Health Wallet

Customer Information Sheet

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

Description is illustrative and not exhaustive

TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
Product Name	Health Wallet	
What am I covered for:	**a. In-patient Treatment-** Covers hospitalisation expenses for period more than 24 hrs. **b. Pre-Hospitalisation-** Medical expenses incurred in 60 days before the hospitalisation. **c. Post-Hospitalisation-** Medical expenses incurred in 90 days after the hospitalisation. **d. Day-Care Procedures-** Medical expenses for day care procedures. **e. Domiciliary Treatment-** Medical expenses incurred for availing medical treatment at home which would otherwise have required hospitalisation. **f. Organ Donor-** Medical expenses on harvesting the organ from the donor for organ transplantation. **g. Ambulance -** Upto Rs. 2,000 per hospitalisation for utilizing ambulance service for transporting insured person to hospital in case of an emergency. **h. AYUSH Treatment -** The Medical Expenses for in-patient treatment taken under Ayurveda, Unani, Sidha and Homeopathy **i. Recovery -** Lumpsum benefit of Rs 10,000 for hospitalisation exceeding 10 days **j. Worldwide Emergency Care -** Covers emergency hospitalisation expenses outside India upto the specified limit **k. Restore Benefit-** Re-instatement of the basic sum insured if the basic sum insured and multiplier benefit has been exhausted during the policy year. The Restore Sum Insured can be used for only future claims made by the Insured Person and not against any claim for an illness/disease (including its complications) for which a claim has been paid in the current policy year. If the restore sum insured is not utilised in a policy year, it shall not be carried forward to any subsequent policy year. **l. Reserve Benefit -** Covers expenses incurred on out-patient treatment, diagnostic procedures, consultations and other incidental expenses such as co-payments, deductibles etc.	Section 1 a) Section 1 b) Section 1 c) Section 1 d) Section 1 e) Section 1 f) Section 1 g) Section 1 h) Section 1 i) Section 1 j) Section 2 Section 5
What are the major exclusions in the policy:	Following is a partial list of the policy exclusions. Please refer to the policy wording for the complete list of exclusions. War or any act of war, nuclear, chemical and biological weapons, radiation of any kind, breach of law with criminal intent, intentional or attempted suicide, participation or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing, abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, treatment of obesity and any weight control program, external congenital diseases, defects or anomalies, genetic disorders; sleep apnoea, expenses arising from HIV or AIDs and related diseases, sterility, treatment to effect or to treat infertility, any fertility, sub-fertility, surrogate or vicarious pregnancy, birth control, circumcisions, treatment for correction of refractive error, plastic surgery or cosmetic surgery unless required due to an Accident, Cancer or Burns, any non allopathic treatment.	Section 7.c)
Waiting Period	• 30 days for all illnesses (except accident) in the first year and is not applicable in subsequent renewals • 24 months for specific illness • Pre-existing Diseases will be covered after a waiting period 36 months.	Section 7.a i) Section 7.a ii) Section 7.a iil)
Payout basis	• In-patient Hospitalisation benefit on indemnity payment basis. • Recovery benefit on lumpsum payment basis.	Section 1 Section 1
Cost Sharing	• Deductible (if applicable) as mentioned on policy schedule.	Section 6
Renewal Conditions	• Policy is ordinarily life-long renewable, subject to application for renewal and the renewal premium in full has been received by the due dates and realisation of premium. • Grace period of 30 days for renewing the policy is provided. To avoid any confusion any claim incurred during break-in period will not be payable under this policy.	Section 8.n)
Renewal Benefits	**Multiplier Benefit –** 50% increase in your basic sum insured for every claim free year, subject to a maximum of 100%. In case a claim is made during a policy year, the limit under this benefit would be reduced by 50% of the basic sum insured in the following year. However this reduction will not reduce the Sum Insured below the basic Sum Insured of the policy. **Health Check-up –** At each renewal, we will pay upto the amount stated for preventive medical check-up.	Section 4 Section 3
Cancellation	This policy would be cancelled on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation by any Insured Person, upon giving 30 days notice.	Section 8. j, k)

How to Claim	Please contact Us atleast 7 days prior to an event which might give rise to a claim. For any emergency situations, kindly contact Us within 24 hours of the event. For any claim related query, information or assistance You can also contact Our Toll Free Line at 1800-102-0333 or visit Our website www.apollomunichinsurance.com or e-mail Us at customerservice@apollomunichinsurance.com	Section 10

Note:

- Pre-Policy Check-up at our network may be required based upon the age and Basic Sum Insured. We will reimburse 100% of the expenses incurred on the acceptance of the proposal. The medical reports are valid for a period of 90 days from the date of Pre-Policy Check-up.
- In order to be eligible for portability benefits you may apply 45 days in advance of the policy renewal date.

Apollo Munich Health Insurance Company Limited will cover all the Insured Persons under this Policy upto the **Sum Insured**. The insurance cover is governed by, and subject to the terms, conditions and exclusions of this Policy.

Section I. Inpatient Benefits

This section of benefits is applicable when

- An insured suffers an Accident or Illness, which is covered under this Policy
- Hospitalisation is necessary & is done for treatment OR
- Day care treatment is necessary and is done OR
- Domiciliary treatment is necessary and is done

IMPORTANT: Claims made under these benefits will impact eligibility for Multiplier Benefit.

	We will cover the Medical Expenses for:	In addition to the waiting periods (Section 7a) and general exclusions (Section 7c), We will also not cover expenses	Important terms you should know
1.	a. In-Patient Treatment. This includes • Hospital room rent or boarding; • Nursing; • Intensive Care Unit • Medical Practitioners (Fees) • Anaesthesia • Blood • Oxygen • Operation theatre • Surgical appliances; • Medicines, drugs & consumables; • Diagnostic procedures.	If as per any or all of the Medical references herein below containing guidelines and protocols for Evidence Based Medicines, the Hospitalisation for treatment under claim is not necessary or the stay at the hospital is found unduly long: • Medical text books, • Standard treatment guidelines as stated in clinical establishment act of Government of India, • World Health Organisation (WHO) protocols, • Published guidelines by healthcare providers, • Guidelines set by medical societies like cardiological society of India, neurological society of India etc.	**Sum Insured** means the sum shown in the Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period, and in relation to a Family Floater represents Our maximum liability for any and all claims made by You and all of Your Dependents during the Policy Period. **Out-patient Treatment** means the medical consultation, investigations or treatment taken in a clinic / hospital or associated facility like a consultation room. Important to note that out-patient treatment does not require admission to day care or in-patient sections of hospital. **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 the scope and jurisdiction of licence. And is NOT a member of the Insured Person's family or stays with him.
	b. Pre-Hospitalisation expenses for consultations, investigations and medicines incurred upto 60 days before the date of admission to the hospital (In-patient or Day Care).	i) Claims which have NOT been admitted under 1 a) and 1d) ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.	
	c. Post-Hospitalisation expenses for consultations, investigations and medicines incurred upto 90 days after discharge from the Hospital.	i) Claims which have NOT been admitted under 1 a) and 1d) ii) Expenses not related to the admission and not incidental to the treatment for which the admission has taken place.	
	d. Day Care Procedures Medical treatment or surgical procedure which is undertaken under general or local anaesthesia, which require admission in a Hospital/Day Care Centre for stay less than 24 hours. Treatment normally taken on out-patient basis is not included in the scope of this definition. Indicative list of Day Care Procedures • Cancer Chemotherapy • Liver biopsy • Coronary angiography • Haemodialysis • Operation of cataract • Nasal sinus aspiration	i) Treatment that can be and is usually taken on an out-patient basis is not covered. ii) Treatment NOT taken at a Hospital or a Day Care centre.	
	e. Domiciliary Treatment Medical treatment for an Illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances: i). The condition of the patient is such that he/she is not in a condition to be removed to a Hospital or, ii). The patient takes treatment at home on account of non availability of room in a Hospital. Pre Hospitalisation expenses for consultations, investigations and medicines incurred upto 60 days before hospitalisation	1. Treatment of less than 3 days (Coverage will be provided for expenses incurred in first three days only if treatment period is greater than three days). 2. Post-Hospitalisation expenses.	

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	f. Organ Donor: Medical and surgical Expenses of the organ donor for harvesting the organ where an Insured Person is the recipient. **IMPORTANT**: Expenses incurred by an insured person while donating an organ is NOT covered.	1. Claims which have NOT been admitted under 1a) for insured member. 2. Admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended). 3. The organ donor's Pre and Post-Hospitalisation expenses.
	g. Ambulance Cover Expenses incurred on transportation of Insured Person to a Hospital for treatment in case of an Emergency, subject to Rs. 2000 per Hospitalisation.	1. Claims which have NOT been admitted under Section 1a) and Section 1d). 2. Healthcare or ambulance service provider not registered with road traffic authority.
	h. AYUSH Treatment Expenses incurred on treatment taken under Ayurveda, Unani, Sidha and Homeopathy in a government hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health or any other suitable institutions. **IMPORTANT**: This benefit is not applicable if optional Deductible is chosen.	1. Claims which have NOT been admitted under 1a). 2. Hospitalisation for evaluation, investigation only. 3. Treatment availed outside India. 4. Treatment at a healthcare facility which is NOT a Hospital.
	i. Recovery Benefit If the Insured Person was Hospitalised beyond 10 continuous days, a lumpsum amount, as mentioned in Schedule of Benefits, will be payable. **IMPORTANT**: • This benefit is payable only once per Illness/Accident per Policy Year. • This benefit is not applicable if optional Deductible is chosen	1. Claims which have NOT been admitted under 1a).
	j. Worldwide Emergency Care Expense on treatment of illness or conditions first manifested during the Policy Period while travelling overseas, provided • Hospitalisation or Day Care Procedure was necessary and was done. • The expenses were up to limits specified in the Schedule of benefits. • Condition has been certified as an Emergency by a Medical Practitioner, where such treatment cannot be postponed until the Insured Person has returned to India. **IMPORTANT**: a) For the purpose of this benefit, Hospital means "Any institution established for In-patient treatment and Day Care Treatment of injury or illness and which has been registered as a Hospital or a clinic as per law rules and/ or regulation applicable for the country where the treatment is taken. " b) Any payment will only be on reimbursement basis; c) The payment of any claim under this benefit will be based on the rate of exchange as on the date of invoice from the Hospital. The rate published by Reserve Bank of India (RBI) shall be used for conversion of foreign currency into Indian rupees for payment of claim. Where on the date of invoice, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion; d) Our overall liability will be limited to a maximum of Rs.20 lacs; subject to Policy Sum Insured; e) Section 8 b) General Terms and Conditions do not apply to this benefit.	1. Claims which have NOT been admitted under 1 a) and 1d). 2. Expenses incurred in return transportation to the insured's home by air ambulance is excluded.
Section II. Restore Benefits.		
	If the Basic Sum Insured and Multiplier Benefit (if any) is exhausted due to claims made and paid during the Policy Year and accepted as payable, then it is agreed that a Restore Sum Insured (equal to 100% of the Basic Sum Insured) will be automatically available for the particular Policy Year, provided that: a) The Restore Sum Insured will be enforceable only after the Basic Sum Insured inclusive of the Multiplier Bonus under Section 4 have been completely exhausted in that year; and b) The Restore Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Section 1; c) The Restore Sum Insured can be used for only future claims made by the Insured Person d) No Multiplier Bonus under Section 4 will apply to the Restore Sum Insured; e) The Restore Sum Insured will only be applied once for the Insured Person during a Policy Year;	Illness/Disease for which a claim has already been paid to the Insured Person in the current Policy Year under Section 1. **IMPORTANT:** In a Family Floater the Illness or disease will be covered in case a claim is made by any other Insured Person other than the Insured Person who has already claimed for that Illness or disease.

	f) If the Restore Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year. Incase of Family Floater Policy, Restore Sum Insured will be available for all Insured Persons in the Policy.	

Section III. Preventive Health Checkup

At each renewal, We will reimburse expenses incurred on preventive health check-up by an Insured Person upto the amount mentioned in the table below. This benefit is available ONLY to those Insured Persons who were insured in the previous Policy Year.

IMPORTANT: This benefit does NOT carry forward if it is not claimed and would not be provided if Health Wallet Policy is not renewed further.

Preventive Health Check-up means a package of medical test(s) undertaken for general assessment of health status, it does not include any diagnostic or investigative medical tests for evaluation of illness or a disease.

Reserve Benefit Sum Insured* (Rs)	Plan	5000	10000	15000	20000	25000
For Non Deductible plans	Individual	Not Offered	Upto Rs 1500, per individual	Upto Rs 2500, per individual	Upto Rs 3000, per individual	Upto Rs 3500, per individual
	Family Floater	Not Offered	Upto Rs 3000, per policy	Upto Rs 5000, per policy	Upto Rs 6000, per policy	Upto Rs 7000, per policy
For Deductible plans	Individual	Not Offered	Upto Rs 1000, per individual	Upto Rs 2000, per individual	Upto Rs 2500, per individual	Upto Rs 3000, per individual
	Family Floater	Not Offered	Upto Rs 2000, per policy	Upto Rs 4000, per policy	Upto Rs 5000, per policy	Upto Rs 6000, per policy

*Reserve Benefit has been explained in Section 5 below.

Section IV. Multiplier Benefit

a) If NO claims have been made in respect of any benefit listed under Section 1 in a Policy Year and the Policy is renewed with Us without any break
   i) We will apply a bonus by enhancing the renewed policy's Sum Insured by 50% of the Basic Sum Insured of the previous year's Policy.
   ii) The maximum bonus will not exceed 100% of the Basic Sum Insured in any Policy Year.

