Day2Day Care

Customer Information Sheet

ApolloMunich HEALTH INSURANCE

www.apollomunichinsurance.com

Description is illustrative and not exhaustive

TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
Product Name	Day2Day Care	
What am I covered for:	**a. Outpatient Consultations-** Unlimited Outpatient consultations by a general Medical Practitioner(s) or a specialist Medical Practitioner(s) at network centres. **b. Diagnostics, Vaccination, Physiotherapy & Pharmacy:** Outpatient diagnostic tests (including Pathology and Radiology), cost and administration of vaccination by a medical practitioner, physiotherapy undertaken by the Insured .Medicines purchased by the Insured Person upto the specified amount as per schedule. **c. Annual Health Check-Up (Applicable to Gold Plan only):** health check-up for the Insured Person	Section 2. a) Section 2. b) Section 2. c)
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. Breach of law with criminal intent, intentional or attempted suicide; abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol; Inpatient treatment & day care procedures; Naturopathy treatments(s)	Section 3. b)
Waiting Period	There is no waiting period in the plan.	Section 3. a)
Payout basis	Payout on indemnity & Benefit basis	Section 2
Cost Sharing	20% co-pay would apply on reimbursement of general & specialized consultation, expenses on diagnostic, vaccination, physiotherapy or pharmacy incurred in a non-network center or non-network pharmacy	Section 2. a) & 2. b)
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 4. k)
Renewal Benefits	Not Applicable	
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 4. o)
How to Claim	You can avail the benefits on cashless basis in network centers. In case of reimbursement claims, the Insured Person shall provide Us with any documentation and information We may request to establish the circumstances of the claim under Plan its quantum or Our liability for the claim within 15 days of Our request 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 Email Us at customerservice@apollomunichinsurance.com	Section 6

(LEGAL DISCLAIMER) NOTE: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the Key featured document and the policy document the terms and conditions mentioned in the policy document shall prevail.

Apollo Munich Health Insurance Co. Ltd. • Central Processing Center, 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana • Corp. Off. 1st Floor, SCF-19, Sector-14, Gurgaon-122001, Haryana • Reg. Off. Apollo Hospitals Complex, Jubilee Hills, Hyderabad-500033, Telangana • For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale • IRDAI Registration Number - 131 • Corporate Identity Number: U66030AP2006PLC051760

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AMHI/PR/H/0011/0119/022016/P

Day2Day Care
Policy Wording

ApolloMunich HEALTH INSURANCE
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Apollo Munich Health Insurance Company Limited will provide the insurance cover detailed in the Policy to the Insured Person up to the Sum Insured subject to the terms and conditions of this Policy, Your payment of premium, and Your statements in the Proposal, which is incorporated into the Policy and is the basis of it.

Section 1 Conditions

Claims made in respect of any of the benefits in this policy will be subject to the plan selected. However, Our maximum liability for each benefit under the selected plan shall be limited to the amount specified in the Schedule of Benefits against such benefit. An Insured Person shall only be eligible to take the treatment, consultation or avail the other covered benefits under the opted plan if all of the following requirements are satisfied:

a) The treatment, consultation or other benefits as specified in the policy is taken or undergone by the Insured Person during the Policy Period.
b) The payment of premium in full and in time.

Section 2 Salient Features & Benefits

The Policy may be obtained by the Insured Person for his own use or for any other insured person for one of the specified treatments, consultations or other specified benefits at a clinical establishment under the sections mentioned in a) to c) below:

a) Outpatient Consultations

This benefit covers unlimited Outpatient consultations by a general Medical Practitioner(s) or a specialist Medical Practitioner(s). A maximum of upto 5 consultations can be availed in a policy year for general or specialized consultation after applying a co-pay of 20% in non network centers. The coverage under this benefit will cover consultation services availed under Allopathy, Ayurveda, Unani, Siddha and Homeopathy.

b) