Easy Health

Customer Information Sheet - Standard Plan

ApolloMunich HEALTH INSURANCE

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

The information mentioned below is illustrative and not exhaustive. Information must be read in conjunction with the product brochures and policy document. In case of any conflict between the Key Features Document and the policy document the terms and conditions mentioned in the policy document shall prevail.

TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
Product Name	Easy Health Insurance (Standard)	
What am I covered for:	Inpatient Benefits **a. In-patient Treatment-** Covers hospitalisation expenses for period more than 24 hrs. **b. Pre-Hospitalisation-** Medical Expenses incurred in 30 days before the hospitalisation, can be increased to 60 days if claim is intimated 5 days prior to hospitalisation. **c. Post-Hospitalisation-** Medical Expenses incurred in 60 days after the hospitalisation, can be increased to 90 days if claim is intimated 5 days prior to hospitalisation. **d. Day-Care procedures-** Medical Expenses for enlisted 144 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. Emergency Ambulance-** Upto Rs. 2,000 per hospitalisation for utilizing ambulance service for transporting insured person to hospital in case of an emergency. **h. Ayush Benefit -** The Medical Expenses for in-patient treatment taken under Ayurveda, Unani, Sidha and Homeopathy. **i. Daily Cash for choosing shared accommodation-** Daily cash amount if hospitalised in shared accommodation in network hospital and hospitalisation exceeds 48 hrs.	Section I 1 a) Section I 1 b) Section I 1 c) Section I 1 d) Section I 1 e) Section I 1 f) Section I 1 g) Section I 1 h) Section I 1 i)
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, Psychiatric, mental disorders, congenital internal or external 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, laser treatment for correction of eye due to refractive error, plastic surgery or cosmetic surgery unless required due to an Accident, Cancer or Burns.	Section VI
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 and treatments in the first two years and is not applicable in subsequent renewals • Pre-existing Diseases will be covered after a waiting period of 36 months.	Section VI A i) Section VI A ii) Section VI A iii)
Payout basis	Inpatient Hospitalisation benefit on indemnity payment basis. Daily Cash benefit on benefit payment basis.	Section I, II, III
Cost Sharing	Not Applicable	
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 VII n)
Renewal Benefits	**Cumulative Bonus -** 10% increase in your annual inpatient benefit sum insured for every claim free year, subject to a maximum of 50%. In case a claim is made during a policy year, the cumulative bonus would reduce by 20% in the following year. **Health Check-up -** At the end of a block of every continuous 4 claim free years. We will pay upto the stated percentage of the Sum Insured towards cost of the medical check-up.	Section V a), b), c), d) Section V e), f)
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 without refund of premium.	Section VII r)
How to Claim	Please contact our designated TPA atleast 7 days prior to an event which might give rise to a claim. For any emergency situations, kindly contact Our TPA within 24 hours of the event	Section VII e), f), g), h)

Note: Pre-Policy Checkup at our network may be required based upon the age and Sum Insured. We will reimburse 50% 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 Checkup.

Easy Health
Policy Wording

ApolloMunich HEALTH INSURANCE
10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

Apollo Munich Health Insurance Company Limited will cover all 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

The following benefits are available to all Insured Persons who suffer an Illness or Accident during the Policy Period which requires Hospitalisation on an Inpatient basis or treatment defined as a Day Care Procedure. Any claims made under these benefits will impact eligibility for Cumulative Bonus and Health Checkup.

We will cover the Medical Expenses for:	We will not cover treatment, costs or expenses for*: *The following exclusions apply in addition to the waiting periods and general exclusions specified in Section VI A and C	Important terms You should know
1. a. In-Patient Treatment	1. Prosthetics and other devices NOT implanted internally by surgery 2. Hospitalisation for evaluation, Investigation only For example tests like Electrophysiology Study (EPS), Holter monitoring, sleep study etc are not payable. 3. Treatment availed outside India 4. Treatment at a healthcare facility which is NOT a Hospital.	**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. **In-patient Treatment** means treatment arising from Accident or Illness where Insured Person has to stay in a Hospital for more than 24 hours and includes Hospital room rent or boarding expenses, nursing, Intensive Care Unit charges, Medical Practitioner's charges, anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs, consumables, diagnostic procedures. **Day Care Procedures** means those medical treatment, and/or surgical procedure listed in Appendix 1 which is undertaken under General or Local Anaesthesia in a Hospital/day care centre in less than 24 hours because of technological advancement, and which would have otherwise required a Hospitalisation of more than 24 hours, but treatment normally taken on an Out-patient basis is not included in the scope of this definition. **Out-patient Treatment** means consultation, diagnosis or medical treatment taken by an Insured Person at an out-patient department of a Hospital, clinic or associated facility, provided that he is not Hospitalised. **Domiciliary treatment** means medical treatment for a period exceeding 3 days, 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: 1. The condition of the Insured Person is such that he is not in a condition to be removed to a Hospital or, 2. The Insured Person takes treatment at home on account of non availability of room in a Hospital. **Medical Practitioner** means a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction, and is acting within the scope and jurisdiction of his license.
b. Pre-Hospitalization expenses for consultations, investigations and medicines incurred upto 30 days before Hospitalisation and upto 60 days before Hospitalisation if all medical details, date and place of hospitalisation is intimated 5 days before the hospitalisation. c. Post-Hospitalization expenses for consultations, investigations and medicines incurred upto 60 days after discharge from Hospitalisation and upto 90 days after discharge from Hospitalisation if all medical details, date and place of hospitalisation is intimated 5 days before the hospitalisation.	1. Claims which have NOT been admitted under 1a) and 1 d) 2. Any conditions which are NOT the same as the condition for which Hospitalisation was required.	
d. Day Care Procedures	1. Out-Patient Treatment	
e. Domiciliary Treatment	1. Treatment of less than 3 days 2. Post-Hospitalisation expenses 3. The following medical conditions: a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza, b. Arthritis, Gout and Rheumatism, c. Chronic Nephritis and Nephritic Syndrome, d. Diarrhoea and all type of Dysenteries including Gastroenteritis, e. Diabetes Mellitus and Insupidus, f. Epilepsy, g. Hypertension, h. Psychiatric or Psychosomatic Disorders of all kinds, i. Pyrexia of unknown origin	
f. Organ Donor Medical treatment of the organ donor for harvesting the organ.	1. Claims which have NOT been admitted under 1a). 2. Claims not covered under the Transplantation of Human Organs Act, 1994 (as amended). 3. The organ donor's Pre and Post-Hospitalisation expenses.	
g. Emergency Ambulance Expenses incurred on an ambulance in an emergency, subject to Rs. 2000 per Hospitalisation.	1. Claims which have NOT been admitted under 1a). 2. A non- Emergencies. 3. Non registered healthcare or ambulance service provider ambulances.	
h. Ayush Benefit Expenses incurred on treatment taken under Ayurveda, Unani, Sidha and Homeopathy subject to amounts specified in the Schedule of Benefits .	1. Hospitalisation for evaluation, investigation only 2. Treatment availed outside India 3. Treatment at a healthcare facility which is NOT a Hospital.	

Please retain your policy wording for current and future use. Any change to the policy wording at the time of renewal, post approval from regulator will be updated and available on our website **www.apollomunichinsurance.com**

i. Daily Cash for choosing shared Accommodation Daily cash amount will be payable per day as mentioned in schedule of Benefits if the Insured Person is Hospitalised in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours if the Hospitalisation exceeds 48 hours.	1. Daily Cash Benefit for days of admission and discharge 2. Daily Cash Benefit for time spent by the Insured Person in an intensive care unit 3. Claims which have NOT been admitted under 1a).	**Shared accommodation** means a Hospital room with two or more patient beds.
Section II. Additional Benefits: The following benefits are available to all Insured Persons during the Policy Period. Any claims made under these benefits will be subject to In-patient Sum Insured and will impact eligibility for a Cumulative Bonus and Health Checkup. These benefits are optional and effective only if mentioned in the Schedule of Benefits.		
2. a. Daily Cash for Accompanying an Insured Child If the Insured Person Hospitalised is a child Aged 12 years or less, daily cash amount will be payable as mentioned in schedule of Benefits for 1 accompanying adult for each complete period of 24 hours if Hospitalisation exceeds 72 hours.	1. Daily Cash Benefit for days of admission and discharge Claims which have NOT been admitted under 1a).	
b. Newborn baby Medical Expenses for any medically necessary treatment described at 1)a) while the Insured Person (the Newborn baby) is Hospitalised during the Policy Period as an inpatient provided a proposal form is submitted for the insurance of the newborn baby within 30 working days after the birth, and We have accepted the same and received the premium sought.	1. Claims which have NOT been admitted under 3a) i.e. Maternity Expenses 2. Claims other than Benefit 1	**Newborn Baby** means those babies born to You and Your spouse during the Policy Period Aged between 1 day and 90 days.
Section III. Additional Benefit not related to Sum Insured: The following benefit is available to all Insured Persons during the Policy Period. Any claims made under these benefits will not be subject to In-patient Sum Insured and will not impact eligibility for a Cumulative Bonus and Health Checkup. These benefits are optional and effective only if mentioned in the Schedule of Benefits.		
3. a. Maternity Expenses i. Medical Expenses for a delivery (including caesarean section) as mentioned in schedule of Benefits while Hospitalised or the lawful medical termination of pregnancy during the Policy Period limited to 2 deliveries or terminations or either during the lifetime of the Insured Person ii. Medical Expenses for pre-natal and post-natal expenses per delivery or termination upto the amount stated in the Schedule of Benefits, iii. Medical Expenses incurred for the medically necessary treatment of the new born baby upto the amount stated in the Schedule of Benefits unless the new born baby is covered under 2 b), and iv. The Insured Person must have been an Insured Person under Our Policy for the period of time specified in the Schedule of Benefits.	1. Pre- and post-hospitalisation expenses under 1 b) and 1 c) 2. Ectopic pregnancy under this benefit (although it shall be covered under 1a) 3. Claim for Dependents other than Insured Person's spouse under this Policy.	
b. Outpatient Dental Treatment Reasonable charges upto 50% of any necessary dental treatment taken from a Network dentist by an Insured Person who has been covered under this policy benefit for the previous 3 Policy Years We will pay for X-rays, extractions, amalgam or composite fillings, root canal treatments and prescribed drugs for the same.	1. Any dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for the temporomandibular (jaw) joint, or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer.	

c. Spectacles, Contact Lenses, Hearing Aid Reasonable charges upto 50% for One pair of spectacles or contact lenses, or A hearing aid, excluding batteries every third year provided that: i. If the costs claimed are incurred as Outpatient Treatment expenses then these items must be prescribed by a Network EYE/ENT specialised Medical Practitioner, and ii. Under a Family Floater, Our liability shall be limited to either one pair of spectacles or hearing aid per family.	
d. E-Opinion in respect of a Critical Illness We shall arrange and pay for a second opinion from Our panel of Medical Practitioners, if: - The Insured Person suffers a Critical Illness during the Policy Period; and - He requests an E-opinion; and The Insured Person can choose one of Our panel Medical Practitioners. The opinion will be directly sent to the Insured Person by the Medical Practitioner. "Critical Illness" includes Cancer, Open Chest CABG, First Heart Attack, Kidney Failure, Major Organ/Bone Marrow Transplant, Multiple Sclerosis, Permanent Paralysis of Limbs and Stroke.	1. More than one claim for this benefit in a Policy Year. 2. More than one claim for the same Critical Illness. Any other liability due to any errors or omission or representation or consequences of any action taken in reliance of the E-opinion provided by the Medical Practitioner.
Section IV. Critical Illness Any claims made under this benefit will not be subject to In-patient Sum Insured and will not impact eligibility for a Cumulative Bonus and Health Checkup. This benefit is optional and effective only if mentioned in the Schedule of Benefits.	
4. a. Critical Illness We will pay the Critical Illness Sum Insured as a lump sum in addition to Our payment under 1)a), provided that: i. The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period, and ii. The Insured Person survives for at least 30 days following such diagnosis. This benefit is not renewable beyond age of 70 years. iii. "Critical Illness" includes Cancer, Open Chest CABG, First Heart Attack, Kidney Failure, Major Organ/Bone Marrow Transplant, Multiple Sclerosis, Permanent Paralysis of Limbs and Stroke.	1. The Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the commencement of the Policy Period and the Insured Person has not previously been insured continuously and without interruption under an Easy Health Policy. 2. The Insured Person has already made a claim for the same Critical Illness. 3. A claim for this benefit has already been made 3 times under this Policy or any other Easy Health policy issued by Us.

Section V Renewal Benefits:

Cumulative Bonus

a) A 10% cumulative bonus will be applied on the Sum Insured for next policy year under the Policy after every CLAIM FREE Policy Year, provided that the Policy is renewed with Us and without a break. The maximum cumulative bonus shall not exceed 50% of the Sum Insured in any Policy Year.

b) In relation to a Family Floater, the cumulative bonus so applied will only be available in respect of claims made by those Insured Persons who were Insured Persons in the claim free Policy Year and continue to be Insured Persons in the subsequent Policy Year.

c) If a cumulative bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the cumulative bonus by 20% of the Sum Insured in that following Policy Year. There will be no impact on the Inpatient Sum Insured, only the accrued cumulative bonus will be decreased.

d) Portability benefit will be offered to the extent of sum of previous sum insured and accrued cumulative bonus (if opted for), portability benefit shall not apply to any other additional increased sum insured.

Health Check-up

e) If no claim has been made in respect of Section 1 and 2 under this Policy and You have maintained an Easy Health Policy with Us for the period of time mentioned in the Schedule of Benefits without any break, then at the end of each block of continuous claim free years (as mentioned in the Schedule of benefits) We will pay upto the percentage (mentioned in the Schedule of Benefits) of the Sum Insured for this Policy Year or the subsequent Policy Years (whichever is lower) towards the cost of a medical check-up for those Insured Persons who were insured for the number of previous Policy Years

mentioned in the Schedule.

