drug abuse or due to an Illness.

I.16 Burn Benefit

What is covered

If the Insured Person sustains burns of the nature as specified in the table below solely and directly due to an Accident which occurs during the Policy Period, then We shall pay the percentage of the limit as specified in the Policy Schedule /the Product Benefit Table, and as per the table below:

Nature of Burns	Percentage of Limit for Burns Benefit payable
1. Head	
a. Third degree burns of 8% or more of the total head surface area	100%
b. Second degree burns of 8% or more of the total head surface area	50%
c. Third degree burns of 5% or more, but less than 8% of the total head surface area	80%
d. Second degree burns of 5% or more, but less than 8% of the total head surface area	40%
e. Third degree burns of 2% or more, but less than 5% of the total head surface area	60%
f. Second degree burns of 2% or more, but less than 5% of the total head surface area	30%
2. Rest of the body	
a. Third degree burns of 20% or more of the total body surface area	100%
b. Second degree burns of 20% or more of the total body surface area	50%
c. Third degree burns of 15% or more, but less than 20% of the total body surface area	80%
d. Second degree burns of 15% or more, but less than 20% of the total body surface area	40%
e. Third degree burns of 10% or more, but less than 15% of the total body surface area	60%
f. Second degree burns of 10% or more, but less than 15% of the total body surface area	30%
g. Third degree burns of 5% or more, but less than 10% of the total body surface area	20%
h. Second degree burns of 5% or more, but less than 10% of the total body surface area	10%

Conditions

a) If the Injury results in more than one of the nature of burns specified in the table above, We shall be liable to pay for only the highest Benefit among all.
b) If We have admitted a claim in accordance with this Benefit, which results in 100% of the limit under this Benefit being paid, then cover under this Benefit shall immediately and automatically cease in respect of that Insured Person and shall not be available at the time of Renewal.

I.17 Accidental Medical Expenses

What is covered

If We have accepted a claim under Section I.1 (Accidental Death Cover) or under Section I.2 (Permanent Total Disablement) or Section I.3 (Permanent Partial Disablement), or Section I.12 (Temporary Total Disablement), if opted, then in addition to the amount payable under that Section, We shall pay the Medical Expenses incurred by the Insured Person at a Hospital in India for OPD treatment for Injuries caused by such Accident.

Conditions
Our maximum liability under this Benefit shall be the lowest of the following:
- Actual Medical Expenses
- 10% of the amount payable as per Section I.1 (Accidental Death Cover) in case of death; or
- 40% of the amount payable as per Section I.2 (Permanent Total Disablement) in case of PTD; or
- 40% of the amount payable as per Section I.3 (Permanent Partial Disablement) in case of PPD; or
- 40% of the amount payable as per Section I.12 (Temporary Total Disablement), if opted in case of TTD; or
- Rs 50,000.

I.18 Adventure Sports Cover

What is covered
If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period whilst engaged in a sports activity carried out in accordance with the guidelines, codes of good practice and recommendations laid down by a governing body or authority in respect of that sport, and such Injury results in death or Permanent Total Disablement as per Section I.1 or I.2 respectively, then We shall pay a lump sum amount equal to the limit as specified in the Policy Schedule /the Product Benefit Table, in respect of that Insured Person.

Conditions
a) If We have admitted a claim in accordance with this Benefit, then cover under Section I shall be terminated and shall not be Renewed under this Policy.
b) Permanent Exclusion 16 under Section VI (iv) A shall not be applicable in respect of this Benefit.

I.19 Worldwide Emergency Assistance Services (including Air Ambulance)

What is covered
If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period requiring Emergency medical assistance, We shall provide the Emergency medical assistance as described below provided that the Insured Person is travelling 150 (one hundred and fifty) kilometres or more away from his/her residential address as mentioned in the Policy Schedule.

1) Emergency Medical Evacuation: When an adequate medical facility is not available in the proximity of the Insured Person, as determined by the Emergency service provider, the consulting Medical Practitioner and the Medical Practitioner attending to the Insured Person, transportation under appropriate medical supervision shall be arranged, through an appropriate mode of transport to the nearest medical facility which is able to provide the required care.

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

Conditions
a) No claims for reimbursement of expenses incurred for services arranged by Insured Person shall be allowed unless agreed by Us or Our authorized representative
b) 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 shall 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) International trips exceeding 90 days from residential address without prior notification to Us.

We shall 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 Illness which can be treated by a 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 shall not evacuate or repatriate a child born while the Insured Person was traveling beyond the 28th week.
(iv) With mental or nervous disorders unless Hospitalized.
(v) International trips exceeding 90 days from residential address without prior notification to Us.

I.20 EMI Protect

If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and If We have accepted a claim under Section I.1 (Accidental Death Cover) or Section I.2 (Permanent Total Disablement) or Section I.3 (Permanent Partial Disablement) where such Injury results in completely preventing the Insured Person from performing each and every duty pertaining to his/her employment or occupation for a minimum period of 1 month, then in addition to the amount payable under Section 1.1 or Section 1.2 or Section 1.3 and subject to all other terms, conditions and exclusions under this Policy, We shall pay the amount commensurate with the Insured Person's contribution in EMI of his/her loan account as specified in the Policy Schedule, subject to the maximum limit specified in the Policy Schedule/ the Product Benefit Table.

Conditions
a) Payments under this Benefit shall be subject to the Insured Person satisfying Us that the Permanent Total Disablement or Permanent Partial Disablement has completely prevented him/her from engaging in his/her occupation as mentioned in the Policy Schedule.

b) Payments under this Benefit shall stop when We are satisfied that the Insured Person can engage in his/her occupation again or when We have made payments for a maximum period of 3 months (3 EMIs) beginning from the date the Insured Person suffered the Injury solely and directly due to the Accident where total payment made does not exceed the maximum limit specified in the Policy Schedule/the Product Benefit Table, whichever is earlier.
c) The EMI amount payable under this Section shall not include any arrears due to any reasons whatsoever.

I.21 Loan Protect

If the Insured Person suffers an Injury solely and directly due to an Accident which occurs during the Policy Period and If We have accepted a claim under Section I.1 or under Section I.2, then in addition to the amount payable under that Section, We shall pay an amount commensurate with the balance outstanding loan amount of the Insured Person's loan account specified in the Policy Schedule as on the date of the Accident, subject to the maximum limit specified in the Policy Schedule/ the Product Benefit Table.

Conditions
a) The amount payable under this Section shall not include any arrears in the outstanding loan amount due to any reasons whatsoever.
b) The cover for the Insured Person under this Section shall terminate immediately in the event of admissible claim and settlement of Benefit under this cover.

II. Critical Illness Cover

Section II.A: Basic Covers

The Basic Covers below are in-built Benefits that are available for the Insured Persons under the Policy.

Benefits under this Section are subject to the terms, conditions and exclusions of this Policy. The Sum Insured for the Benefit shall be as specified in the Policy Schedule /the Product Benefit Table. Payment of the Benefit shall be subject to the availability of the Sum Insured for this Benefit.
All claims must be made in accordance with the procedure set out in Section VII

II.A.1 Critical Illness Cover

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

Conditions
(a) For Plan 1 and Plan 2:
- Maximum liability during the lifetime of the Insured Person: 100% of the Sum Insured.
- Cover Termination: Once a claim for a listed condition under either plan is admissible in respect of an Insured Person, no further Renewals shall be allowed for that Insured Person under this Benefit.

(b) For Plan 3:
- Maximum liability during the lifetime of the Insured Person: 100% of the Sum Insured for Critical Illness under List A plus 50% of the Sum Insured, maximum up to Rs. 10 Lacs for Critical Illness under List B.
- Cover Termination: Once a claim for any Critical Illness in List A is admissible in respect of an Insured Person. No further Renewals shall be allowed for that Insured Person under this Benefit. Cover shall continue even after a claim becomes admissible for any Critical Illness in List B.
- Maximum number of claims: One under List A and one under List B.
- A lump sum amount equal to 100% of the Sum Insured as mentioned in the Policy Schedule shall be payable for claim for condition under List A.
- A lump sum amount equal to 50% of Sum Insured as mentioned in the Policy Schedule or Rs. 10 Lacs, whichever is lower shall be payable for claim for condition under List B.
- If there is more than one condition diagnosed within a period of 48 hours, only one claim with the highest Benefit pay-out shall be admissible.
- Payment for condition under List A subsequent to claim for condition under List B shall be over and above the claim amount for condition under List B.
- Transition grid for various scenarios is as below:

Scenario	Event	Benefit Pay out as % of Sum Insured	Cover terminates
1	List B Critical Illness	50% or Rs. 10 Lacs, whichever is lower	No
	List A Critical Illness	100%	Yes
2	List A Critical Illness	100%	Yes

(C) List & Definition of Critical Illnesses as applicable for Plan1, Plan2 and Plan3:

	Name of Critical Illness	Payout as a % of S.I.in Plan 1	Payout as a % of S.I.in Plan 2	Payout as a % of S.I.in Plan 3
1	Cancer of Specified Severity	100%	100%	List A
2	Myocardial Infarction (First Heart Attack of specific severity)	100%	100%	List A
3	Open Chest CABG	100%	100%	List A
4	Open Heart Replacement Or Repair Of Heart Valves	100%	100%	List A
5	Kidney Failure Requiring Regular Dialysis	100%	100%	List A

6	Stroke Resulting In Permanent Symptoms	100%	100%	List A
7	Major Organ / Bone Marrow Transplant	100%	100%	List A
8	Permanent Paralysis Of Limbs	100%	100%	List A
9	Multiple Sclerosis With Persisting Symptoms	100%	100%	List A
10	Coma of Specified Severity	100%	100%	List A
11	Motor Neuron Disease With Permanent Symptoms	100%	100%	List A
12	Third Degree Burns	100%	100%	List A
13	Deafness	100%	100%	List A
14	Loss of Speech	100%	100%	List A
15	Aplastic Anaemia	100%	100%	List A
16	End Stage Liver Failure	100%	100%	List A
17	End Stage Lung Failure	100%	100%	List A
18	Bacterial Meningitis	100%	100%	List A
19	Fulminant Hepatitis	100%	100%	List A
20	Muscular Dystrophy	100%	100%	List A
21	Parkinson's disease	Not Covered	100%	List A
22	Benign Brain Tumor	Not Covered	100%	List A
23	Alzheimer's Disease	Not Covered	100%	List A
24	Aorta Graft Surgery	Not Covered	100%	List A
25	Loss of Limbs	Not Covered	100%	List A
26	Blindness	Not Covered	100%	List A
27	Primary (Idiopathic) Pulmonary Hypertension	Not Covered	100%	List A
28	Apallic Syndrome or Persistent Vegetative State (PVS)	Not Covered	100%	List A
29	Encephalitis	Not Covered	100%	List A
30	Chronic Relapsing Pancreatitis	Not Covered	100%	List A
31	Major Head Trauma	Not Covered	100%	List A
32	Medullary Cystic Disease	Not Covered	100%	List A
33	Poliomyelitis	Not Covered	100%	List A
34	Systemic Lupus Erythematous	Not Covered	100%	List A
35	Brain Surgery	Not Covered	100%	List A
36	Severe Rheumatoid Arthritis	Not Covered	100%	List A
37	Creutzfeldt-Jakob disease	Not Covered	100%	List A
38	Hemiplegia	Not Covered	100%	List A
39	Tuberculosis Meningitis	Not Covered	100%	List A
40	Dissecting Aortic aneurysm	Not Covered	100%	List A
41	Progressive Supranuclear Palsy – resulting in permanent symptoms	Not Covered	100%	List A
42	Myasthenia Gravis	Not Covered	100%	List A
43	Infective Endocarditis	Not Covered	100%	List A
44	Pheochromocytoma	Not Covered	100%	List A
45	Eisenmenger's Syndrome	Not Covered	100%	List A
46	Chronic Adrenal Insufficiency	Not Covered	100%	List A
47	Progressive Scleroderma	Not Covered	100%	List A
48	Elephantiasis	Not Covered	100%	List A
49	Cardiomyopathy – of specified severity	Not Covered	100%	List A

50	Myelofibrosis	Not Covered	100%	List A
51	Angioplasty	Not Covered	Not Covered	List B
52	Pericardectomy	Not Covered	Not Covered	List B
53	Ovarian tumour of borderline malignancy/low malignant potential – with surgical removal of an ovary	Not Covered	Not Covered	List B
54	Keyhole Coronary Surgery	Not Covered	Not Covered	List B
55	Severe Crohn's disease – surgically treated	Not Covered	Not Covered	List B
56	Cardiac Defibrillator insertion or Cardiac Pacemaker insertion	Not Covered	Not Covered	List B
57	Carcinoma in-situ of the cervix uteri – requiring treatment with hysterectomy	Not Covered	Not Covered	List B
58	Carcinoma in-situ of the urinary bladder	Not Covered	Not Covered	List B
59	Carotid Artery Surgery	Not Covered	Not Covered	List B
60	Ductal or Lobular carcinoma in-situ of the breast – with specified treatment	Not Covered	Not Covered	List B
61	Small Bowel Transplant	Not Covered	Not Covered	List B
62	Severe ulcerative colitis – with operation to remove the entire large bowel	Not Covered	Not Covered	List B
63	Testicular carcinoma in situ – requiring surgery to remove at least one testicle	Not Covered	Not Covered	List B
64	Surgical removal of an eyeball	Not Covered	Not Covered	List B

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;
   ix. All tumours in the presence of HIV infection.

2. Myocardial Infarction

(First Heart Attack of specific severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
   I. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
   ii. New characteristic electrocardiogram changes
   iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

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. Other causes of neurological damage such as SLE and HIV are 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 90decibels 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.

II. All psychiatric related causes are excluded.

15. Aplastic Anaemia

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

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

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

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

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

16. 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.

17. 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.

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

21. Parkinson's disease

The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist acceptable to us.
The diagnosis must be supported by all of the following conditions:
a. the disease cannot be controlled with medication;
b. signs of progressive impairment; and
c. inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

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

22. Benign Brain Tumor

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.
II. This brain tumor must result in at least one of the following and must be confirmed by the relevant specialist Medical Practitioner.
   I. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
   ii. Undergone surgical resection or radiation therapy to treat the brain tumor.
III. The following conditions are excluded:
   Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

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

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

The following conditions are however not covered:
a. non-organic diseases such as neurosis and psychiatric Illnesses;
b. alcohol related brain damage; and
c. any other type of irreversible organic disorder/dementia.

24. Aorta Graft Surgery
The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.
The Insured Person understands and agrees that we shall not cover:
a. Surgery performed using only minimally invasive or intra-arterial techniques.
b. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.
The aorta is the main artery carrying blood from the heart. Aortic graft surgery benefit covers Surgery to the aorta wherein part of it is removed and replaced with a graft.

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

26. Blindness
I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.
II. The Blindness is evidenced by
    I. corrected visual acuity being 3/60 or less in both eyes or;
    ii. the field of vision being less than 10 degrees in both eyes.
III. The diagnosis of blindness must be confirmed and must not be correctable by aides or surgical procedure.

27. Primary (Idiopathic) Pulmonary Hypertension
I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.
II. The NYHA Classification of Cardiac Impairment are as follows:
    I. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
    ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.
III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

28. Apallic Syndrome or Persistent Vegetative State (PVS)
Apallic Syndrome or Persistent vegetative state (PVS) or unresponsive wakefulness syndrome (UWS) is a universal necrosis of the brain cortex with the brainstem remaining intact. The patient should be in a vegetative state for a minimum of four weeks in order to be classified as UWS, PVS, Apallic Syndrome.
The diagnosis must be confirmed by a Neurologist acceptable to Us and the condition must be documented for at least one month.
In this condition, the patient with severe brain damage progresses who was in coma, progresses to a wakeful conscious state, but not in a state of true awareness.

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

The permanent deficit should result in permanent inability to perform three or more Activities for Loss of Independent Living.
Exclusions:
Encephalitis in the presence of HIV infection is excluded.

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

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

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

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

IV. The following are excluded:
   I. Spinal cord injury;

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

33. Poliomyelitis
The unequivocal diagnosis of infection with the polio virus must be established by a Consultant Neurologist. The infection must result in irreversible paralysis as evidenced by impaired motor function or respiratory weakness. Expected permanence and irreversibility of the paralysis must be confirmed by a Consultant Neurologist after at least 6 months since the beginning of the event.
Exclusions:
- Cases not involving irreversible paralysis shall not be eligible for a claim
- Other causes of paralysis such as Guillain-Barré Syndrome are specifically excluded.

34. Systemic Lupus Erythematous
A multi-system, multifactorial, autoimmune disorder characterised by the development of auto- antibodies directed against various self-antigens. Systemic lupus erythe-matosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V lupus nephritis, established by renal biopsy, and in accordance with the World Health Organization (WHO) classification). The final diagnosis must be confirmed by a registered Medical Practitioner specialising in Rheumatology and Immunology acceptable to Us, Other forms, discoid lupus, and those forms with only haematological and joint involvement are however not covered:
The WHO lupus classification is as follows:
a. Class I: Minimal change – Negative, normal urine.
b. Class II: Mesangial – Moderate proteinuria, active sediment.
c. Class III: Focal Segmental – Proteinuria, active sediment.
d. Class IV: Diffuse – Acute nephritis with active sediment and/or nephritic syndrome.
e. Class V: Membranous – Nephrotic Syndrome or severe proteinuria.

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

36. Severe Rheumatoid Arthritis
Unequivocal Diagnosis of systemic immune disorder of rheumatoid arthritis where all of the following criteria are met:
- Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis;
- Permanent inability to perform at least two (2) "Activities of Daily Living";
- Widespread joint destruction and major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet; and
- The foregoing conditions have been present for at least six (6) months.
- Elevated levels of Creactive protein (CRP), or erythrocyte sedimentation rate (ESR)

37. Creutzfeldt-Jacob disease
Creutzfeldt-Jacob disease is an incurable brain infection that causes rapidly progressive deterioration of mental function and movement. A registered doctor who is a neurologist must make a definite diagnosis of CreutzfeldtJacob disease based on clinical assessment, EEG and imaging. There must be objective neurological abnormalities on exam along with severe progressive dementia.