In Family Floater policy,

1. The Multiplier Benefit shall be available on Family Floater basis and accrue only if no claims have been made in respect of any Insured Person during the previous Policy Year.
2. Accrued Multiplier Benefit is available to all Insured Persons under the Policy.

b) If a Multiplier Benefit has been applied and a claim is made in any Policy Year , then in the subsequent Policy Year We will automatically decrease the accrued Multiplier Benefit at the same rate at which it is accrued . However this reduction will not reduce the Sum Insured below the Basic Sum Insured of the policy, and only the accrued multiplier bonus will be decreased.

c) If the Insured Persons in the expiring policy are covered on individual basis and thus have accrued the multiplier bonus for each member in the expiring policy, and such expiring policy is renewed with Us on a Family Floater basis, then the multiplier bonus to be carried forward for credit in the Policy would be the lowest accrued multiplier bonus amongst all the Insured Persons from the expiring Policy.

d) Portability benefit will be offered to the extent of sum of previous sum insured and accrued multiplier bonus, portability benefit shall not apply to any other additional increased Sum Insured.

e) This benefit does not apply to Reserve Benefit.

Section V. Reserve Benefit

Any claims made under this benefit will not be subject to In-patient Benefit Sum Insured and will not impact eligibility for a Multiplier Benefit. Sum Insured limit will apply on Individual basis in case of individual Sum Insured policy and on Family Floater basis in case of Family Floater Policy. Exclusions mentioned in Section 7 c v) to xv) will not apply to this benefit.

- We will apply a 6% bonus on the un-utilized Reserve Benefit Sum Insured available at the end of the Policy Year irrespective whether claim is made on the expiring policy. This un-utilized Reserve Benefit Sum Insured plus the bonus amount will be carried forward to the next Policy Year.
- At each renewal the 6% bonus will be applied on the balance Reserve Benefit Sum Insured, irrespective of any change in the Basic Sum Insured or Reserve Benefit Sum Insured opted.
- The Sum Insured shown in the policy schedule will be the maximum amount that can be claimed during any given Policy Year. The available Reserve Benefit in the current Policy Year will be total of un-utilized Reserve Benefit sum insured plus bonus amount and the Reserve Benefit Sum Insured of the current Policy Year.
- Bonus on the Reserve Benefit shall not accrue if the Policy is not renewed with Us within the Grace Period.
- The mentioned bonus percentage would be reviewed annually. Change if any, to the bonus percentage shall be done post seeking prior approval from the Insurance Regulatory and Development Authority of India (IRDAI).
- The claims incurred under Reserve Benefit during a Policy Year if claimed in the subsequent Policy Year(s) would be accounted in the Policy Year in which the claim amount was incurred. In such cases the Reserve Benefit Sum Insured would be suitably adjusted at the time of renewal.

An illustration of the working of the Reserve Benefit

Consider an individual who has chosen a Reserve Benefit Sum Insured of Rs. 5000 at inception of the policy.

Policy Year	(A) Reserve Benefit Sum Insured Opted (Rs)	(B) Bonus for previous Year announced on or before March 31st of the next year	(C) Reserve Benefit Sum Insured eligible for bonus for the year (Rs) C = F (previous year) – E +A	(D) Bonus amount (Rs) D=BXC	(E) Amount claimed from Reserve Benefit Sum Insured during the year (Rs)	(F) Reserve Benefit Sum Insured with Bonus amount by end of the year (Rs) F = C +D	(G) Reserve Benefit Sum Insured available for utilization/ withdrawal (Rs) G = F +A
Year 1	5000	6%	5000	300	NA	5300	5000
Year 2	5000	6%	10300	618	0	10918	10300
Year 3	5000	6%	15918	955.08	0	16873.08	15918
Year 4	5000	6%	21873.08	1312.385	500	22685.46	21873.08
Year 5	5000	6%	27685.46	1661.128	0	29346.59	27685.46

At each subsequent renewal We will inform You of the amount available for Reserve Benefit in your policy schedule.

This benefit covers

1) Out-patient expenses. This includes

- Diagnostic Tests
- Vaccinations
- Pharmacy Consultations with a Medical Practioner, Physiotherapist, Dietician, Speech therapist, Psychologist
- Dental expenses
- Spectacles, contact lenses,
- Hearing aids
- Medical devices like C-PAP, Bi-PAP, Blood Pressure monitors, Blood sugar monitors and supplies, Heart rate monitors, Portable ECG's, Pulse Oxymeters, Prosthetics etc.
- Special health foods and supplements (food for diabetics/hypertensives and special health conditions, proteins and supplements etc

ii. Incidental medical expenses. This includes

- Co-payment and / or Deductible for any health insurance claim
- Standard non-payable items under any health insurance claim
- Other Medical Expenses not covered under any medical insurance(For example cosmetic treatment, Alzheimer's, etc

iii. Continuation of cover

If the Policy has been renewed with Us for a continuous period of 5 years, , then the Insured Person has an option to pay upto 50% of the renewal premium from accrued Reserve Benefit for subsequent year(s), in such cases portion of renewal premium would be deducted from the accumulated Reserve Benefit Sum Insured. Provided that

- We receive a written request 30 days in advance of the renewal due date from the Insured Person(s)
- There is sufficient Reserve Benefit Sum Insured to pay that portion of renewal premium

If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Reserve Benefit sum insured plus bonus amount for each Insured Person under the expiring Policy, and such expiring Policy has been renewed with Us on a Family Floater basis then the Reserve Benefit sum insured plus bonus that will be carried forward for credit in such renewed Policy shall be the total of all the Insured Persons migrating to a family floater plan. If the Insured Persons in the expiring Policy are covered on a Family Floater basis and such Insured Persons renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater/individual policies then the un-utilised Reserve Benefit sum insured plus bonus amount of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each renewed policy Bonus on the Reserve Benefit sum insured shall not accrue if the Policy is not renewed with us within the Grace Period.

Section VI. Deductible

Where optional Deductible is chosen, then all claims made for benefits listed Section 1 of the Policy will be payable only if the aggregate of covered eligible Medical Expenses, in respect to Hospitalisation (s) in a Policy Year is in excess of the Deductible as stated in the Schedule. Occurrence of the same Illness after a lapse of 45 days as stated above will be considered as fresh Illness for the purpose of this Policy.

Deductible is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for eligible medical expenses upto a specified rupee amount as opted and mentioned in the Policy Schedule i.e. it is the amount upto which the insurance company will not pay for all the claims incurred in a Policy Year under the Policy

- The Deductible will apply on Individual basis in case of individual Sum Insured Policy and on Family Floater basis in case of Family Floater Policy.
- A Deductible does not reduce the Sum Insured.
- If opted will apply to all Insured Person (s) under the Policy

Section VII. Waiting Period and Exclusions

a) Waiting Periods

All Illnesses and treatments shall be covered subject to the waiting periods specified below:

i) We are not liable for any claim arising due to condition for which appearance of signs/symptoms, consultation, investigation, treatment or admission started within 30 days from Policy Commencement Date, except for the claims arising due to an Accident.

ii) A waiting period of 24 months from the first policy commencement date will be applicable to the medical and surgical treatment of illnesses / diagnoses or surgical procedures mentioned in the following table. However this waiting period will not be applicable where the underlying cause is cancer(s).