Plan	Standard	Exclusive	Premium
Easy Health Individual	Upto 1% of Sum Insured per Insured Person, only once at the end of a block of every continuous four claim free years.	Upto 1% of Sum Insured subject to a Maximum of Rs.5,000 per Insured Person, only once at the end of a block of every continuous three claim free years	Upto 1% of Sum Insured subject to a Maximum of Rs.5,000 per Insured Person, only once at the end of a block of every continuous two claim free years
Easy Health Family	Upto 1% of Sum Insured per Policy, only once at the end of a block of every continuous four claim free years	Upto 1% of Sum Insured per Policy subject to a Maximum of Rs. 5,000 per Insured Person, only once at the end of a block of every continuous three claim free years.	Upto 1% of Sum Insured per Policy subject to a Maximum of Rs. 5,000 per Insured Person, only once at the end of a block of every continuous two claim free years.

f) Incase of family floater, if any of the members have made a claim under this Policy, the health check-up benefit will not be offered to the whole family.

Section VI. Special terms and conditions

A. Waiting Period

All claims payable will be subject to the waiting periods specified below:

i) General waiting period of 30 days for all claims payable under the Policy except claims arising due to an Accident.

ii) A waiting period of 24 months shall apply to the treatment, whether medical or surgical, of the disease/conditions mentioned below. Additionally the said 24 months waiting period shall be applicable to all surgical procedures mentioned under surgeries in the following table, irrespective of the disease/condition for which the surgery is done, except claims payable due to the occurrence of cancer.

Sl No	Organ / Organ System	Illness	Treatment
a.	ENT	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for nasal septum deviation • Nasal concha resection
b.	Gynaecological	• Cysts, polyps including breast lumps • Polycystic ovarian disease • Fibroids (fibromyoma)	• Dilatation and curettage (D&C) • Myomectomy for fibroids
c	Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Osteoarthritis and Osteoporosis	• Surgery for prolapsed inter vertebral disk • Joint replacement surgeries
d.	Gastrointestinal	• Calculus diseases of gall bladder including Cholecystitis • Pancreatitis • Fissure/fistula in anus, hemorrhoids, pilonidal sinus • Ulcer and erosion of stomach and duodenum • Gastro Esophageal Reflux Disorder (GERD) • All forms of cirrhosis (Please Note: All forms of cirrhosis due to alcohol will be excluded) • Perineal Abscesses • Perianal Abscesses	• Cholecystectomy • Surgery of hernia
e.	Urogenital	• Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone. • Benign Hyperplasia of prostate	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
f.	Eye	• Cataract	Nil
g.	Others	Nil	• Surgery of varicose veins and varicose ulcers
h.	General (Applicable to all organ systems/ organs/ disciplines whether or not described above)	• Internal tumors, cysts, nodules, polyps, skin tumors	• NIL

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

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 issued by the insurance regulator, OR

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

Then:

(a) The waiting periods specified in Section VI A i), ii) and iii) of the Policy stand deleted; AND :

(b) The waiting periods specified in the Section VI 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.

(d) We will retain the right to underwrite the proposal as per Our underwriting guidelines.

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 claim history 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.

Important terms You should know

Pre-existing Condition means any condition, ailment or injury or related condition(s) for which Insured Person had signs or symptoms, and / or were diagnosed, and / or received medical advice/ treatment, within **36 months** prior to your first policy with any insurer.

C. General exclusions

We will not pay for any claim in respect of any Insured Person directly or indirectly for, 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) Breach of law:

Any Insured Person committing or attempting to commit a breach of law with criminal intent, or intentional self injury or attempted suicide while sane or insane.

iii) 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

iv) Substance abuse and de-addiction programs:

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.

v) Cosmetic, aesthetic and re-shaping treatments and surgeries:

a. Treatment of obesity and any weight control program.

b. 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.

c. Treatment for correction of eye due to refractive error

d. 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.

vi) Types of treatment, defined Illnesses/ conditions/ supplies:

a. Save as and to the extent provided for under 1 h) Non allopathic treatment.

b. Conditions for which Hospitalization is NOT required.

c. Experimental, investigational or unproven treatment devices and pharmacological regimens.

d. Admission primarily for diagnostic purposes not related to Illness for which Hospitalization has been done.

e. Convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care.

f. Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment); any physical, psychiatric or psychological examinations or testing.

g. 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.

h. Save as and to the extent provided in 3 c) 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.

i. Artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively).

j. Psychiatric, mental disorders (including mental health treatments), Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down condition"), sleep-apnoea.

k. Congenital internal or external diseases, defects or anomalies, genetic disorders.

l. Stem cell Therapy or surgery, or growth hormone therapy. Venereal disease, sexually transmitted disease or illness; "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.

m. Save as and to the extent provided for under 3a) 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 in relation to a claim under 1a) for In-patient Treatment only.

n. Sterility, treatment whether to effect or to treat infertility, any fertility, sub-fertility or assisted conception procedure, surrogate or vicarious pregnancy, birth control, contraceptive supplies or services including complications arising due to supplying services.

o. Expenses for organ donor screening, or save as and to the extent provided for in 1f), the treatment of the donor (including surgery to remove organs from a donor in the case of transplant surgery).

p. 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.

q. Save as and to the extent provided for under 3)b), dental treatment and surgery of any kind, unless requiring Hospitalisation.

vii) Unnecessary medical expenses:

a. Items of personal comfort and convenience including but not limited to television (wherever specifically charged for), charges for access to telephone and telephone calls (wherever specifically charged for), foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as

well as similar incidental services and supplies.

b. Vitamins and tonics unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

viii) Specified healthcare providers (Hospitals /Medical Practitioners)

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.

c. Any treatment or part of a treatment that is not of a reasonable charge, not Medically Necessary; drugs or treatments which are not supported by a prescription.

d. Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing.

ix) Any specific timebound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured, as per Our underwriting guidelines.

Section VII. General 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) 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.

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.

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.

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 in respect of that Insured Person under the Policy.

Sum Insured from Rs. 100,000 to 1,000,000 can be opted upto 60 years of Age. Sum Insured from Rs. 100,000 to 200,000 can be opted from 61 to 65 years of Age.

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 through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 7 days.

Please note that We will issue Policy only after getting Your consent.

e. Notification of Claim

	Treatment, Consultation or Procedure:	We or Our TPA must be notified:
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.
iv)	If any treatment, consultation or procedure for which a claim may be made is required in an Emergency:	Within 7 days of completion of such treatment, consultation or procedure.
v)	In all other cases:	Of any event or occurrence that may give rise to a claim under this Policy at least 7 days prior to any consequent treatment, consultation or procedure and We or Our TPA must pre-authorise such treatment, consultation or procedure.

Please note that if any time period is specifically mentioned in Section 1-4, then this shall supersede the time periods mentioned in 1)-5) above.

f. Cashless Service:

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Service is Available:	Notice period for the Insured Person to take advantage of the cashless service*: *Written notice must be accompanied by full particulars.
i)	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	Immediately and in any event at least 48 hours prior to the start of the Insured Person's Hospitalisation.
ii)	Any treatment, consultation or procedure for which a claim may be made 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 of the start of the Insured Person's Hospitalisation.

g. Supporting Documentation & Examination

The Insured Person or someone claiming on the Insured Person's behalf will provide Us with any documentation, medical records and information We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the either 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 with detailed breakup of charges(including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.

iii) Original payment receipts

iv) All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries.

v) Discharge Summary, with Date of admission and discharge, clinical history, past history, procedure details and details of treatment taken

vi) Invoice/Sticker of the Implants.

vii) A precise diagnosis of the treatment for which a claim is made.

viii) A detailed list of the individual medical services and treatments provided and a unit price for each.

ix) Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. Prescriptions must be submitted with the corresponding Medical Practitioner's invoice.

h. The Insured Person will 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 will 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 or Our TPA has 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 or at Your direction. If an Insured Person submits the requisite claim documents and information along with a declaration in a format acceptable to Us of having incurred the expenses, this person will be deemed to be authorised by You to receive the concerned payment. In the event of Your death, We will make payment to the Nominee (as named in the Schedule).

iii) 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.

j. Fraud

If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy will be void and all premiums and benefits payable under it will be forfeited.

k. Other Insurance

If at the time when any claim arises under this Policy, there is in existence any other Policy where the Insured Person is covered and the claim is totally or partially covered under the same, We shall pay Our rateable proportion (Apollo Munich Health Policy Sum Insured / Total sum insured for the Insured Person by all insurers) of the claim. This clause shall not apply to Cancer Insurance Policy issued in collaboration with Indian Cancer Society. This clause is only applicable to indemnity policies and benefit.

l. Subrogation

The Insured Person must do all acts and things that We may necessarily and reasonably require to enforce/ secure any civil / criminal rights and remedies or to obtain relief / indemnity from any other party because of making reimbursement under the Policy. This would be irrespective of whether such necessity has arisen before or after the reimbursement. These subrogation rights must NOT be prejudiced in any manner by the Insured Person. The Insured Person must provide Us with whatever assistance or cooperation is required to enforce such rights. We would deduct any amounts paid or payable and expenses of effecting recovery from any recovery that We make pursuant to this clause and pay the balance to You. This clause is only applicable to indemnity policies and benefits.

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 unless the Insured Person or anyone acting on behalf of an Insured Person has acted in an improper, dishonest or fraudulent manner or there has been any misrepresentation under or in relation to this Policy or the renewal of the Policy poses a moral hazard.

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 premium (other than due to change in Age) will be done with the approval of the Insurance Regulatory and Development Authority and will be intimated to You atleast 3 months in advance.

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.

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 or entity is authorised to receive any notice on Our behalf unless explicitly stated in writing by Us.

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

i) 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 has been made under the Policy

1 Year Policy		2 Year Policy	
Length of time Policy in force	**Refund of premium**	**Length of time Policy in force**	**Refund of premium**
Upto 1 Month	75.00%	Upto 1 Month	87.50%
Upto 3 Months	50.00%	Upto 3 Months	75.00%
Upto 6 Months	25.00%	Upto 6 Months	62.50%
Exceeding 6 Months	Nil	Upto 12 Months	50.00%
		Upto 15 Months	37.50%
		Upto 18 Months	25.00%
		Exceeding 18 Months	Nil

ii) We may terminate this Policy on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation by You or any Insured Person or anyone acting on Your behalf or on behalf of an Insured Person after 30 days of giving You a notice and We would issue and send an endorsement in this regard at Your address shown in the Schedule without refund of any premium.

Section VIII. 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** or **Accidental** means a sudden, unforeseen and involuntary event caused by external and visible means (but does not include any Illness) which results in physical bodily injury.

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

Def. 3. **Commencement Date** means the commencement date of this Policy as specified in the Schedule.

Def. 4. **Critical Illness** means Cancer of specified severity, Open Chest CABG, First Heart Attack of specified severity, Kidney Failure requiring regular dialysis, Major Organ/Bone Marrow Transplant, Multiple Sclerosis with Persisting Symptoms, Permanent Paralysis of Limbs, Stroke resulting in Permanent Symptoms as defined below only:

i) Cancer of specified severity:

A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist.

The term cancer includes leukemia, lymphoma and sarcoma.

Excluded are:

- Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as pre-malignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3
- Any skin cancer other than invasive malignant melanoma
- 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.....
- Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
- Chronic lymphocyctic leukaemia less than RAI stage 3
- Microcarcinoma of the bladder
- All tumours in the presence of HIV infection.

ii) Open Chest CABG:

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The Diagnosis must be supported by coronary angiography and realisation of the surgery has to be confirmed by a specialist Medical Practitioner (Cardiologist/Cardiac Surgeon).

Excluded are:

- Angioplasty and / or Any other intra-arterial procedures
- Any Key-hole surgery or laser surgery

iii) First Heart Attack of Specified Severity:

The first occurrence of 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 this will be evidenced by all of the following criteria:

- A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain).
- New characteristic electrocardiogram changes.
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

Excluded are:

- Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T.
- Other acute Coronary Syndromes.
- Any type of angina pectoris

iv) Kidney Failure requiring Regular Dialysis:

End stage renal disease presented as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out.

The diagnosis has to be confirmed by a specialist Medical Practitioner (Nephrologist).

v) Major Organ/ Bone Marrow Transplant:

The actual undergoing of a transplant of:

- One of the following human organs - heart, lung, liver, pancreas, kidney, that resulted from irreversible end-stage failure of the relevant organ or;
- Human bone marrow using haematopoietic stem cells.

The undergoing of a transplant must be confirmed by specialist medical practitioner (Transplant Surgeon/Haematologist).

Excluded are:

- Other Stem-cell transplants
- Where only islets of langerhans are transplanted

vi) Multiple Sclerosis with Persisting Symptoms:

The definite occurrence of Multiple Sclerosis.The diagnosis must be supported by any one of the following:

- Investigation including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple Sclerosis.
- There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of atleast 180 days.

- Well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast 30 days apart.

Excluded is:

- Other causes of neurological damage such as SLE and infection with HIV or AIDS

vii) Permanent Paralysis of Limbs:

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 (Physician / Neurologist) must be of the opinion that paralysis will be permanent with no hope of recovery and must be present for atleast 90 days.

Excluded is:

- Paralysis due to Guillain-Barré-Syndrome

viii) Stroke resulting in Permanent Symptoms:

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and embolisation from an extracranial source.

The diagnosis has to be confirmed by a specialist Medical Practitioner (Physician / Neurologist) 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 atleast 90 days must be produced.

Excluded are:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular diseases affecting only the eye or optic nerve or vestibular functions

Def. 5. **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 21 years if they are unmarried

iii) Your natural parents or parents that have legally adopted You, provided that the parentwas below 65 years at his initial participation in the Easy Health Policy, and

Def. 6. **Dependent Child** means a child (natural or legally adopted), who is financially dependent on You and does not have his / her independent sources of income.

Def. 7. **Family Floater** means a Policy described as such in the Schedule whereunder 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 each Policy Period.

Def. 8. **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. 9. **Hospital** means any institution in India established for Inpatient care and day care treatment of sickness and/or injuries and which has been registered as a hospital 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 at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places,
- has qualified nursing staff under its employment round the clock,
- 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. 10. **Hospitalisation** or **Hospitalised** means the Insured Person's admission into a Hospital for Medically Necessary treatment as an inpatient for a continuous period of at least 24 hours following an Illness or Accident occurring during the Policy Period.

Def. 11. **Illness** means a sickness (a condition or an ailment affecting the general soundness and health of the Insured Person's body) or a disease (affliction of the bodily organs having a defined and recognised pattern of symptoms) or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical Treatment. For the avoidance of doubt, Illness does not mean and this Policy does not cover any mental illness or sickness or disease (including but not limited to a psychiatric condition, disorganisation of personality or mind, or emotions or behaviour) even if caused by or aggravated by or related to an Accident or Illness.

Def. 12. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

Def. 13. **Insured Person** means You and the persons named in the Schedule.

Def. 14. **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. 15. **Medical Expenses** means those reasonable and medically necessary expenses that an Insured Person has necessarily and actually incurred for medical treatment during the Policy Period on the advice of a Medical Practitioner due to Illness or Accident occurring during the Policy Period, 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. 16. **Medically Necessary** 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. 17. **Network** means any such hospitals, day care centre or other provider that the We/ TPA have mutually agreed with, to provide services like cashless access to policyholders. The list is available with Us/ TPA and subject to amendment from time to time.

Def. 18. **Non Network** means any hospital, day care centre or other provider that is not part of the network.

Def. 19. **Policy** means Your statements in the proposal form, this policy wording (including endorsements, if any), Appendix 1 and the Schedule (as the same may be amended from time to time).

Def. 20. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def. 21. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 22. **Pre-existing Condition** means any condition, ailment or injury or related condition(s) for which Insured Person had signs or symptoms, and / or were diagnosed, and / or received medical advice/ treatment, within 36 months prior to your first policy with any insurer.

Def. 23. **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. 24. **Reasonable 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 by comparable providers, taking into account the nature of illness/ injury involved

Def. 25. **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. 26. **TPA** means the third party administrator that We appoint from time to time as specified in the Schedule.

Def. 27. **We/Our/Us** means the Apollo Munich Health Insurance Company Limited

Def. 28. **You/Your/Policyholder** means the person named in the Schedule who has concluded this Policy with Us.

Section IX. Claim Related Information

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

- Website : www.fhpl.net
- Toll Free : 1800 - 425 - 4080
- Fax : +91-40-23541400
- Courier : Claims Department,
  Family Health Plan Ltd,
  Srinilaya - Cyber Spazio,
  Suite No. 101, 102, 109 & 110,
  Ground Floor,
  Road No. 2, Banjara Hills,
  Hyderabad-500034

Section X. 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:

- Our 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.

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., 10th Floor, Building No. 10, Tower-B, DLF Cyber City, DLF City Phase II,Gurgaon, Haryana-122002**

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.

Ombudsman Offices

Jurisdiction	Office Address
Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu	Shri P. Ramamoorthy (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C.U. Shah College, Ashram Road, **AHMEDABAD-380 014.** Tel.:- 079-27546840 Fax : 079-27546142 Email: ins.omb@rediffmail.com
Madhya Pradesh & Chhattisgarh	Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, **BHOPAL(M.P.)-462 023.** Tel.:- 0755-2569201 Fax : 0755-2769203 Email: bimalokpalbhopal@airtelmail.in
Orissa	Shri B. P. Parija (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, **BHUBANESHWAR-751 009.** Tel.:- 0674-2596455 Fax : 0674-2596429 Email: ioobbsr@dataone.in
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh	Shri Manik Sonawane (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D, **CHANDIGARH-160 017.** Tel.:- 0172-2706468 Fax : 0172-2708274 Email: ombchd@yahoo.co.in
Tamil Nadu, UT-Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, **CHENNAI-600 018.** Tel.:- 044-24333668 /5284 Fax : 044-24333664 Email: chennaiinsuranceombudsman@gmail.com
Delhi & Rajasthan	Shri Surendra Pal Singh (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, **NEW DELHI-110 002.** Tel.:- 011-23239633 Fax : 011-23230858 Email: iobdelraj@rediffmail.com
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Shri D.C. Choudhury (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road, **GUWAHATI-781 001 (ASSAM).** Tel.:- 0361-2132204/5 Fax : 0361-2732937 Email: ombudsmanghy@rediffmail.com
Andhra Pradesh, Karnataka and UT of Yanam - a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, **HYDERABAD-500 004**. Tel : 040-65504123 Fax: 040-23376599 Email: insombudhyd@gmail.com
Kerala, UT of (a) Lakshadweep, (b) Mahe - a part of UT of Pondicherry	Shri R. Jyothindranathan (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, **ERNAKULAM-682 015.** Tel : 0484-2358759 Fax : 0484-2359336 Email: iokochi@asianetindia.com
West Bengal , Bihar , Jharkhand and UT of Andeman & Nicobar Islands , Sikkim	Ms. Manika Datta (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindusthan Bldg. Annexe, 4, C.R.Avenue, **KOLKATTA - 700 072.** Tel: 033 22124346/(40) Fax: 033 22124341 Email: iombsbpa@bsnl.in
Uttar Pradesh and Uttaranchal	Shri G. B. Pande (Ombudsman) Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, **LUCKNOW-226 001.** Tel : 0522 -2231331 Fax : 0522-2231310 Email: insombudsman@rediffmail.com
Maharashtra , Goa	Insurance Ombudsman, Office of the Insurance Ombudsman, S.V. Road, Santacruz(W), **MUMBAI-400 054.** Tel : 022-26106928 Fax : 022-26106052 Email: ombudsmanmumbai@gmail.com

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

Appendix I: Day Care Procedure

Day Care Procedures will include following Day Care Surgeries & Day Care Treatments

Microsurgical operations on the middle ear

1. Stapedotomy
2. Stapedectomy
3. Revision of a stapedectomy
4. Other operations on the auditory ossicles
5. Myringoplasty (Type -I Tympanoplasty)
6. Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
7. Revision of a tympanoplasty
8. Other microsurgical operations on the middle ear under general / spinal anesthesia

Other operations on the middle & internal ear

9. Myringotomy
10. Removal of a tympanic drain
11. Incision of the mastoid process and middle ear
12. Mastoidectomy
13. Reconstruction of the middle ear
14. Other excisions of the middle and inner ear
15. Fenestration of the inner ear
16. Revision of a fenestration of the inner ear
17. Incision (opening) and destruction (elimination) of the inner ear
18. Other operations on the middle and inner ear under general /spinal anesthesia

Operations on the nose & the nasal sinuses

19. Excision and destruction of diseased tissue of the nose
20. Operations on the turbinates (nasal concha)
21. Other operations on the nose
22. Nasal sinus aspiration

Operations on the eyes

23. Incision of tear glands
24. Other operations on the tear ducts
25. Incision of diseased eyelids
26. Excision and destruction of diseased tissue of the eyelid
27. Operations on the canthus and epicanthus
28. Corrective surgery for entropion and ectropion
29. Corrective surgery for blepharoptosis
30. Removal of a foreign body from the conjunctiva
31. Removal of a foreign body from the cornea
32. Incision of the cornea
33. Operations for pterygium
34. Other operations on the cornea
35. Removal of a foreign body from the lens of the eye
36. Removal of a foreign body from the posterior chamber of the eye
37. Removal of a foreign body from the orbit and eyeball
38. Operation of cataract
39. Retinal detachment

Operations on the skin & subcutaneous tissues

40. Incision of a pilonidal sinus
41. Other incisions of the skin and subcutaneous tissues
42. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
43. Local excision of diseased tissue of the skin and subcutaneous tissues
44. Other excisions of the skin and subcutaneous tissues
45. Simple restoration of surface continuity of the skin and subcutaneous tissues
46. Free skin transplantation, donor site
47. Free skin transplantation, recipient site
48. Revision of skin plasty
49. Other restoration and reconstruction of the skin and subcutaneous tissues
50. Chemosurgery to the skin
51. Destruction of diseased tissue in the skin and subcutaneous tissues

Operations on the tongue

52. Incision, excision and destruction of diseased tissue of the tongue
53. Partial glossectomy
54. Glossectomy
55. Reconstruction of the tongue
56. Other operations on the tongue

Operations on the salivary glands & salivary ducts

57. Incision and lancing of a salivary gland and a salivary duct
58. Excision of diseased tissue of a salivary gland and a salivary duct
59. Resection of a salivary gland
60. Reconstruction of a salivary gland and a salivary duct
61. Other operations on the salivary glands and salivary ducts

Other operations on the mouth & face

62. External incision and drainage in the region of the mouth, jaw and face
63. Incision of the hard and soft palate
64. Excision and destruction of diseased hard and soft palate
65. Incision, excision and destruction in the mouth
66. Plastic surgery to the floor of the mouth
67. Palatoplasty
68. Other operations in the mouth under general/spinal anesthesia

Operations on the tonsils & adenoids

69. Transoral incision and drainage of a pharyngeal abscess
70. Tonsillectomy without adenoidectomy
71. Tonsillectomy with adenoidectomy
72. Excision and destruction of a lingual tonsil
73. Other operations on the tonsils and adenoids under general /spinal anesthesia

Trauma surgery and orthopaedics

74. Incision on bone, septic and aseptic
75. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
76. Suture and other operations on tendons and tendon sheath
77. Reduction of dislocation under GA
78. Arthroscopic knee aspiration

Operations on the breast

79. Incision of the breast
80. Operations on the nipple

Operations on the digestive tract

81. Incision and excision of tissue in the perianal region
82. Surgical treatment of anal fistulas
83. Surgical treatment of haemorrhoids
84. Division of the anal sphincter (sphincterotomy)

85. Other operations on the anus
86. Ultrasound guided aspirations
87. Sclerotherapy etc.

Operations on the female sexual organs

88. Incision of the ovary
89. Insufflation of the Fallopian tubes
90. Other operations on the Fallopian tube
91. Dilatation of the cervical canal
92. Conisation of the uterine cervix
93. Other operations on the uterine cervix
94. Incision of the uterus (hysterotomy)
95. Therapeutic curettage
96. Culdotomy
97. Incision of the vagina
98. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
99. Incision of the vulva
100. Operations on Bartholin's glands (cyst)

Operations on the prostate & seminal vesicles

101. Incision of the prostate
102. Transurethral excision and destruction of prostate tissue
103. Transurethral and percutaneous destruction of prostate tissue
104. Open surgical excision and destruction of prostate tissue
105. Radical prostatovesiculectomy
106. Other excision and destruction of prostate tissue
107. Operations on the seminal vesicles
108. Incision and excision of periprostatic tissue
109. Other operations on the prostate

Operations on the scrotum & tunica vaginalis testis

110. Incision of the scrotum and tunica vaginalis testis
111. Operation on a testicular hydrocele
112. Excision and destruction of diseased scrotal tissue
113. Plastic reconstruction of the scrotum and tunica vaginalis testis
114. Other operations on the scrotum and tunica vaginalis testis

Operations on the testes

115. Incision of the testes
116. Excision and destruction of diseased tissue of the testes
117. Unilateral orchidectomy
118. Bilateral orchidectomy
119. Orchidopexy
120. Abdominal exploration in cryptorchidism
121. Surgical repositioning of an abdominal testis
122. Reconstruction of the testis
123. Implantation, exchange and removal of a testicular prosthesis
124. Other operations on the testis under general /spinal anesthesia

Operations on the spermatic cord, epididymis and ductus deferens

125. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
126. Excision in the area of the epididymis
127. Epididymectomy
128. Reconstruction of the spermatic cord
129. Reconstruction of the ductus deferens and epididymis
130. Other operations on the spermatic cord, epididymis and ductus deferens

Operations on the penis

131. Operations on the foreskin
132. Local excision and destruction of diseased tissue of the penis
133. Amputation of the penis
134. Plastic reconstruction of the penis
135. Other operations on the penis

Operations on the urinary system

136.Cystoscopical removal of stones

Other Operations

137. Lithotripsy
138. Coronary angiography
139. Haemodialysis
140. Radiotherapy for Cancer
141. Cancer Chemotherapy
142. Renal biopsy
143. Bone marrow biopsy
144. Liver biopsy

Note: The standard exclusions and waiting periods are applicable to all of the above Day Care Procedures depending on the medical condition/ disease under treatment. Only 24 hours hospitalization is not mandatory

Easy Health
Policy Wording

ApolloMunich HEALTH INSURANCE
10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

Schedule of benefits-Easy Health Individual

Benefits	Easy Health Standard	Easy Health Exclusive		Easy Health Premium	
Sum Insured per Insured Person per Policy Year (Rs. In Lakh)	1.00, 1.50, 2.00, 2.50 3.00, 4.00, 5.00	3.00, 4.00, 5.00	7.50	3.00, 4.00, 5.00	7.50, 10.00
1 a) In-patient Treatment	Covered	Covered		Covered	
1 b) Pre-hospitalisation	Covered	Covered		Covered	
1 c) Post-hospitalisation	Covered	Covered		Covered	
1 d) Day-Care Procedures	Covered	Covered		Covered	
1 e) Domiciliary Treatment	Covered	Covered		Covered	
1 f) Organ Donor	Covered	Covered		Covered	
1 g) Emergency Ambulance	Upto Rs.2,000 per hospitalisation	Upto Rs.2,000 per hospitalisation		Upto Rs.2,000 per hospitalisation	
1 h) Ayush Benefit	Upto Rs 20,000	Upto Rs 25,000		Upto Rs 25,000	
1 i) Daily cash for choosing shared accommodation	Rs. 500 per day, Maximum Rs.3,000	Rs.500 per day, Maximum Rs.3,000	Rs.800 per day, Maximum Rs.4,800	Rs.500 per day, Maximum Rs.3,000	Rs.800 per day, Maximum Rs.4,800
2 a) Daily Cash for accompanying an insured child	Not Covered	Rs.300 per day, Maximum Rs.9,000	Rs.500 per day, Maximum Rs.15,000	Rs.300 per day, Maximum Rs.9,000	Rs.500 per day, Maximum Rs.15,000
2 b) Newborn baby	Not Covered	Optional		Optional	
3 a) Maternity Expenses with waiting period of 6 years	Not Covered	Normal Delivery Rs. 15,000* Caesarean Delivery Rs. 25,000* (*Including Pre/Post Natal limit of Rs. 1,500 and New Born limit of Rs.2,000)	Normal Delivery Rs. 25,000* Caesarean Delivery Rs. 40,000* (*Including Pre/Post Natal limit of Rs. 2,500 and New Born limit of Rs.3,500)	Normal Delivery Rs. 15,000* Caesarean Delivery Rs. 25,000* (*Including Pre/Post Natal limit of Rs. 1,500 and New Born limit of Rs.2,000)	Normal Delivery Rs. 25,000* Caesarean Delivery Rs. 40,000* (*Including Pre/Post Natal limit of Rs. 2,500 and New Born limit of Rs.3,500)
3 b) Out-patient Dental Treatment with waiting period of 3 years	Not Covered	Not Covered		Upto 1 % of Sum insured subject to a Maximum of Rs. 5,000	
3 c) Spectacles, Contact Lenses, Hearing Aid every third year	Not Covered	Not Covered		Upto Rs.5,000	
3 d) E-Opinion in respect of a Critical Illness	Not Covered	Not Covered		Covered	
4) Critical Illness	Not Covered	Optional, if opted then the Critical Illness Sum Insured as mentioned in the Schedule		Optional, if opted then the Critical Illness Sum Insured as mentioned in the Schedule	
5) Health Check-up	Upto 1% of Sum Insured per Insured Person, only once at the end of a block of every continuous 4 claim free years	Upto 1% of Sum Insured subject to a Maximum of Rs.5,000 per Insured Person, only once at the end of a block of every continuous 3 claim free years		Upto 1% of Sum Insured subject to a Maximum of Rs.5,000 per Insured Person, only once at the end of a block of every continuous 2 claim free years.	
Benefits under 3b), 3c), 3d) and 5) are subject to pre-authorisation by the TPA					

Schedule of benefits-Easy Health Family

Benefits	Easy Health Standard	Easy Health Exclusive		Easy Health Premium	
Sum Insured per Policy Year (Rs. In Lakh)	2.00, 3.00, 4.00, 5.00	3.00, 4.00, 5.00	7.50	4.00, 5.00	7.50, 10.00
1 a) In-patient Treatment	Covered	Covered		Covered	
1 b) Pre-hospitalisation	Covered	Covered		Covered	
1 c) Post-hospitalisation	Covered	Covered		Covered	
1 d) Day-Care Procedures	Covered	Covered		Covered	
1 e) Domiciliary Treatment	Covered	Covered		Covered	
1 f) Organ Donor	Covered	Covered		Covered	
1 g) Emergency Ambulance	Upto Rs.2,000 per hospitalisation	Upto Rs.2,000 per hospitalisation		Upto Rs.2,000 per hospitalisation	
1 h) Ayush Benefit	Upto Rs 20,000	Upto Rs 25,000		Upto Rs 25,000	
1 i) Daily cash for choosing shared accommodation	Rs.500 per day, Maximum Rs.3,000	Rs.500 per day, Maximum Rs.3,000	Rs.800 per day, Maximum Rs.4,800	Rs.500 per day, Maximum Rs.3,000	Rs.800 per day, Maximum Rs.4,800
2 a) Daily cash for accompanying an insured child	Not Covered	Rs.300 per day, Maximum Rs.9,000	Rs.500 per day, Maximum Rs.15,000	Rs.300 per day, Maximum Rs.9,000	Rs.500 per day, Maximum Rs.15,000
2 b) Newborn baby	Not Covered	Optional		Optional	
3 a) Maternity Expenses with waiting period of 4 years	Not Covered	Normal Delivery Rs. 15,000* Caesarean Delivery Rs. 25,000* (*Including Pre/Post Natal limit of Rs. 1,500 and New Born limit of Rs.2,000)	Normal Delivery Rs. 25,000* Caesarean Delivery Rs. 40,000* (*Including Pre/Post Natal limit of Rs. 2,500 and New Born limit of Rs.3,500)	Normal Delivery Rs. 15,000* Caesarean Delivery Rs. 25,000* (*Including Pre/Post Natal limit of Rs. 1,500 and New Born limit of Rs.2,000)	Normal Delivery Rs. 25,000* Caesarean Delivery Rs. 40,000* (*Including Pre/Post Natal limit of Rs. 2,500 and New Born limit of Rs.3,500)
3 b) Outpatient Dental Treatment with waiting period 3 years	Not Covered	Not Covered		Upto 1 % of Sum insured subject to a Maximum of Rs. 5,000	
3 c) Spectacles, Contact Lenses, Hearing Aid every third year	Not Covered	Not Covered		Upto Rs.5,000	
3 d) E-Opinion in respect of a Critical Illness	Not Covered	Not Covered		Covered	
4) Critical Illness	Not Offered	Optional, if opted then the Critical Illness Sum Insured as mentioned in the Schedule		Optional, if opted then the Critical Illness Sum Insured as mentioned in the Schedule	
5) Health Check-up	Upto1% of Sum Insured per Policy, only once at the end of a block of every continuous 4 claim free years	Upto 1% of Sum Insured per Policy subject to a Maximum of Rs.5,000 per Insured Person, only once at the end of a block of every continuous 3 claim free years		Upto 1% of Sum Insured per Policy subject to a Maximum of Rs.5,000 per Insured Person, only once at the end of a block of every continuous 2 claim free years	
Benefits under 3b), 3c), 3d) and 5) are subject to pre-authorisation by the TPA					

AMHI/PR/H/0012/0084/032012/P

Easy Health
Claim Procedure

ApolloMunich HEALTH INSURANCE
10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

Please review your Easy Health policy and familiarize yourself with the benefits available and the policy exclusions.

In order to provide you fast and efficient service , we request you to kindly make a note of the following points.

1. We recommend that you keep copies of all documents submitted to the TPA or Apollo Munich Health Insurance Co. Ltd.
2. Please quote your member ID/policy number in all your correspondences.

In case you need to avail inpatient hospitalisation services, you can go to any hospital* of your choice, i.e. a Hospital* in our network or a hospital* outside the network. The difference between the two is that with a network hospital you can use "Cashless Services", whereas for a non network hospital, you will have to settle the bills and claim for reimbursement.

Hospitalisation in Non Network Hospitals	**Hospitalisation in Network Hospitals**
Emergency Hospitalisation **Step 1:** Get admitted into the hospital **Step 2:** As soon as possible, inform the TPA about the hospitalisation **Step 3:** At the time of discharge, settle the hospital bills in full and collect all the bills, documents and reports **Step 4:** Lodge your claim with our TPA for processing and reimbursement **Planned Hospitalisation** **Step 1:** Inform the TPA about the planned hospitalisation 7 days prior to the admission **Step 2:** Get admitted into the hospital. **Step 3:** At the time of discharge, settle the hospital bills in full and collect all the bills, documents and reports. **Step 4:** Lodge your claim with our TPA for processing and reimbursement.	**Emergency Hospitalisation** **Step 1:** Get admitted into the hospital. **Step 2:** As soon as possible inform the TPA and coordinate with the hospital to have the details sent to the TPA for authorization for cashless service. **Step 3:** A) In cases of a very short stay at the hospital or if the authorisation for "Cashless Service" was not received from the TPA or if "Cashless Service" was denied by the TPA i) At the time of discharge settle the hospital bills in full and collect all the bills documents and reports. ii) Lodge your claim with the TPA for processing and reimbursement. OR B) If authorisation for "Cashless Service" from the TPA has been received at the time of discharge a) Pay for those items that are not reimbursable under the Easy Health policy including applicable copayment. b) Verify the bills and sign on all the bills and the authorisation letter. c) Leave the original discharge summary and other investigations reports with the hospital. Retain a Photo copy for your records. d) Sign the Claim Form. **Planned Hospitalisation** **Step 1:** Please co ordinate with your doctor and the hospital and send in all the details of your planned hospitalisation including the plan of treatment, cost estimates etc. to our TPA. Also indicate the address or fax number to where the authorisation is to be sent along with the mobile no. to receive updates on your claims and authorisations This should be sent to the TPA at least 7 days prior to the admission **Step 2:** A) If authorisation for "Cashless Service" from the TPA has been received by you • At the time of admission, hand in the authorisation letter and a photocopy of your ID card to the hospital. • At the time of discharge: a) Pay for those items that are not reimbursable under the Easy Health policy. b) Verify the bills and sign on all the bills c) Leave the original discharge summary and other investigations reports with the hospital. Retain a Photo copy for your records d) Sign the Claim Form OR B) In case "Cashless Service" was denied by the TPA • At the time of discharge settle the hospital bills in full and collect all the bills documents and reports and Payment Receipt. • If you wish, lodge your claim with our TPA for processing and reimbursement.

***Hospital** means any institution in India established for In-patient care and day care treatment of sickness and/or injuries and which has been registered as a Hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all

Easy Health
Claim Procedure

ApolloMunich HEALTH INSURANCE
10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

minimum criteria as under:

- has at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places,
- has qualified nursing staff under its employment round the clock,
- 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.

Intimation & Assistance	**Procedure for Reimbursement of Medical Expenses**	**Procedure to avail Cashless facility**
Please contact our designated TPA atleast 48 hours prior to an event which might give rise to a claim. For any emergency situations, kindly contact our TPA within 24 hours of the event. Our TPA can be contacted through: - 24 x 7 Toll free: 1800 - 425 - 4080 - E-mail at: info@fhpl.net - Fax at: 040-23541400 Post/ Courier to: Claims Department, Family Health Plan(TPA) Ltd., Srinilaya – Cyber Spazio, Suite # 101,102,109 & 110, Ground Floor, Road No. 2, Banjara Hills, Hyderabad-500 034 Please use the Claim Intimation Form for intimation of a claim.	• Please send the duly signed claim form and all the information/documents mentioned* therein to your designated TPA within 15 days of the completion of the treatment. * Please refer to claim form for complete documentation. • If there is any deficiency in the documents/ information submitted by you, the TPA will send the deficiency letter within 7 days of receipt of the claim documents. • On receipt of the complete set of claim documents, your designated TPA will send the cheque for the admissible amount, along with a settlement statement within 15 days. • The cheque will be sent in the name of the proposer. **Note: Payment will only be made for items covered under your policy and upto the limits therein.**	• For any emergency hospitalisation, your designated TPA must be informed no later than 24 hours of the start of the Insured Person's hospitalization. • For any planned hospitalization, kindly seek cashless authorization from your designated TPA atleast 48 hours prior to the start of the Insured Person's hospitalization. • TPA will check your coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent, the same shall be communicated to the hospital within 6 hours of receipt of documents. • Please pay the non-medical and expenses not covered to the hospital prior to the discharge. • In case the ailment /treatment is not covered under the policy a rejection letter would be sent to the provider within 6 hours. **Note:** • **Insured person is entitled for cashless only in our empanelled hospitals.** • **Please refer to the list of empanelled hospitals on our website or welcome kit.** • **Rejection of cashless in no way indicates rejection of the claim.**

Claim Procedure for E-opinion & Critical Illness

Intimation & Assistance	**Claims Procedure**
Please contact Your designated TPA within 14 days of diagnosis of first occurrence of Critical Illness. Our TPA can be contacted through: - 24 x 7 Toll free: 1800 - 425 - 4080 - E-mail at: info@fhpl.net - Fax at: 040-23541400 Post/ Courier to: Claims Department, Family Health Plan(TPA) Ltd., Srinilaya – Cyber Spazio, Suite # 101,102,109 & 110, Ground Floor, Road No. 2, Banjara Hills, Hyderabad-500 034 Please use the Claim Intimation Form for intimation of a claim.	**E-opinion** • Please submit duly filled claim form along with the copy of all medical reports including investigation reports and discharge summary (if any) at any of TPA Branch Office. • You need to select Our Panel Doctor from whom You would prefer to take the e-opinion. (Please refer Our Website or call at 24X 7 Toll Free line to obtain the list of Our Panel Doctors) • On receipt of the complete set of documents TPA will forward the same to the concerned doctor. • The E-Opinion will be forwarded to the member within 7 working days of the receipt of the complete set of documents. **Critical Illness** • You must intimate Your TPA within 14 days of diagnosis of first occurrence of Critical Illness. • You must submit a duly filled claim form along with specified documents within 45 days of completion of survival period for the Critical Illness against which the claim is made. • If there is any deficiency in the documents/information submitted by You, Your TPA will send the deficiency letter within 7 days of receipt of the claim documents. • Any additional information requested must be submitted within 15 days of TPA request. • On receipt of the complete set of claim documents, TPA will send the cheque for the admissible amount, along with a settlement statement within 15 days.

For any doubt or clarifications and/or information, call our Toll Free Line at 1800-102-0333 or log on to our website www.apollomunichinsurance.com or e-mail us at customerservice@apollomunichinsurance.com

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