38. Hemiplegia
The total and permanent loss of the use of one side of the body through paralysis caused by Illness or Injury, except when such Injury is self-inflicted.

39. Tuberculosis Meningitis
Meningitis caused by tubercle bacilli. Such a diagnosis must be supported by 1) and 2) and 3)
1) Findings in the cerebrospinal fluid (csf) report
2) Presence of acid fast bacilli in the cerebrospinal fluid or growth of M. Tuberculosis demonstrated in the culture report or Nucleic acid amplification tests like PCR
3) Certification by a registered doctor who is a specialist in neurology, or a physician with a degree of MD

40. Dissecting Aortic aneurysm
A condition where the inner lining of the aorta (intima layer) is interrupted so that blood enters the wall of the aorta and separates its layers. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The diagnosis must be made by a registered Medical Practitioner who is a specialist with computed tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiograph (MRA) or angiogram. Emergency surgical repair is required.

41. Progressive Supranuclear Palsy
Confirmed by a registered doctor who is a specialist in neurology of a definite diagnosis of progressive supranuclear palsy. There must be permanent clinical impairment of motor function, eye movement disorder and postural instability for a minimum period of 30 days

42. Myasthenia Gravis
An acquired autoimmune disorder of neuromuscular transmission leading to fluctuating muscle weakness and fatigability, where all of the following criteria are met:
- Presence of permanent muscle weakness categorized as Class IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification below; and
- The Diagnosis of Myasthenia Gravis and categorization are confirmed by a registered Medical Practitioner who is a neurologist.

Myasthenia Gravis Foundation of America Clinical Classification:
Class I: Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere.
Class II: Eye muscle weakness of any severity, mild weakness of other muscles.
Class III: Eye muscle weakness of any severity, moderate weakness of other muscles.
Class IV: Eye muscle weakness of any severity, severe weakness of other muscles.
Class V: Intubation needed to maintain airway.

43. Infective Endocarditis
Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:
- Positive result of the blood culture proving presence of the infectious organism(s);
- Presence of at least moderate heart valve incompetence (meaning regurgitant fraction of 20% or above) or moderate heart valve stenosis (resulting in heart valve area of 30% or less of normal value) attributable to Infective Endocarditis; and
- The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a registered Medical Practitioner who is a cardiologist

44. Pheochromocytoma
Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines requiring the actual undergoing of surgery to remove the tumour.
The Diagnosis of Pheochromocytoma must be supported by plasma metanephrine levels and / or urine catecholamines and metanephrines and confirmed by a registered doctor who is an endocrinologist.

45. Eisenmenger's Syndrome
Development of severe pulmonary hypertension and shunt reversal resulting from heart condition. The diagnosis must be made by a registered Medical Practitioner who is a specialist with echocardiography and cardiac catheterisation and supported by the following criteria:
- Mean pulmonary artery pressure > 40 mm Hg;
- Pulmonary vascular resistance > 3mm/L/min (Wood units); and
- Normal pulmonary wedge pressure < 15 mm Hg

46. Chronic Adrenal Insufficiency
An autoimmune disorder causing a gradual destruction of the adrenal gland resulting in the need for life long glucocorticoid and mineral corticoid replacement therapy. The disorder must be confirmed by a registered Medical Practitioner who is a specialist in endocrinology through one of the following:
- ACTH simulation tests;
- insulin-induced hypoglycemia test;
- plasma ACTH level measurement;
- Plasma Renin Activity (PRA) level measurement.

Only autoimmune cause of primary adrenal insufficiency is included. All other causes of adrenal insufficiency are excluded.

47. Progressive Scleroderma
A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.
The following conditions are excluded:
- Localised scleroderma (linear scleroderma or morphea);
- Eosinophilicfascitis; and
- CREST syndrome

48. Elephantiasis
Massive swelling in the tissues of the body as a result of destroyed regional lymphatic circulation by chronic filariasis infection. The unequivocal diagnosis of elephantiasis must be confirmed by a registered Medical Practitioner who is a specialist physician. There must be clinical evidence of permanent massive swelling of legs, arms, scrotum, vulva, or breasts. There must also be laboratory confirmation of microfilariae infection. Swelling or lymphedema caused by infection with a sexually transmitted disease, trauma, post-operative scarring, congestive heart failure, or congenital lymphatic system abnormalities is excluded.

49. Cardiomyopathy of specified severity
An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association Classification Class III or Class IV, or its equivalent, based on the following classification criteria:
Class III - Marked functional limitation. Affected patients are comfortable at rest but performing activities involving less than ordinary exertion will lead to symptoms of congestive cardiac failure.
Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance.
Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

50. Myelofibrosis
A disorder which can cause fibrous tissue to replace the normal bone marrow and results in anaemia, low levels of white blood cells and platelets and enlargement of the spleen. The condition must have progressed to the point that it is permanent and the severity is such that the Insured Person requires a blood transfusion at least monthly. The diagnosis of myelofibrosis must be supported by bone marrow biopsy and confirmed by a registered Medical Practitioner who is a specialist.

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

52. Pericardectomy
The undergoing of a pericardectomy as a result of pericardial disease or undergoing of any Surgical Procedure requiring keyhole cardiac surgery. Both these Surgical Procedures must be certified to be absolutely necessary by a specialist in the relevant field.

53. Ovarian tumour of borderline malignancy/low malignant potential – with surgical removal of an ovary
An ovarian tumour of borderline malignancy / low malignant potential that has been positively diagnosed with histological confirmation and has resulted in surgical removal of an ovary.
For this definition the following are not covered:
Removal of an ovary due to a cyst.

54. Keyhole Coronary Surgery
The undergoing for the first time for the correction of the narrowing or blockage of one or more major coronary arteries with bypass grafts via "Keyhole" surgery. All intra-arterial catheter based techniques are excluded from this benefit. The Surgery must be considered medically necessary by a consultant cardiologist. Major coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

55. Severe Crohn's disease- surgically treated
Crohn's Disease is a chronic, transmural inflammatory disorder of the bowel. To be considered as severe, there must be evidence of continued inflammation in spite of optimal therapy, with all of the following having occurred:
- Stricture formation causing intestinal obstruction requiring admission to Hospital, and
- Fistula formation between loops of bowel, and
- At least one bowel segment resection.

The diagnosis must be made by a registered Medical Practitioner who is a specialist Gastroenterologist and be proven histologically on a pathology report and/or the results of sigmoidoscopy or colonoscopy.

56. Cardiac Defibrillator insertion or Cardiac Pacemaker insertion
I. Insertion of a permanent cardiac pacemaker that is required as a result of serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be absolutely necessary by a specialist in the relevant field; or
II. Insertion of a permanent cardiac defibrillator as a result of cardiac arrhythmia which cannot be treated via any other method. The Surgical Procedure must be certified to be absolutely necessary by a specialist in the relevant field. Documentary evidence of ventricular tachycardia or fibrillation must be provided.

57. Carcinoma in-situ of the cervix uteri – requiring treatment with hysterectomy
Carcinoma in-situ of the cervix uteri (cervix) that requires treatment with hysterectomy.
The hysterectomy must have been performed on the advice of a specialist to treat carcinoma in-situ of the cervix.
The following are excluded:
a) All grades of dysplasia
b) Cervical squamous epithelial lesion (SIL) and Cervical intra-epithelial neoplasia (CIN), unless carcinoma in-situ is present
c) Carcinoma in-situ of any other gynaecological organ (for example the ovary, or the fallopian tube)
d) Any other disease or disorder of the cervix or other gynaecological organs that is treated with hysterectomy.

58. Carcinoma in-situ of the urinary bladder
Carcinoma in-situ of the urinary bladder that has been histologically confirmed on a pathology report.
The following conditions are not covered:
a) Non-invasive papillary carcinoma
b) Stage Ta bladder carcinoma
c) All other forms of non-invasive carcinoma

59. Carotid Artery Surgery
The undergoing of carotid artery endarterectomy or carotid artery stenting of symptomatic stenosis of the carotid artery. The procedure must be considered necessary by a qualified specialist which has been necessitated as a result of an experience of Transient Ischaemic Attacks (TIA). Endarterectomy of blood vessels other than the carotid artery is specifically excluded.

60. Ductal or Lobular carcinoma in-situ of the breast – with specified treatment
Diagnosis of ductal or lobular carcinoma in-situ of the breast, that is histologically confirmed, and results in undergoing surgical removal on the advice of the Medical Practitioner.

61. Small Bowel Transplant
The receipt of a transplant of small bowel with its own blood supply via a laparatomy resulting from intestinal failure.