Organ / Organ System	Organ / Organ System	Organ / Organ System
Ear, Nose & Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for Nasal septum deviation • Surgery for Turbinate hypertrophy • Nasal concha resection • Nasal polypectomy
Gynaecological	• Cysts, polyps including breast lumps • Polycystic ovarian diseases • Fibromyoma • Adenomyosis • Endometriosis • Prolapsed Uterus	• Hysterectomy
Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Osteoporosis • Ligament, Tendon and Meniscal tear • Prolapsed inter vertebral disk	• Joint replacement surgeries
Gastrointestinal	• Cholelithiasis • Cholecystitis • Pancreatitis • Fissure/fistula in anus, Hemorrhoids, Pilonidal sinus • Gastro Esophageal Reflux Disorder (GERD), Ulcer and erosion of stomach and duodenum • Cirrhosis (However Alcoholic cirrhosis is permanently excluded) • Perineal and Perianal Abscess • Rectal Prolapse	• Cholecystectomy • Surgery of hernia
Urogenital	Calculus diseases of Urogenital system including Kidney, ureter, bladder stones • Benign Hyperplasia of prostate • Varicocele	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
Eye	• Cataract • Retinal detachment • Glaucoma	• Nil
Others	• NIL	• Surgery of varicose veins and varicose ulcers
General (Applicable to all organ systems/ organs whether or not described above)	• Benign tumors of Non infectious etiologye.eg. cysts, nodules, polyps, lump, growth, etc	• Nil

iii) 36 months waiting period from policy Commencement Date for all Pre-existing Conditions declared and/or accepted at the time of application.

Pls Note: Coverage under the policy for any past illness/condition or surgery is subject to the same being declared at the time of application and accepted by Us without any exclusion.

b) Reduction in waiting periods

1) If the proposed Insured Person is presently covered and has been continuously covered without any lapses under:

(a) any health insurance plan with an Indian non life insurer as per guidelines on portability, Or

(b) any other similar health insurance plan from Us,

Then:

(a) The waiting periods specified in Section 7 a i), ii) and iii) of the Policy stands waived; And :

(b) The waiting periods specified in the Section 7 a i), ii) and iii) shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy; And

(c) If the proposed Sum Insured for a proposed Insured Person is more than the Sum Insured applicable under the previous health insurance policy, then the reduced waiting period shall only apply to the extent of the Sum Insured and any other accrued Sum Insured under the previous health insurance policy.

2) The reduction in the waiting period specified above shall be applied subject to the following:

a) We will only apply the reduction of the waiting period if We have received the database and past claim history related information as mandated under portability guidelines issued by insurance regulator from the previous Indian insurance company (if applicable);

b) We are under no obligation to insure all Insured Persons or to insure all Insured Persons on the proposed terms, or on the same terms as the previous health insurance policy even if You have submitted to Us all documentation and information.

c) We will retain the right to underwrite the proposal.

d) We shall consider only completed years of coverage for waiver of waiting periods. Policy extensions if any sought during or for the purpose of porting insurance policy shall not be considered for waiting period waiver.

c) General exclusions

We will not pay for any claim which is caused by, arising from or in any way attributable to:

Non Medical Exclusions	i) War or similar situations: Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind. ii) Any Insured Person committing or attempting to commit a breach of law with criminal intent. iii) Intentional self injury or attempted suicide while sane or insane. iv) Dangerous acts (including sports): An Insured Person's participation or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing in a professional or semi professional nature.
Medical Exclusions	v) Treatment of illness or injury as a consequence of the use of alcohol, tobacco, narcotic or psychotropic substances. vi) Prosthetic and other devices which are self detachable /removable without surgery involving anaesthesia vii) Treatment availed outside India, except for claims arising under Emergency Worldwide Care benefit viii) Treatment at a healthcare facility which is NOT a Hospital. ix) Treatment of obesity and any weight control program. x) Treatment for correction of eye sight due to refractive error xi) Cosmetic, aesthetic and re-shaping treatments and surgeries: a. Plastic surgery or cosmetic surgery or treatments to change appearance unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, cancer or burns. b. 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. xii) Types of treatment, defined Illnesses/ conditions/ supplies: a. Save as and to the extent provided for under Section 1 h.)Non allopathic treatment. b. Conditions for which treatment could have been done on an outpatient basis without any Hospitalisation. c. Charges related to peritoneal dialysis, including supplies d. Admission primarily for administration of monoclonal antibodies or IV immunoglobulin infusion. e. Experimental, investigational or unproven treatment devices and pharmacological regimens. f. Admission primarily for diagnostic and evaluation purposes only g. Any diagnostic expenses which is not related and not incidental to any illness which is not covered in this Policy h. Convalescence, rest cure, sanatorium treatment, rehabilitation measures, respite care, long-term nursing care, custodial care, safe confinement, de-addiction, general debility or exhaustion ("run-down condition"). i. Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment); j. Admission for enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements k. Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products. l. Parkinson and Alzheimer's disease, m. Sleep-apnoea. n. External congenital diseases, defects or anomalies, genetic disorders. o. Stem cell therapy or surgery, or growth hormone therapy. p. Venereal disease, sexually transmitted disease or illness; q. "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. r. Any expense attributable directly or indirectly to pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or child birth (including caesarean section), except in the case of ectopic pregnancy in relation to a claim under 1a) for In-patient Treatment only. s. Treatment for sterility, infertility (primary or secondary) , assisted conception or other related conditions and complications arising out of the same.

	t. Birth control, and similar procedures including complications arising out of the same. u. The expense incurred by the insured on organ donation. v. 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. w. Dental treatment and surgery of any kind, unless requiring Hospitalisation. xiii) Any non-medical expenses mentioned Any non-medical expenses mentioned on our website (http://www.apollomunichinsurance.com/download-forms/List-of-Non-Medical-Expenses.pdf) . xiv) Healthcare providers (Hospitals /Medical Practitioners) We will not pay for a. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed. b. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover. xv) Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary. Drugs or treatments which are not supported by a prescription. xvi) Any specific time bound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured. xvii) Admission for administration of Intra-articular or Intra-lesional injections, Monoclonal antibodies like Rituximab/Infliximab/Tratsuzumab, etc (Trade name Remicade, Rituxan, Herceptin, etc), Supplementary medications like Zolendronic acid (Trade name Zometa, Reclast, etc) or IV immunoglobulin infusion

Section VIII. General Terms and Conditions

a. Conditions to be followed

The fulfilment of the terms and conditions of this Policy including the payment of premium by the due dates mentioned in the Schedule and the correct disclosures in a complete manner in the proposal form insofar as they relate to anything to be done or complied with by You or any Insured Person shall be conditions precedent to Our liability. The premium for the policy will remain the same for the policy period as mentioned in policy schedule. The policy will be issued for a period for 1 year.

b. Geography

This Policy only covers medical treatment taken within India. All payments under this Policy will only be made in Indian Rupees within India. For the purpose of policy issuance, the premium will be computed basis the city of residence provided by the insured person in the proposal form. The premium that would be applicable zone wise and the cities defined in each zone are as under:

- Delhi NCR/Mumbai MMR- Delhi, Gurgaon, Noida, Faridabad, Ghaziabad, Greater Noida ,Mumbai, Navi Mumbai , Thane, Kalyan, Dombivali, Bhayandar, Ulhasnagar, Bhiwandi, Vasai, Virar.
- Rest of India- All other cities

The premium will be modified in case of midterm address change involving migration from one zone to another and would be calculated on pro-rata basis.

c. Insured Person

Only those persons named as Insured Persons in the Schedule shall be covered under this Policy. Any eligible person may be added during the Policy Period after his application has been accepted by Us and additional premium has been received. Insurance cover for this person shall only commence once We have issued an endorsement confirming the addition of such person as an Insured Person.