62. Severe ulcerative colitis – with operation to remove the entire large bowel
Acute fulminant ulcerative colitis with life threatening electrolyte disturbances.
All of the following criteria must be met:
- the entire colon is affected, with severe bloody diarrhoea; and
- the necessary treatment is total colectomy and ileostomy; and
- the diagnosis must be based on histopathological features and confirmed by a registered Medical Practitioner who is a specialist in gastroenterology

63. Testicular carcinoma in situ – requiring Surgery to remove at least one testicle
Diagnosis of, and having specified treatment of carcinoma in-situ of the testicle (also known as intratubular germ cell neoplasia unclassified or ITGCNU), histologically confirmed by biopsy, and as a result treated with orchidectomy (complete surgical removal of the testicle).

64. Surgical removal of an eyeball
Surgical removal of an eyeball as a result of Injury or disease.
For the above definition, the following is not covered:
- Self-inflicted Injuries

(d) Survival Period:
The payment of a Benefit under Section II.A.1 shall be subject to survival of the Insured Person for the number of days as specified in Policy Schedule/ the Product Benefit Table following the first diagnosis of the Critical Illness/undergoing the Surgical Procedure for the first time.

Section II.B: Optional Covers
The following additional cover shall apply only if the premium in respect of the additional cover has been received and the Policy Schedule states that the additional cover is in force and is available for the Insured Persons under the Policy.

Benefits under this Section II.B are subject to the terms, conditions and exclusions of this Policy.

II.B.1 Second E Opinion

What is covered
If the Insured Person is diagnosed with a Critical Illness during the Policy Period, the Insured Person may at his/her sole discretion choose to avail a second E-opinion from Our panel of Medical Practitioners for the Critical Illness and We shall arrange for and cover the second E- opinion.

Conditions
a) This Benefit can be availed by the Insured Person only once in the Policy Period for the same Critical Illness.
b) The second E-opinion shall be based only on the information and documentation provided to Us.
c) Under this Benefit, We are only providing the Insured Person with access to an E-opinion and We shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.
d) 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. Costs under this Benefit shall not be available on a reimbursement basis

III. Cancer Secure Cover

Section III.A: Basic Covers

The Basic Covers below are in-built Benefits that are available for the Insured Persons under the Policy.

Benefits under this Section are subject to the terms, conditions and exclusions of this Policy. The Sum Insured for the Benefit shall be as specified in the Policy Schedule /the Product Benefit Table. Payment of the Benefit shall be subject to the availability of the Sum Insured for this Benefit.
All claims must be made in accordance with the procedure set out in Section VII

III.A.1 Cancer Secure Plan

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

Conditions
(a) For Cancer Secure plan
- Maximum liability during the lifetime of the Insured Person: 150% of the Sum Insured as specified in the Policy Schedule.
- Cover Termination: Once a claim for major or Advanced stage of Cancer becomes admissible, coverage under Section III shall terminate.
- Maximum number of claims: One under Early Stage Cancer and/or one under Major or Advanced Stage.
- For any of the specified Early Stage Cancer Condition or Carcinoma-in-situ (CIS) 50% of the Sum Insured as specified in the Policy Schedule or Rs. 10 Lacs, whichever is lower shall be payable only once and only for the first event of early stage/CIS cancer.
- For specified Major Stage Cancer, 100% of the Sum Insured as specified in the Policy Schedule shall be payable. Once a claim for Major stage becomes admissible, this cover shall terminate.
- For specified Advanced Stage Cancer, 150% of the Sum Insured as specified in the Policy Schedule shall be payable. Once the Advanced stage becomes admissible, this cover shall terminate.
- Payment for Major or Advanced Stage Cancer subsequent to Early Stage Cancer shall be over and above the claim amount for Early Stage Cancer, subject to maximum liability during the lifetime of the Insured Person.
- If there is more than one condition diagnosed within a period of 48 hours, only one claim, with the highest Benefit pay-out shall be admissible.
- Transition grid for various scenarios is as below:

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

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

Early Stage:
This shall include the following:
1. Carcinoma in situ of the following sites: breast, uterus, ovary, fallopian tube, vulva, vagina, cervix uteri, colon, rectum, penis, testis, lung, liver, stomach, nasopharynx or bladder. Carcinoma in situ means the focal autonomous new growth of carcinomatous cells confined to the cells in which it originated and has not yet resulted in the invasion and/or destruction of surrounding tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The diagnosis of the Carcinoma in situ must always be supported by a histopathological report. Furthermore, the diagnosis of Carcinoma in situ must always be positively diagnosed upon the basis of a microscopic examination of the fixed tissue, supported by a biopsy result. Clinical diagnosis does not meet this standard. Clinical diagnosis or Cervical Intraepithelial Neoplasia (CIN) classification which reports CIN I, CIN II, and CIN III (severe dysplasia without carcinoma in situ) does not meet the required definition and are specifically excluded. Carcinoma in situ of the biliary system is also specifically excluded.
2. Prostate Cancer that is histologically described using the TNM Classification as T1N0M0 or Prostate cancers described using another equivalent classification. Thyroid Cancer that is histologically described using the TNM Classification as T1N0M0. Tumours of the Urinary Bladder histologically classified as T1N0M0 (TNM Classification). Chronic Lymphocytic Leukaemia (CLL) RAI Stage 1 or 2. CLL RAI Stage 0 or lower is excluded. Malignant melanoma that has not caused invasion beyond the epidermis. Other skin carcinoma are excluded.

Major Stage (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 & CIN-3.
   ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
   iii. Malignant melanoma that has not caused invasion beyond the epidermis;
   iv. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
   v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
   vi. Chronic lymphocytic leukaemia less than RAI stage 3
   vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
   viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
   ix. All tumours in the presence of HIV infection.

Advanced Stage (Metastatic Cancer):
All Stage IV malignant tumor with the presence of distant metastasis. A spread to lymph nodes only is not covered under this definition. The diagnosis of malignancy must be confirmed by histological evidence.
Metastatic cancer is a cancer that has spread from the part of the body where it started (the primary site) to other parts of the body. When cancer cells break away from a tumour, they can travel to other areas of the body through the bloodstream, the lymph system (which contains a collection of vessels that carry fluid and immune system cells) or through the peritoneum
Following is excluded:
I. All tumours in presence of HIV infection
ii. Locally advanced cancers (these will be considered as Early Stage/ Stage II Major for the purpose of this policy)
iii. Any leukaemia and lymphoma (these will be considered as Stage II Major for the purpose of this policy)

(b) Survival Period:
The payment of a Benefit under Section III.A shall be subject to survival of the Insured Person for the number of days as specified in Policy Schedule/ the Product Benefit Table following the first diagnosis of the Critical Illness/undergoing the Surgical Procedure for the first time.

(c) Cancer Cumulative Bonus

What is covered
If the Insured Person has not made any claim under Section III.A.1 in a Policy Year, then We shall apply a Cancer Cumulative Bonus of 10% on the Sum Insured as specified for Section III in the Policy Schedule for that Insured Person. The maximum Cancer Cumulative Bonus shall not exceed 100% of the Sum Insured as specified for Section III in the Policy Schedule for that Insured Person. This accrued Cancer Cumulative Bonus shall be available for any claim under Section III of this Policy.
If a Cancer Cumulative Bonus is applied and a claim is made, then at the time of Renewal, the accrued Cancer Cumulative Bonus shall be reduced by 10% of the Sum Insured as specified for Section III in the Policy Schedule for that Insured Person.

Conditions
a) Cancer Cumulative Bonus shall not accrue if the Policy is not Renewed with Us by the end of the Grace Period.
b) If the Policy Period is for either two years or for three years, then any Cancer Cumulative Bonus that has accrued for the first Policy Year or the second Policy Year as the case may be shall be credited at the end of the first Policy Year or the second Policy Year as the case may be and shall be available for any claims made in the subsequent Policy Year.
c) If the Sum Insured under the Policy has been increased at the time of Renewal, then the Cancer Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
d) The Cancer Cumulative Bonus is subject to revision in case a claim is being reported under the expiring Policy Year.

Section III.B: Optional Covers
The following additional covers shall apply only if the premium in respect of the additional cover has been received and the Policy Schedule states that the additional cover is in force and is available for the Insured Persons under the Policy.

Benefits under this Section III.B are subject to the terms, conditions and exclusions of this Policy.

III.B.1 Second E Opinion

What is covered
If the Insured Person is diagnosed with Cancer of Specified Severity or Metastatic Cancer during the Policy Period, the Insured Person may at his/her sole discretion choose to avail a second E-opinion from Our panel of Medical Practitioners for the Critical Illness of the nature specified herein and We shall arrange for and cover the second E- opinion.

Conditions
e) This Benefit can be availed by the Insured Person only once in the Policy Period.
f) The second E-opinion shall be based only on the information and documentation provided to Us.
g) Under this Benefit, We are only providing the Insured Person with access to an E-opinion and We shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.
h) 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. Costs under this Benefit shall not be available on a reimbursement basis

IV. Hospital Cash Cover
Benefits under this Section are subject to the terms, conditions and exclusions of this Policy. The sub-limit for each Benefit under this Section is specified against that Benefit in the Policy Schedule. Payment of the Benefit shall be subject to the availability of the applicable sub-limit for that Benefit.
Benefits shall be applicable on an Individual basis. The limit per Policy Year specified in the Policy Schedule for the Insured Person shall be Our maximum, total and cumulative liability for the number of days of Hospitalization for any and all claims arising under this Benefit in respect of that Insured Person.

All claims under this Section must be made in accordance with the procedure set out in Section VII

IV.1 Hospital Cash Plan

What is covered
If the Insured Person is Hospitalized in India during the Policy Period for Medically Necessary Treatment of an Illness or Injury which occurs during the Policy Period, We shall pay the Daily Cash Benefit specified in the Policy Schedule for each continuous and completed period of 24 hours of Hospitalization.

Conditions
(a) A Deductible of one day shall be applicable for each claim.
(b) Total number of days for this Benefit, including the days for which claim is payable as per Section IV.2, shall not exceed as specified in the Policy Schedule / the Product Benefit Table.

What is not covered
No Day Care Treatment shall be covered under this Benefit.

IV.2 Double Benefit Cover

What is covered
For one or more of the following conditions that occur during the Policy Period, We shall pay 2 times the Daily Cash Benefit specified in the Policy Schedule for each continuous and completed period of 24 hours of Hospitalization. This Benefit shall be available for maximum 10 days per Policy Year. This limit for number of days is included within the per Policy Year Limit as specified in the Policy Schedule.

a) ICU Hospitalization Days: If the Insured Person is Hospitalized in an Intensive Care Unit (ICU) during the Policy Period for Medically Necessary Treatment of an Illness or an Injury that occurred during the Policy Period. The double benefit shall be paid only for the days the Insured person is Hospitalized in ICU and not for the complete stay in the Hospital.

b) Hospitalization due to Road Traffic Accident: If the Insured Person is Hospitalized due to an Injury that occurred due to a road traffic Accident during the Policy Period.

Conditions
(a) A Deductible of one day shall be applicable for each claim. If one Hospitalization event also consists of days of Hospitalization in the ICU, then the first day shall be considered for Deductible, irrespective of whether it is a day of Hospitalization in the ICU or not.
(b) The Hospitalization must be for Medically Necessary Treatment of an Illness, or Injury that occurred during the Policy Period.
(c) For any given day of Hospitalization, if the Benefit is payable under Section IV.2, then there shall be no additional payment under Section IV.1.
(d) If Hospitalization for the above health conditions as mentioned in IV.2 a) or b) continues beyond the limit of 10 days as defined for this cover, then for days beyond this limit, Benefit shall be payable as per Section IV.1.

IV.3 Convalescence Benefit

What is covered
If the Insured Person is Hospitalized in India during the Policy Period and if We have paid a claim for 7 days or more under Section IV.1 or IV.2 then, We shall additionally pay a lump sum amount equal to the Daily Cash Benefit as specified in the Policy Schedule towards convalescence.

Conditions
(a) This Benefit is payable only once per Policy Year.
(b) Claim is admissible under Sections IV.1 and/or IV.2 for 7 days or more

IV.4 Parental Accommodation Benefit

What is covered
If the Insured Person Aged 12 years or less is Hospitalized in India during the Policy Period and if We have paid a claim for 3 days or more under Section IV.1 or IV.2, then We shall additionally pay a lump sum amount equal to the Daily Cash Benefit as specified in the Policy Schedule towards accommodation expenses of the parent(s) of the said Insured Person.

Conditions
(a) This Benefit is payable only once per child who is an Insured Person under this Policy per Policy Year.
(b) Claim is admissible under Sections IV.1 and/or IV.2 for 3 days or more

IV.4 Parental Accommodation Benefit

What is covered
If the Insured Person Aged 12 years or less is Hospitalized in India during the Policy Period and if We have paid a claim for 3 days or more under Section IV.1 or IV.2, then We shall additionally pay a lump sum amount equal to the Daily Cash Benefit as specified in the Policy Schedule towards accommodation expenses of the parent(s) of the said Insured Person.

Conditions
(a) This Benefit is payable only once per child who is an Insured Person under this Policy per Policy Year.
(b) Claim is admissible under Sections IV.1 and/or IV.2 for 3 days or more

V. Optional Cover
The following additional cover shall apply only if the premium in respect of the additional cover has been received and the Policy Schedule states that the additional cover is in force and is available for the Insured Persons under the Policy.
Benefits under this Section V are subject to the terms, conditions and exclusions of this Policy.

V.1 Wellness Coach

What is covered
In order to educate, empower and engage Insured Persons to become more aware of their health and proactively manage it, each Insured Person shall have access to wellness coaching in areas such as:
(i) Weight management
(ii) and fitness
(iii) Nutrition
(iv) Tobacco cessation

Conditions
(a) These coaches shall be available as a chat service on Our mobile application and website or as a call back service.
(b) It is agreed and understood that Our wellness 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.

Doctor on call
Upon the Insured Person's request, We shall also provide access to a general Medical Practitioner, available as a chat service on Our mobile application and website or as a call back service.
We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this Benefit.

Section VI. Waiting periods and Permanent Exclusions

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

i. Initial waiting period
For Section I Personal Accident Cover, no initial waiting period is applicable.

For Section II 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 the following number of days from the Inception Date of cover.

(a) Plan 1 and Plan 2: 90 days
(b) Plan 3:
- For conditions listed as List A: 90 days
- For conditions listed as List B: 180 days

For Section III Cancer Secure Cover, We shall not be liable to make any payment in respect of any Critical Illness of the nature specified in Section III.A.1 whose signs or symptoms first occur within the following number of days from the Inception Date of cover.

(a) Cancer Secure plan:
- For Major and Advanced Stage Cancer: 90 days
- For Early Stage Cancer: 180 days

For Section IV, Hospital Cash Cover, We shall not be liable to make any payment for Hospitalization undertaken during the first 30 days from the Inception Date, unless the same is required as a result of an Accident that occurs during the Policy Period.

For Section V Optional Cover, no initial waiting period is applicable.

ii. Two Year waiting periods (applicable only for Section IV)
A waiting period of 24 months from the Inception Date of cover shall apply for Benefit under Section IV (Hospital Cash Cover) for Hospitalization, whether treatment is medical or surgical and is for the Illnesses/conditions and their complications mentioned below:

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

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

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 as described in Section VI. iii below.

iii. Pre-Existing Disease waiting Period (Applicable for Section II, III and Section IV)
All Pre-Existing Diseases, that have been declared by You or detected at the time of pre- policy medical tests and accepted by Us at the time of inception of this Policy, shall be covered only after a period of 48 months have elapsed since the Inception Date or after a period as specified in the Policy Schedule.

iv. Permanent Exclusions:

A. Permanent Exclusions specific to Section I (Personal Accident Cover)
We shall not be liable to make any payment for any claim under any Benefit under Section I 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 maximum liability in that period would exceed the Sum Insured. This would not apply to payments made under the Optional Covers under Section I.B.
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. Congenital Anomaly whether Internal Congenital Anomaly or External Congenital Anomaly, congenital internal or external diseases, defects or 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, Acquired Immune Deficiency Syndrome (AIDS) whether or not arising out of HIV, AIDS related complex syndrome (ARCS) and any Injury caused by and/or related to HIV.
12. Any change of profession after Inception 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. Insured Persons whilst 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. Insured Persons involved 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 benefit under this cover 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 B and as also provided on Our website adityabirlahealth.com/healthinsurance

B. Permanent Exclusions Specific to Section II and III (Critical Illness Cover and Cancer Secure Cover)

We shall not be liable to make any payment under Section II and III 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, Acquired Immune Deficiency Syndrome (AIDS) whether or not arising out of HIV, AIDS related complex syndrome (ARCS) and all diseases/Illness/Injury caused by and/or related to HIV.
3. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilus, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, whether or not arising out of conditions listed under 3 above.
4. Any condition arising out of use, abuse or consequence or influence of any substance, intoxicant, drug, alcohol or hallucinogen.
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. Congenital external diseases, defects or anomalies of the Insured Person.
11. Insured Persons whilst 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, or involving a naval, military or air force operation.
12. Participation by 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.
13. 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 any diagnosis or treatment that is not scientifically recognized or Unproven/Experimental treatment, or is not Medically Necessary Treatment or any kind of self-medication and its complications.
14. Any treatment/Surgery for change of sex, Cosmetic Surgery or plastic Surgery or any elective Surgery or cosmetic procedure that improves physical appearance, surgical and non-surgical treatment of obesity, including morbid obesity (unless certified to be life threatening) and weight control programs, or treatment of an optional nature including complications/Illness arising as a consequence thereof.
15. Any Critical Illness arising out of or resulting from the Insured Person committing any breach of law or participating in an actual or attempted felony, riot, crime, misdemeanor or civil commotion with criminal intent.
16. In the event of the death of the Insured Person within the stipulated survival period as set out above.
17. Birth control procedures and hormone replacement therapy.
18. Any mental Illness, psychiatric or psychological disorders.
19. Any treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including Caesarian section), abortion or complications of any of these. This exclusion shall not apply to ectopic pregnancy.

C. Permanent Exclusions Specific to Section IV (Hospital Cash Cover)

We shall not be liable to make any payment under Section IV of this Policy in respect of any Hospitalization, directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following or as specified in the Policy Schedule:

1. Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, uprising, revolution, insurrection, military or usurped acts, nuclear weapons / materials, chemical and biological weapons, ionizing radiation, contamination by radioactive material or radiation of any kind, nuclear fuel, nuclear waste.
2. An Insured Person committing or attempting to commit a breach of law with criminal intent, intentional self- Injury or attempted suicide whether the Insured Person is medically sane or insane.
3. Wilful or deliberate exposure to danger, intentional self- Injury, non-adherence to Medical Advice, participation or involvement in naval, military or air force operation, circus personnel, racing in wheels or horseback, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing, bungee jumping, parasailing, ballooning, skydiving, river rafting, polo, snow and ice sports in a professional or semi-professional nature.
4. Abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services, or supplies.
5. Weight management programs or treatment in relation to the same including vitamins and tonics, treatment of obesity (including morbid obesity).
6. Treatment for correction of eye sight due to refractive error including routine examination.
7. All routine examinations and preventive health check-ups.
8. Cosmetic Surgery or treatments, aesthetic and re-shaping treatments and Surgeries.
9. Plastic Surgery or Cosmetic Surgery or treatments to change appearance unless medically necessary and certified by the attending Medical Practitioner for reconstruction following an Accident, cancer or burns.
10. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment); aesthetic or change-of-life treatments of any description such as sex transformation operations.
11. Non allopathic treatment.
12. Conditions for which treatment could have been done on an Outpatient basis without any Hospitalization.
13. Unproven/Experimental treatment devices and pharmacological regimens.
14. Admission primarily for diagnostic purposes not related to Illness for which Hospitalization has been done.
15. Convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care.
16. Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment), any physical, psychiatric or psychological examinations or testing.
17. Admission for enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

18. Hospitalization for treatment and use of hearing aids, spectacles or contact lenses including optometric therapy, multifocal lens.
19. Treatment for alopecia, baldness, wigs, or toupees, and all treatment related to the same.
20. Hospitalization for treatment and use of medical supplies including elastic stockings, diabetic test strips, and similar products.
21. Hospitalization for use of prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively. Cost of artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively).
22. Psychiatric or psychological disorders, mental disorders (including mental health treatments), Parkinson and Alzheimer's disease, general debility or exhaustion ("rundown condition"), sleep-apnea, stress.
23. External Congenital Anomalies, dieases or defects, genetic disorders.
24. Stem cell therapy or Surgery, or growth hormone therapy.
25. Venereal disease, all sexually transmitted disease or Illness including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
26. "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus) including but not limited to conditions related to or arising out of HIV/AIDS such as ARC (AIDS Related Complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis.
27. Complications arising out of pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or birth (including caesarean section) except in the case of ectopic pregnancy for In-patient only.
28. Treatment for sterility, infertility, sub-fertility or other related conditions and complications arising out of the same, assisted conception, surrogate or vicarious pregnancy, birth control, and similar procedures contraceptive supplies or services including complications arising due to supplying services.
29. 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).
30. Admission for Organ Transplant but not compliant under the Transplantation of Human Organs Act, 1994 (amended).
31. Hospitalization as donor for another person's organ transplantation.
32. 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.
33. Hospitalisation for treatment and use of dentures and artificial teeth, Dental Treatment and Surgery of any kind, unless requiring Hospitalization due to an Accident.
34. Hospitalisation 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.
35. Hospitalisation for treatment of artificial life maintenance, including life support machine use, where such treatment shall not result in recovery or restoration of the previous state of health.
36. Treatment for developmental problems, learning difficulties eg. Dyslexia, behavioral problems including attention deficit hyperactivity disorder (ADHD).
37. Treatment for Age Related Macular Degeneration (ARMD) , treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.
38. Treatment taken from a person not falling within the scope of definition of Medical Practitioner.

39. Treatment by any Medical Practitioner acting outside the scope of license or registration granted to him by any medical council.
40. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him.
41. Any treatment or part of a treatment that is not of a reasonable charge, is not a Medically Necessary Treatment, or drugs or treatments which are not supported by a prescription.
42. Insured Person whilst flying or taking part in aerial activities except as a fare-paying passenger in a regular scheduled airline or air charter company.

Section VII: Claims

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. Claims terms applicable to all Benefits under the Policy

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

(1) On the occurrence or discovery of any event that may give rise to a claim under this Policy, the claims procedure set out in the Policy shall be followed.
(2) The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed.
(3) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
(4) We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

C. Claims Assessment– Applicable to all benefits under the Policy

a) At Our discretion, We may investigate claims to determine the validity of a claim. This investigation shall be conducted not later than 6 months (or such other period as may be prescribed under the applicable regulations for the time being in force) from the date of receipt of claim intimation. All costs of investigation shall be borne by Us and all investigations shall be carried out by those individuals/entities that are authorised by Us.

b) If there are any deficiencies in the necessary claim documents which are not met or are partially met, We shall send a deficiency letter. If the deficiency is not met or partially met then We shall send a rejection letter or make a part-payment if we have not received the deficiency documents after 45 days from the date of the initial request for such documents. However, documents/details received beyond such period shall be considered if there are valid reasons for any delay.
c) We shall settle or reject a claim, as the case may be, within 30 days of the receipt of the last necessary information and documentation set out above. In case of any suspected fraud, the last "necessary" document may include the receipt of the investigation report from Our investigator/representatives.
d) Payment for reimbursement claims shall be made to the Insured Person. In the unfortunate event of the Insured Person's death, We shall pay the Nominee named in the Policy Schedule or their legal heir or legal representatives holding a valid succession certificate.
e) In case of delay in payment, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us.

D. 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.

E. Claims Documents for Section I Personal Accident Cover
Documents required for all Benefits under Personal Accident Cover
a) Claim Form (in original) duly completed and signed as prescribed by Us
b) Photo ID and Age proof of Insured Person / Nominee (if Insured Person is not alive)
c) Claim intimation or claim reference number (if any)
d) Attested copy of medico legal certificate copy / first information report copy / Panchnama (spot / inquest)
e) Copies of consultation letters detailing the treatment taken immediately after Accident
f) Radiological investigation reports like X ray, CT scan, MRI etc with films supporting the diagnosis of Injury
g) Cancelled cheque for NEFT

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.

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

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

3) Education Benefit
a) Document pertaining to the section under which the Benefit is payable i.e. Accidental Death Cover and Permanent Total Disablement
b) Proof of relationship with the Insured Person and Age proof of the Dependent Child
c) Proof that the Dependent Child is pursuing educational course as a full time student

4) Emergency Road Ambulance Cover
a) Original invoice and paid receipt from the registered Ambulance carrier.

5) Funeral Expenses
a) All documents listed under Accidental Death Cover, invoice and payment receipt for expenses incurred during funeral

6) Repatriation of Remains
a) All documents listed under Accidental Death Cover
b) Proof of repatriation (bills and payment receipt of transportation)

7) Orphan Benefit:
a) All documents listed under Accidental Death Cover
b) Age proof of the surviving Dependent Child

8) Modification Benefit (Residence and vehicle)

Residence modification:

a) All documents listed under Permanent Total Disablement/ Permanent Partial Disablement
b) Original bills and payment receipt of actual expenses incurred towards improvements carried out in the Insured Person's residence following the Insured Person's disablement

Vehicle modification:

a) All documents listed under Permanent Total Disablement/ Permanent Partial Disablement
b) Original bills and payment receipt of actual expenses incurred towards improvements carried out in the Insured Person's or vehicle following the Insured Person's disablement

9) Compassionate visit

a) All documents listed under Accidental Death Cover/ Permanent Total Disablement Benefit
b) Ticket of the Immediate Relative of the Insured Person to travel to the place of Hospitalization of the Insured Person
c) Original bills and payment receipt for travel expense incurred
d) Proof of the relationship of the 'Immediate Relative' as defined in the Policy (such as marriage certificate, ration card)

10) Temporary Total Disablement (TTD)

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

11) Accidental in-patient Hospitalization Cover

a) Original Hospital discharge summary / day care summary / transfer summary
b) Original final Hospital bill with all original deposit and final payment receipt.
c) Original invoice with payment receipt and implant stickers for all implants used during Surgeries i.e. sticker & invoice of nails, plates, screws, wires, implants, etc.
d) All original diagnostic reports (including imaging and laboratory) along with the Medical Practitioner's prescription and invoice / bill with receipt from diagnostic center.
e) All original medicine / pharmacy bills along with the Medical Practitioner's prescription.
f) Medico legal certificate copy / first information report copy
g) Copy of death summary and death certificate (in death claims only)
h) Pre and post- operative imaging reports – where applicable
i) Copy of the Hospital's registration certificate / copy of Form C in case of Hospitalization
j) 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 in detail)

For Contribution Claims Only:

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

12) Broken Bones Benefit

a) All documents listed under Permanent Total Disablement (under Section I.2) / Permanent Partial Disablement (under Section I.3) and Temporary Total Disablement (under Section I.12)
b) All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription and invoice / bill with receipt from diagnostic center
c) Pre and post-operative radiological imaging reports with films confirming the extent of the fracture
d) Medico legal certificate copy / first information report copy / Panchnama (spot / inquest)
e) Medical documents / Hospital records evidencing the Fracture

13) Coma Benefit

All documents listed under Permanent Total Disablement / Permanent Partial Disablement Condition of coma as confirmed by a specialist Medical Practitioner which documents:

i. No response to external stimuli continuously for at least 96 hours
ii. Life support measures are necessary to sustain life
iii. Cause of coma
iv. Whether coma has resulted from alcohol consumption or any intoxicating substance
v. Clinical summary of the comatose patient (original discharge card / day care summary / transfer summary)

14) Burn Benefit

(a) Treating Medical Practitioner's certificate stating:
  I. Incident details of Accident / trauma.
  ii. Degree of burns and extent of area involved
  iii. Cause of burns whether accidental or self-inflicted
  iv. Whether the patient was under the influence of alcohol or any intoxicating substance during incident /\ accident.
  v. Photo of the burns
(b) Medico legal certificate copy / first information report copy

15) EMI Protect

i. Documents listed under Accidental Death / Permanent Total Disablement Benefit / Permanent Partial Disability
ii. Current Outstanding Loan Certificate from financer, along with copies of documents submitted
iii. Loan disbursement letter along with payment record till the date of accident
iv. Repayment schedule showing the EMI details
v. Medical fitness certificate from treating doctor confirming the date to resume the duties (required in case of Permanent Partial Disability claims only)

16) Loan Protect

i. Documents listed under Accidental Death / Permanent Total Disablement Benefit
ii. Current Outstanding Loan Certificate from financer, along with copies of documents submitted
iii. Loan disbursement letter along with payment record till the date of accident
iv. Repayment schedule showing the EMI details

17) Accidental Medical Expenses

a) Original medicine prescription and advice from treating Medical Practitioner
b) Original invoices, bills, receipts of Medical Practitioner consultations / laboratory reports / radiology investigations / pharmacy bills / original investigation report

18) Adventure Sports Cover

a) Documents listed under Accidental Death Cover / Permanent Total Disablement

F. Claim Documents for Section II Critical Illness Cover, Section III Cancer Secure Cover and for Section IV Hospital Cash Cover

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

We may call for any additional documents/information as required based on the circumstances of the claim.

Additional documents for submission of claims under Critical Illness Cover and Cancer Secure Cover:
The Insured Person at their own expenses shall submit the following documents within 30 (ninety) 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:

a) Medical certificate confirming the diagnosis of Critical Illness
b) Certificate from attending Medical Practitioner confirming that the claim does not relate to any Pre-Existing Disease or any Illness or Injury which was diagnosed within the first 90 days of the Inception Date
c) Photocopy of discharge certificate/ card from the Hospital, if any
d) Photocopy of investigation test reports confirming the diagnosis
e) Photocopy of first consultation letter and subsequent prescriptions
f) Photocopy of indoor case papers if applicable
g) Specific documents (if any) listed under the respective Critical Illness
h) 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.

Additional documents for submission of claims under Hospital Cash Cover:
The following documents as per the Benefit being sought must be provided to Us within 30 of the occurrence of the event giving rise to a claim under the Policy:

a) Discharge card / day care summary / transfer summary
b) Final Hospital bill
c) Previous consultation papers indicating history and treatment details for current ailment.
d) Diagnostic test reports (including imaging and laboratory) along with the medical prescription & copy of invoice / bill and receipt from the diagnostic centre.
e) MLC / FIR copy – in Accidental cases only
f) Death summary & death certificate (in death claims only)

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

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.

G. For Section I.13 please follow the process as under for Cashless Hospitalization:
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 on Our toll free number as specified in the Policy Schedule.
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.

Process to be followed for availing Cashless facilities in Emergencies

(I) We must be contacted to pre-authorize 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-authorization must be accompanied with all the following details:
1. Name and address of the Insured Person in respect of whom the request is being made;
2. Nature of the Injury and the treatment/Surgery required;
3. Name and address of the attending Medical Practitioner;
4. Hospital where treatment/Surgery is proposed to be taken;

(ii) 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.

(iii) When We have obtained sufficient details to assess the request, We shall 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 shall 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.

VIII. Terms and Conditions

A. Portability & Continuity Benefits

1. From another Insurer to Us

(I) If the proposed Insured Person was insured continuously and without a break under another Indian retail health insurance policy with any other Indian General Insurance company or standalone Health Insurance company, it is understood and agreed that:
a) If the Insured Person wishes to avail the Portability benefit, he/she must apply to Us with the completed application form and Portability Form with complete documentation at least 45 days before, but not earlier than 60 days, from the expiry of the existing health insurance policy.

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

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

d) Waiting period credits shall be extended to Pre-Existing Diseases and time bound exclusions/waiting periods in accordance with the existing IRDAI guidelines as applicable.

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

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

2. From Our existing health insurance Policy to this Policy

(I) If the proposed Insured Person was insured continuously and without a break under another health insurance policy with Us, it is understood and agreed that:
a) If the Insured Person wishes to avail the Portability benefit, he/she must apply to Us with the completed application form and Portability Form with additional documentation as may be required at least 45 days before, but not earlier than 60 days, from the expiry of the existing health insurance policy with Us.

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

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

d) Waiting period credits shall be extended to Pre-Existing Diseases and time bound exclusions/waiting periods in accordance with the existing IRDAI guidelines as applicable.

e) Subject to the applicable Portability norms issued by the IRDAI, Portability benefit shall be applied by Us within 15 days of receiving the Insured Person's completed application form and Portability Form subject to the following:
- The Insured Person shall give Us all additional documentation and/or information We request;
- The Insured Person shall pay Us the applicable premium in full;
- We may, subject to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be in Our sole and absolute discretion and in accordance with Our board approved underwriting policy;
- There is no obligation on Us to insure all the Insured Persons or to insure all the Insured Persons on the proposed terms, even if the Insured Person(s) have given Us all documentation.

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

We reserve the right to modify or amend the terms and the applicability of the Portability benefit in accordance with the provisions of the regulations, circulars and guidelines issued by the IRDAI from time to time.

B. Free Look Period

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

C. 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.

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

E. 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.

F. Contribution
In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, each insurer shall make the claim payments independent of payments received under other similar polices.
If two or more policies are taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Policyholder/Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

1. In all such cases the insurer who has issued the chosen policy 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. Claims under other policy/ies may be made after exhaustion of sum insured in the earlier chosen policy / policies. It is clarified that the Policyholder/Insured Person having multiple policies shall also have the right to prefer claims from other policy/policies for the amounts disallowed under the earlier chosen policy/policies, even if the sum insured is not exhausted. The insurer shall then settle the claim subject to the terms and conditions of the other policy/policies so chosen.
3. If the amount to be claimed exceeds the sum insured under a single policy after considering the Deductibles or co-pay, the Policyholder/Insured Person shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where the Policyholder/Insured Person has policies from more than one insurer to cover the same risk on indemnity basis, the Policyholder/Insured Person shall only be indemnified the Hospitalization costs in accordance with the terms and conditions of the chosen policy.

G. Geography
This Policy applies to events or occurrences taking place anywhere in the world for Personal Accident Cover, unless limited in a particular Benefit. However, for Accidental in-patient Hospitalization Cover (Section I.13) and Accidental Medical Expenses Cover (Section I.17), the scope thereof is restricted to India only.
In case of Critical Illness Cover, Benefits shall be paid to an Insured Person provided he/ she is Resident in India. Resident for the purpose of this Clause shall mean and include a person who satisfies the conditions prescribed under the Income Tax Act, 1961 for treating a person as Resident in India for that financial year.
In case of Hospital Cash Cover, Benefit shall be paid only for Hospitalization in India.

H. 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.

I. 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.

J. Payment of premium in case of instalment
If the Policy Schedule specifies the premium payment mode of the Policy other than single premium, then You shall pay the premium instalment within maximum 15 days from the due date of the instalment payable. If We do not receive the due instalment of premium within this stipulated time period, the Policy shall be terminated. 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.

In case an event giving rise to a claim under this Policy occurs during this time period wherein We have not received the due premium instalment, We shall deduct the amount equivalent to all remaining instalments of premium for the balance Policy Period from the admissible claim amount.

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

Modification of cover(s) may be requested by You at the time of Renewal of the Policy. However, any such modification shall come into effect only upon acceptance of Your request by Us and subject to realization of any additional premium, as applicable. In case of enhancement of any sum insured under the Policy, all waiting periods as mentioned in the Policy shall apply afresh for this enhanced limit from the effective date of such enhancement.

We may revise the Renewal premium payable under the Policy or the terms of cover provided that all such changes are approved by the IRDAI in accordance with the applicable rules and regulations as may be issued by the IRDAI from time to time. Renewal premium shall not be altered based on individual claims experience. Subject to applicable law, any such change shall be intimated to You atleast 3 months in advance.
In the likelihood that We withdraw this Policy, We shall provide the Insured Person with an option to migrate to the nearest substitute product/plan available with Us as approved by the IRDAI subject to Portability conditions. We shall intimate You/ the Insured Person regarding the withdrawal of the Policy atleast 3 months in advance.