Any Insured Person in the policy has the option to migrate to suitable health insurance policy available with us at the time of renewal subject to underwriting with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period etc. provided the policy has been maintained without a break as per portability guidelines.

If an Insured Person dies, he will cease to be an Insured Person upon Us receiving all relevant particulars in this regard. We will return a rateable part of the premium received for such person IF AND ONLY IF there are no claims other than claims under Reserve Benefit in respect of that Insured Person under the Policy.

d. Loadings

We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis / medical condition and an overall risk loading of over 150% per person. These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured).

We will inform You about the applicable risk loading or exclusion or both as the case may be through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 7 days of the receipt of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 7days, We shall cancel Your application and refund the premium paid within next 7 days. We will issue Policy only after getting Your consent and additional premium (if any). Please visit our nearest branch to refer our underwriting guidelines if required.

PI Note: The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in Section 7 a i), ii) & iii) above or specifically mentioned on the Policy Schedule shall be applied on illness/condition, as applicable.

e. Notification of Claim

i)	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation:	Immediately and in any event at least 48 hours prior to the Insured Person's admission.
ii)	If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an Emergency:	Within 24 hours of the Insured Person's admission to Hospital.

iii)	For all benefits which are contingent on Our prior acceptance of a claim under Section 1)a):	Within 7 days of the Insured Person's discharge post-hospitalisation.

f. Cashless Service:

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Service is Available:	We must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars:
i)	If any planned treatment, consultation or procedure for which a claim may be made:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	At least 48 hours before the planned treatment or Hospitalisation
ii)	If any treatment, consultation or procedure for which a claim may be made to be taken in an Emergency:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Within 24 hours after the treatment or Hospitalisation

g. Supporting Documentation & Examination

The Insured Person or someone claiming on Your behalf shall provide Us with any documentation, medical records and information We may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured. Such documentation will include but is not limited to the following:

i) Our claim form, duly completed and signed for on behalf of the Insured Person.
ii) Original Bills (including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.
iii) All reports and records, including but not limited to all medical reports, case histories/indoor case papers, investigation reports, treatment papers, discharge summaries.
iv) A precise diagnosis of the treatment for which a claim is made.
v) A detailed list of the individual medical services and treatments provided and a unit price for each (detailed break up).
vi) Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Doctor's invoice.
vii) All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made
viii) All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses or detection
ix) Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident
x) Copy of settlement letter from other insurance company or TPA
xi) Stickers and invoice of implants used during surgery
xii) Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident
xiii) Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements
xiv) Legal heir certificate

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

i. Claims Payment

i) We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We have requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.
ii) We will only make payment to You under this Policy. Receipt of payment by You shall be considered as a complete discharge of Our liability against the respective claim under this Policy. In the event of Your death, We will make payment to the Nominee (as named in the Schedule), payments under this Policy shall only be made in Indian Rupees within India.
iii) The assignment of benefits payable under this Policy shall be subject to applicable law.
iv) We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person had taken reasonable care, or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.
v) Cashless service: If any treatment, consultation or procedure for which a claim may be made is to be taken at a Network Hospital, then We will provide a cashless service by making payment to the extent of Our liability direct to the Network Hospital as long as We are given notice that the Insured Person wishes to take advantage of a cashless service accompanied by full particulars at least 48 hours before any planned treatment or Hospitalisation or within 24 hours after Hospitalisation in the case of an emergency.
vi) We shall make the payment of claim that has been admitted as payable by Us under the Policy terms and conditions within 30 days of receipt of last necessary document(s) / information and any other additional information required for the settlement of the claim. All claims will be settled in accordance with the applicable regulatory guidelines, including IRDAI (Protection of Policyholders Regulation), 2017. In case of delay in payment of any claim that has been admitted as payable by Us under the Policy terms and condition, beyond the time period as prescribed under IRDAI (Protection of Policyholders Regulation), 2017, we shall pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document(s) to the date of payment of claim. For the purpose of this clause, 'bank rate' shall mean the bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

vii) Where the circumstances of a claim warrant an investigation in our Opinion, We shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, We shall settle the claim within 45 days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days , We shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim

viii) Where Deductible is opted Our liability to make payment under this policy will only begin when the Deductible as mentioned in Schedule is exceeded. We will pay to the Insured Person, Medical Expenses over and above Deductible but not exceeding the Sum Insured for the Policy Period. Any claim under this Policy shall be payable by Us only if the aggregate of covered Medical Expenses in respect to Hospitalisation(s) of Insured Person (on Individual basis in case of individual Sum Insured Policy and on Family Floater basis in case of Family Floater Policy) exceeds the Deductible and all limits of reimbursement under any other Health Insurance policy available to the insured person/s have been exhausted, and Claim payable under this Policy will be the amount by which the aggregate of covered Medical Expenses in respect of Hospitalisations with dates of admission falling within the policy period exceeds the Deductible amount mentioned in the policy schedule.

j. Non Disclosure or Misrepresentation:

If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

- cancelled ab-initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, at our sole discretion, upon 30 day notice by sending an endorsement to Your address shown in the Schedule ; and
- the claim under such Policy if any, shall be rejected/repudiated forthwith.

k. Fraudulent Claims:

If any claim is in any manner fraudulent, or is supported by any fraudulent means or devices, whether by You or the Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be:

- cancelled ab-initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, at our sole discretion, upon 30 day notice by sending an endorsement to Your address shown in the Schedule ; and
- all benefits payable, if any, under such Policy shall be forfeited with respect to such claim.

l. Other Insurance

If at the time when any claim is made under this Policy, insured has two or more policies from one or more Insurers to indemnify treatment cost, which also covers any claim (in part or in whole) being made under this Policy, then the Policy holder shall have the right to require a settlement of his claim in terms of any of his policies. The insurer so chosen by the Policy holder shall settle the claim, as long as the claim is within the limits of and according to terms of the chosen Policy.