L. Endorsements

The Policy shall allow the following endorsements during the Policy Period. Any request for endorsement must be made by You in writing. 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.

(i) Non-Financial Endorsements – which do not affect the premium.
1) Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)
2) Rectification in gender of the Proposer/ Insured Person (if this does not impact the premium)*
3) Rectification in relationship of the Insured Person with the Proposer
4) Rectification of date of birth of the Insured Person (if this does not impact the premium)*
5) Change in the correspondence address of the Proposer
6) Change/Updation in the contact details viz., Phone No., E-mail Id, alternate contact address of the Proposer etc.
7) Change in Nominee Details
8) Updation of PAN/Aadhaar/passport/EIA/CKYC No.
9) Change in Height, weight, marital status (if this does not impact the premium)*
* These endorsements, if impact the premium, and if accepted, shall be effective from the Inception 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) Rectification in gender of the Proposer/ Insured Person
5) Change in occupation
6) Change in Height, weight

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

M. Communication & Notices

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

i. The Policyholder's, at the address as specified in the Policy Schedule.
ii. To Us , at the address specified in the Policy Schedule.
iii. No insurance agents, brokers, other person or entity is authorised to receive any notice on behalf of Us unless explicitly stated in writing by Us.

N. Duty of Disclosure

The Policy shall be null and void and no Benefit shall be payable hereunder in the event of an untrue or incorrect statement, misrepresentation, mis-description or non-disclosure of any material particular in the Proposal Form, personal statements, declarations, medical history and connected documents, or any material information having been withheld by the Policyholder or any one acting on their behalf, under this Policy. Under such circumstances We may at Our sole discretion cancel the Policy and the premium paid shall be forfeited to Us.

O. Fraudulent Claims

If any claim is found to be fraudulent, or if any false declaration is made, or if any fraudulent devices are used by You or the Insured Person or anyone acting on their behalf to obtain any Benefit under this Policy, then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons. All sums paid under this Policy shall be repaid to Us by You on behalf of all Insured Persons who shall be jointly liable for such repayment.

P. Special Provisions

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

Q. Cancellation (other than Free Look Cancellation)

1. Cancellation by You

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

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

2. Automatic Cancellation:

a. Individual Policy:

The Policy shall automatically terminate on the death of the Insured Person.

b. Family Policy

The Policy shall automatically terminate in the event of the death of all the Insured Persons.

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

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

4. In case of change in occupation of the Insured Person resulting in change in the Risk Class to uninsurable occupations, Personal Accident Cover shall terminate for that Insured Person. In such cases, pro-rata premium shall be refunded provided that no claim has been paid or is outstanding with respect to that Insured Person under Section I, Basic and/or Optional covers, if any.
Uninsurable occupations include but are not limited to, occupations like firemen, law enforcement agencies (including police, para military, military forces etc.), demolition workers, junk or salvage workers, lumber mill workers etc.

R. Electronic Transactions
The Policyholder agrees to comply with all the terms and conditions of electronic transactions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as the internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, in respect of this Policy and claim related details, shall constitute legally binding when done in compliance with Our terms for such facilities.
Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Policyholder. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent shall be subsequently validated / confirmed by the Policyholder.

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

T. Complete Discharge
We shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy. The payment made by Us to the Insured Person or to the Nominee/legal representative or to the Hospital, as the case may be, of any Medical Expenses or compensation or Benefit under the Policy shall in all cases be complete, valid and construe as an effectual discharge in favour of Us.

U. Assignment
The payment due under any Benefit under this Policy can be assigned in accordance with provisions of applicable law.

V. Grievances Redressal Procedure
In case of a grievance, the Insured Person/ Policyholder can contact Us with the details through:
Our website: adityabirlacapital.com
Email: care.healthinsurance@adityabirlacapital.com
Toll Free : 1800 270 7000
Address : Aditya Birla Health insurance Company Limited 10th Floor, Rtech, Nirlon IT park, Western Express highway, Goregaon east, Mumbai 400063

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

The Insured Person/Policyholder can also walk-in and approach the grievance cell at any of Our branches. If in case the Insured Person/Policyholder is not satisfied with the response then they can contact Our Head of Customer Service at the following email carehead.healthinsurance@adityabirlacapital.com.
If the Insured Person/Policyholder is not satisfied with Our redressal, he/she may use the Integrated Grievance management Services (IGMS). For registration in IGMS please visit IRDAI website www.irda.gov.in
If You are still not satisfied, You may approach the nearest Insurance Ombudsman. The contact details of the Ombudsman offices are provided on Our website and in this Policy at Annexure [A].

IX. Definitions
1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Age or Aged** means the completed age (in years) of the Insured Person as on his/ her last birthday.
3. **Ambulance** means a road vehicle operated by a licenced/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
4. **Annexure** means a document attached and marked as Annexure to this Policy.
5. **Benefit** means any benefit shown in the Policy.
6. **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.
7. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
8. **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.
9. **Cosmetic Surgery** means Surgery or medical treatment that modifies, improves, restores or maintains normal appearance of a physical feature, irregularity, or defect.
10. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
11. **Daily Cash Benefit** means the per day Sum Insured unit opted under Section IV and specified in the Policy Schedule.

12. **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 the 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.
13. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
    i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    ii. which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.
14. **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.
15. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
16. **Dependent Child** means a child (natural or legally adopted), who is financially dependent on the Insured Person, does not have his / her independent source of income, is up to the Age of 25 years and unmarried.
17. **Disclosure to information norm:** The policy shall be void and all premiums paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
18. **Emergency** means a serious medical condition or symptom resulting from Injury or sickness 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.
19. **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.
20. **Expiry Date** means the date on which this Policy expires as specified in the Policy Schedule.
21. **Family Policy** means a Policy described as such in the Policy Schedule in terms of which, two or more persons of a family are named in the Policy Schedule as Insured Persons. In a Family Policy, family means a unit comprising of members who are related to each other in the following manner:
    i) Legally married spouse as long as they continue to be married; and/or
    ii) Up to four of their children; and/or
    iii) Up to 2 parents; and/or
    iv) Up to 2 parents in law.
22. **Fracture** means a break in continuity of the bone which is evidenced by an X-ray and certified by the attending Medical Practitioner.
23. **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.
24. **Hazardous Activities** means any sport or activity, which is potentially dangerous to the Insured Person whether he is trained in such sport or activity or not. Such sport/activity includes without limitation stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/obstacle riding, bobsleighing/using skeletons, bouldering, boxing, canyoning, cavin/pot holing, cave tubing, rock climbing/trekking/mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labour, marathon running, martial arts, micro-lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo riding, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling any type.
25. **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 the enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:
    i) has qualified nursing staff under its employment round the clock;
    ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    iii) has qualified medical practitioner(s) in charge round the clock;
    iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v) maintains daily records of patients and makes this accessible to the insurance company's authorized personnel.
26. **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.
27. 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
28. **Inception Date** means the inception date of this Policy as specified in the Policy Schedule.
29. **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.
30. **In-patient** means an Insured Person who is admitted to a Hospital and stays for at least 24 hours for the sole purpose of receiving treatment.
31. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
32. **Insured Person** means the person(s) who is/are covered under this Policy as mentioned in the Policy Schedule, for whom the insurance is proposed by You, accepted by Us and the appropriate premium received.
33. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

34. **ICU 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.
35. **IRDAI means** the Insurance Regulatory and Development Authority of India.
36. **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
37. **Maternity expenses** means:
    a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b) expenses towards lawful medical termination of pregnancy during the policy period.
38. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
39. **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.
40. **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.
41. **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.
42. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.
43. **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.
44. **New Born Baby** means baby born during the Policy Period and is aged upto 90 days.
45. **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.
46. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communications.
47. **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.
48. **Outpatient** means an Insured Person who is taking OPD treatment or any other treatment for which Hospitalization is not required.
49. Policy means this Policy document, the Proposal Form and the Policy Schedule which form part of the Policy including endorsements, as amended from time to time which form part of the Policy and shall be read together.
50. **Policy Period** means the period between the Inception 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.
51. **Policy Schedule** means the schedule attached to and forming part of this Policy mentioning the details of 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.
52. **Policy Year** means a period of 12 consecutive months commencing from the Inception Date.
53. **Portability** means transfer by an individual health insurance policyholder (including family cover) of the credit gained for Pre-Existing Diseases and time- bound exclusions if he/she chooses to switch from one insurer to another or from one plan to another plan of the same insurer.
54. **Pre-Existing Disease** means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and/or were diagnosed, and/or for which medical advice/ treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.
55. **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.
56. **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.
57. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
58. **Sum Insured** means the amount specified in the Policy Schedule against a Benefit which subject to terms, conditions and exclusions of this Policy, is the amount representing Our maximum, total and cumulative liability for any or all claims arising under that Benefit in respect of the Insured Person.
59. **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.
60. **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.
61. **We/ Our/ Us** means Aditya Birla Health Insurance Co. Limited.
62. **You/Your/Policyholder** means the person named in the Policy Schedule as the policyholder and who has concluded this Policy with Us.