Provided further that, If the amount to be claimed under the Policy chosen by the Policy holder, exceeds the sum insured under a single Policy after considering the deductibles or co-pay (if applicable), the Policy holder shall have the right to choose the insurers by whom claim is to be settled. In such cases, the respective insurers may then settle the claim by applying the Contribution clause. This clause shall only apply to indemnity sections of the policy.

m. Endorsements

This Policy constitutes the complete contract of insurance. This Policy cannot be changed by anyone (including an insurance agent or broker) except Us. Any change that We make will be evidenced by a written endorsement signed and stamped by Us.

n. Renewal

This policy is ordinarily renewable for life except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured

a) We are NOT under any obligation to:
   i) Send renewal notice or reminders.
   ii) Renew it on same terms or premium as the expiring Policy. Any change in benefit or premium (other than due to change in Age) will be done with the approval of the Insurance Regulatory and Development Authority of India (IRDAI) and will be intimated to You atleast 3 months in advance. In the likelihood of this policy being withdrawn in future, we will intimate you about the same 3 months prior to expiry of the policy. You will have the option to migrate to suitable health insurance policy available with us at the time of renewal with all the accrued continuity benefits such as multiplier benefit, waiver of waiting period etc. provided the policy has been maintained without a break as per portability guidelines.

b) We will not apply any additional loading on your policy premium at renewal based on claim experience.

c) Sum Insured can be enhanced only at the time of renewal subject to the underwriting norms and acceptability criteria of the policy. If the insured increases the sum insured one grid up, no fresh medicals shall be required. In cases where the sum insured increase is more than one grid up, the case may be subject to medicals, the cost of such medicals would be borne by You and upon acceptance of your request We shall refund 100% of the expenses incurred on medical tests. In case of increase in the Sum Insured waiting period will apply afresh in relation to the amount by which the Sum Insured has been enhanced. The quantum of increase shall be at the discretion of the company.

d) We shall be entitled to call for any information or documentation before agreeing to renew the Policy. Your Policy terms may be altered based on the information received.

e) All applications for renewal of the Policy must be received by Us before the end of the Policy Period. A Grace Period of 30 days for renewing the Policy is available under this Policy. Any disease/ condition contracted during the Grace Period will not be covered and will be treated as a Pre-existing Condition.

o. Change of Policyholder

The Policyholder may be changed only at the time of renewal. The new policyholder must be a member of the Insured Person's immediate family. Such change would be subject to Our acceptance and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The Policyholder may be changed in case of his demise or him moving out of India during the Policy Period.

p. Notices

Any notice, direction or instruction under this Policy shall be in writing and if it is to:

i) Any Insured Person, it would be sent to You at the address specified in Schedule / endorsement

ii) Us, shall be delivered to Our address specified in the Schedule.

iii) No insurance agents, brokers, other person/ entity is authorised to receive any notice on Our behalf.

q. Dispute Resolution Clause

Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law.

r. Termination (Other than Free Look)

i) In-patient Benefits

a. You may terminate this Policy at any time by giving Us written notice. The cancellation shall be from the date of receipt of such written notice. Premium shall be refunded as per table below IF AND ONLY IF no claim other than claims under Reserve Benefit has been made under the Policy.

Length of time Policy in force	% of premium refunded
Upto 1 Month	75.00%
Upto 3 Months	50.00%
Upto 6 Months	25.00%
Exceeding 6 Months	Nil

b. We shall terminate this Policy for the reasons as specified under aforesaid section 6 j) (Non Disclosure or Misrepresentation) & section 6 k) (Fraudulent Claims) of this Policy and such termination of the Policy shall be ab initio from the inception date or the renewal date (as the case may be), upon 30 day notice, by sending an endorsement to Your address shown in the Schedule.

ii) Reserve Benefit

In case Your policy is terminated in conjunction with point a) as above or is not renewed with Us in time including the grace period, then any unclaimed accumulated Reserve Benefit would be available for reimbursement for a claim over the next 12 months from the date of cancellation without any further credit of bonus amount.

s. Free Look Period

You have 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 have the option of cancelling the Policy stating the reasons for cancellation and You will be refunded the premium paid by You after adjusting the amounts spent on any medical check-up, stamp duty charges and proportionate risk premium. You can cancel Your Policy only if You have not made any claims under the Policy. All Your rights under this Policy will immediately stand extinguished on the free look cancellation of the Policy. Free look provision is not applicable and available at the time of renewal of the Policy.

t. Waiver of Deductible

We will offer the Insured Person an option to waive the Deductible and to opt for any indemnity health insurance Policy (without any Deductible) offered by Us for same Sum Insured without re-evaluation of health status or any pre policy check provided that:

i. Insured Person has been insured with Us for first time under this Policy before the age of 50 years and has renewed with Us continuously and without any interruption,

ii. This option for waiver of Deductible shall be exercised by the Insured Person during the age group of 55 to 60 years, and certainly at the time of renewal only.

Or

At the beginning of 6th policy year i.e ; provided that it has been renewed with Us continuously and without any interruption.

iii. Insured Person will be offered continuity of coverage in terms of waiver of waiting periods to the extent of benefits covered under this Policy.

iv. Premium for the opted indemnity health insurance Policy (without any Deductible) would be charged as per the age of insured member at renewal.

In all cases, No benefits shall accrue to any Insured Person by virtue of continuity of coverage in the event of discontinuation of this Policy at any point of time or shifting to any other health insurance Policy with Us.

Section IX. Other Important Terms You should know

The terms defined below and at other junctures in the Policy Wording have the meanings ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same:

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

Def. 2. **Age** or **Aged** means completed years as at the Commencement Date.

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

Def. 4. **Any one illness** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

Def. 5. **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 approved.

Def. 6. **Commencement Date** means the commencement date of this Policy as specified in the Schedule.

Def. 7. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def. 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

Def. 9. **Contribution** means essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

Def. 10. **Co-payment** means a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

Def. 11. **Cumulative Bonus (Multiplier Benefit)** means any increase in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 12. **Day Care centre** means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—

- has qualified nursing staff under its employment;
- has qualified medical practitioner/s in charge;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

Def. 13. **Day Care Treatment** means medical treatment, and/or surgical procedure which is

i. undertaken under General or Local Anaesthesia in a Hospital/day care centre in less than 24 hours because of technological advancement,

ii. which would have otherwise required a Hospitalisation of more than 24 hours.

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

Def. 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.

Def. 15. **Dental treatment** means treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

Def. 16. **Dependents** means only the family members listed below:

i) Your legally married spouse as long as she continues to be married to You;

ii) Your children Aged between 91 days and 25 years if they are unmarried

iii) Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his initial participation in the Health Wallet Policy.

iv) Your Parent -in-law as long as Your spouse continues to be married to You and were below 65 years at his initial participation in the Health Wallet Policy.

All Dependent parents must be financially dependent on You.

Def. 17. **Dependent Child** means a child (natural or legally adopted), who is unmarried, Aged between 91 days and 25 years, financially dependent on the primary Insured or Proposer and does not have his / her independent sources of income.

Def. 18. **Domiciliary Hospitalisation** medical treatment for an illness/disease/injury which in the normal course would require a care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

- The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
- The patient takes treatment at home on account of non availibity of a room in a hospital

Def. 19. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event o f misrepresentation, mis-description or non-disclosure of any material fact.

Def. 20. **Emergency** means a severe 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.

Def. 21. **Emergency Care** means management for a severe 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.

Def. 22. **Family Floater** means a Policy described as such in the Schedule where under You and Your Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your Dependents during the Policy Period.

Def. 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.

Def. 24. **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 the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- has qualified nursing staff under its employment round the clock,
- has at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
- has qualified Medical Practitioner(s) in charge round the clock,
- has a fully equipped operation theatre of its own where surgical procedures are carried out,
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def. 25. **Hospitalisation or Hospitalised** means admission in a Hospital for a minimum 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.

Def. 26. **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 means 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 means a disease, illness, or injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests

- it needs ongoing or long-term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it comes back or is likely to recur.

Def. 27. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

Def. 28. **In-patient Care means** treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

Def. 29. **Insured Person means** You and the persons named in the Schedule.

Def. 30. **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.

Def. 31. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensive charges.

Def. 32. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

Def. 33. **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.

Def. 34. **Medically Necessary Treatment** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

- Is required for the medical management of the Illness or injury suffered by the Insured Person;
- Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity.
- Must have been prescribed by a Medical Practitioner.
- Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Def. 35. **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 the scope and jurisdiction of license. Medical Practitioner who is sharing the same residence with the Insured Person's and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

Def. 36. **Network Provider** means Hospitals enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility

Def. 37. **Non Network means** any Hospital, day care centre or other provider that is not part of the Network

Def. 38. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication

Def. 39. **OPD treatment** means the treatment 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

Def. 40. **Portability** means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

Def. 41. **Pre-existing Condition** 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.

Def. 42. **Preventive Health Check-up** means a package of medical test(s) undertaken for general assessment of health status, it does not include any diagnostic or investigative medical tests for evaluation of illness or a disease.

Def. 43. **Pre- Hospitalisation** Medical Expenses means the Medical expenses incurred immediately before the Insured Person is Hospitalised, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

Def. 44. **Post- Hospitalisation** Medical Expenses means Medical expenses incurred immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required and

ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company

Def. 45. **Policy** means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any) and the policy schedule (as the same may be amended from time to time).

Def. 46. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 47. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 48. **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India

Def. 49. **Reasonable & Customary Charges** means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/ injury involved.

Def. 50. **Room Rent** means the amount charged by a hospital for the occupancy of a bed on per day (24 hrs) basis and shall include associated medical expenses.

Def. 51. **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.

Def. 52. **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 of suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

Def. 53. **Unproven/Experimental treatment** means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

Def. 54. **We/Our/Us** means the Apollo Munich Health Insurance Company Limited.

Def. 55. **You/Your/Policyholder** means the person named in the Schedule who has concluded this Policy with Us.

Section X. Claim Related Information

For any claim related query, intimation of claim and submission of claim related documents, You can contact Apollo Munich through:

Website : www.apollomunichinsurance.com
Email : customerservice@apollomunichinsurance.com
Toll Free : 1800 102 0333
Fax : 1800 425 4077
Courier : Claims Department,
Apollo Munich Health insurance Co. Ltd
Ground floor, Srinilaya – Cyber Spazio
Suite # 101,102,109 & 110, Ground Floor,
Road No. 2, Banjara Hills,
Hyderabad-500 034
or : Apollo Munich Health Insurance Company Ltd.,
Central Processing Center, iLABS Centre, 2nd & 3rd Floor, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana.

Additional Note: Please refer to the list of empanelled network centers on our website Or the list provided in the welcome kit.

Section XI. Grievance Redressal Procedure

If you have a grievance that you wish us to redress, you may contact us with the details of Your grievance through:

Website : www.apollomunichinsurance.com
Email : customerservice@apollomunichinsurance.com
Toll Free : 1800 102 0333
Fax : +91 124 4584111
Courier : Any of Our Branch office or corporate office

You may also approach the grievance cell at any of Our branches with the details of Your grievance during Our working hours from Monday to Friday.

As per guidelines on special provision for Insured Persons who are senior citizens, We will provide a separate channel for addressing grievances of our senior citizen customers. You may avail this service by contacting the above mentioned toll free no and selecting suitable option provided on Our Interactive Voice Response (IVR) system.

If You are not satisfied with Our redressal of Your grievance through one of the above methods, You may contact Our Head of Customer Service at:

The Grievance Cell, Apollo Munich Health Insurance Company Ltd., Central Processing Center, 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana

If You are not satisfied with Our redressal of Your grievance through one of the above methods, You may approach the nearest Insurance Ombudsman for resolution of Your grievance. The contact details of Ombudsman offices are mentioned below.

Address & Contact Details of Ombudsmen Centres

Office of the Executive Council of Insurers'
(Monitoring Body for Offices of Insurance Ombudsman) 3rd Floor, Jeevan SevaAnnexe, Santacruz(West), Mumbai – 400054. **Tel:** 26106671/ 6889. **Email id:** inscoun@ecoi.co.in **Website:** www.ecoi.co.in
If you have a grievance, approach the grievance cell of Insurance Company first. If complaint is not resolved/ not satisfied/not responded for 30 days then You can approach The Office of the Insurance Ombudsman (Bimalokpal) Please visit our website for details to lodge complaint with Ombudsman.

Office of the Insurance Ombudsman, 6th Floor, Jeevan Prakash Bldg, Tilak Marg, Relief Road, **AHMEDABAD - 380001.** **Tel:** 079-25501201/02/05/06 **Email:** bimalokpal.ahmedabad@ecoi.co.in	**Office of the Insurance Ombudsman,** 2nd Floor, Janak Vihar Complex, 6, Malviya Nagar, **BHOPAL - 462 003**. **Tel:** 0755 - 2769201/ 9202 **Fax:** 0755 - 2769203 **Email:** bimalokpal.bhopal@ecoi.co.in
Office of the Insurance Ombudsman, 62, Forest Park, **BHUBANESHWAR - 751 009.** **Tel:** 0674 - 2596455/2596003 **Fax:** 0674 - 2596429 **Email:** bimalokpal.bhubaneswar@ecoi.co.in	**Office of the Insurance Ombudsman,** SCO No.101-103,2nd Floor, Batra Building, Sector 17-D, **CHANDIGARH - 160 017.** **Tel:-** 0172 - 2706468/2772101 **Fax:** 0172 - 2708274 **Email:** bimalokpal.chandigarh@ecoi.co.in
Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, **CHENNAI - 600 018.** **Tel:** 044 - 24333668/ 24335284 **Fax:** 044 - 24333664 **Email:** bimalokpal.chennai@ecoi.co.in	**Office of the Insurance Ombudsman,** 2/2 A, Universal Insurance Bldg.,Asaf Ali Road, **NEW DELHI - 110 002.** **Tel:** 011 - 23234057/ 23232037 **Fax:** 011 - 23230858 **Email:** bimalokpal.delhi@ecoi.co.in

Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, S.S. Road, **GUWAHATI - 781 001.** **Tel:** 0361 - 2132204/ 5, **Fax:** 0361 - 2732937 **Email:** bimalokpal.guwahati@ecoi.co.in	**Office of the Insurance Ombudsman,** 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, **HYDERABAD-500 004.** **Tel:** 040 - 65504123/ 23312122, **Fax:** 040 - 23376599 **Email:** bimalokpal.hyderabad@ecoi.co.in
Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., M.G. Road, **ERNAKULAM-682 015.** **Tel:** 0484 - 2358759/ 2359338, **Fax:** 0484 - 2359336 **Email:** bimalokpal.ernakulam@ecoi.co.in	**Office of the Insurance Ombudsman,** Hindustan Building. Annexe, 4th Floor, C.R.Avenue, **KOLKATA - 700072** **Tel:** 033 - 22124339/ 22124346, **Fax:** 22124341 **Email:** bimalokpal.kolkata@ecoi.co.in
Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, **LUCKNOW-226 001**. **Tel:** 0522 - 2231331/ 2231330, **Fax:** 0522 - 2231310 **Email:** bimalokpal.lucknow@ecoi.co.in	**Office of the Insurance Ombudsman,** 3rd Floor, Jeevan Seva Annexe,S.V. Road, Santacruz(W), **MUMBAI-400 054.** **Tel:** 022 - 26106960/ 26106552, **Fax :** 022 - 26106052 **Email:** bimalokpal.mumbai@ecoi.co.in
Office of the Insurance Ombudsman, Ground Floor, Jeevan Nidhi II, Bhawani Singh Road, **JAIPUR – 302 005.** **Tel:** 0141 - 2740363 **Email:** bimalokpal.jaipur@ecoi.co.in	**Office of the Insurance Ombudsman,** 3rd Floor, Jeevan Darshan, N.C. Kelkar Road, Narayanpet **PUNE – 411 030.** **Tel:** 020 - 32341320 **Email:** Bimalokpal.pune@ecoi.co.in
Office of the Insurance Ombudsman, 24th Main Road, Jeevan Soudha Bldg., JP Nagar, 1st Phase, Ground Floor **BENGALURU – 560 025. Tel:** 080 - 26652049/ 26652048 **Email:** bimalokpal.bengaluru@ecoi.co.in	**Office of the Insurance Ombudsman,** 4th Floor, Bhagwan Sahai Palace, Main Road, Naya Bans, Sector-15, **NOIDA – 201 301. Tel:** 0120 - 2514250/ 51/ 53 **Email:** bimalokpal.noida@ecoi.co.in
Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, **PATNA – 800 006. Tel:** 0612 - 2680952 **Email id:** bimalokpal.patna@ecoi.co.in	

IRDAI REGULATION NO 5: This policy is subject to regulation 5 of IRDAI (Protection of Policyholder's Interests) Regulation.

Annexure I

List of excluded expenses (non-medical) under indemnity policy are uploaded on our website.
Please login to http://www.apollomunichinsurance.com/download-forms/List-of-Non-Medical-Expenses.pdf

Schedule of benefits - Health Wallet Individual

Basic Sum Insured per Insured Person per Policy Year (Rs. in Lakh)	3.00, 5.00, 10.00, 15.00, 20.00, 25.00 & 50,00
1a) In-patient Treatment	Covered
1b) Pre-Hospitalization	Covered, upto 60 Days
1c) Post-Hospitalization	Covered, upto 90 Days
1d) Day Care Procedures	Covered
1e) Domiciliary Treatment	Covered
1f) Organ Donor	Covered
1g) Ambulance	Upto Rs.2,000 per Hospitalisation
1h) Ayush Treatment **This benefit is not applicable if optional Deductible is chosen**	Covered
1i) Recovery Benefit **This benefit is not applicable if optional Deductible is chosen**	Rs 10,000 for hospitalisation exceeding consecutive 10 days
1j) Worldwide Emergency Care	50% of Sum Insured upto a maximum of Rs.20 lacs
2) Restore Benefit	Equal to 100% of Basic Sum Insured
3) Preventive Health Check-up	As per grid mentioned in the benefit
4) Multiplier Benefit	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal
5) Reserve Benefit per Insured Person per Policy Year (Rs)	5,000; 10,000; 15,000; 20,000 & 25,000
6) Deductible (Optional) per Insured Person per Policy Year (Rs in Lakh)	2.00; 3.00; 5.00 & *10.00 *10.00 deductible available for SI of 20 lacs and above
7) Optional Rider - Critical Advantage Cover per Insured Person per Policy Year (USD) Offered with base policy Sum Insured of Rs. 10 lacs & above	USD 250,000; USD 500,000; USD 10,00,000 • Offered if base policy Sum Insured is Rs. 10 lacs & above • Illness covered under the rider are as following a. Cancer Treatment: b. Coronary Artery by-pass surgery: c. Heart Valve replacement or repair: d. Neurosurgery: e. Live-donor organ transplant: f. Bone Marrow Transplant: g. Aorta Graft Surgery h. Pulmonary artery graft surgery

Health Wallet - Family Floater

Basic Sum Insured per Policy per Policy Year (Rs. in Lakh)	3.00, 5.00, 10.00, 15.00, 20.00, 25.00 & 50,00
1a) In-patient Treatment	Covered
1b) Pre-Hospitalization	Covered, upto 60 Days
1c) Post-Hospitalization	Covered, upto 90 Days
1d) Day Care Procedures	Covered
1e) Domiciliary Treatment	Covered
1f) Organ Donor	Covered
1g) Ambulance	Upto Rs.2,000 per Hospitalisation
1h) Ayush Treatment **This benefit is not applicable if optional Deductible is chosen**	Covered
1i) Recovery Benefit **This benefit is not applicable if optional Deductible is chosen**	Rs 10,000 for hospitalisation exceeding consecutive 10 days
1j) Worldwide Emergency Care	50% of Sum Insured upto a maximum of Rs.20 lacs
2) Restore Benefit	Equal to 100% of Basic Sum Insured
3) Preventive Health Check-up	As per grid mentioned in the benefit
4) Multiplier Benefit	Bonus of 50% of the Basic Sum Insured for every claim free year, maximum upto 100%. In case of claim, bonus will be reduced by 50% of the Basic Sum Insured at the time of renewal
5) Reserve Benefit As per grid mentioned in the benefit	5,000; 10,000; 15,000; 20,000 & 25,000
6) Deductible (Optional) per Insured Person per Policy Year (Rs in Lakh)	2.00; 3.00; 5.00 & *10.00 *10.00 deductible available for SI of 20 lacs and above
7) Optional Rider - Critical Advantage Cover per Insured Person per Policy Year (USD) Offered with base policy Sum Insured of Rs. 10 lacs & above	USD 250,000; USD 500,000; USD 10,00,000 • Offered if base policy Sum Insured is Rs. 10 lacs & above • Illness covered under the rider are as following i. Cancer Treatment: j. Coronary Artery by-pass surgery: k. Heart Valve replacement or repair: l. Neurosurgery: m. Live-donor organ transplant: n. Bone Marrow Transplant: o. Aorta Graft Surgery p. Pulmonary artery graft surgery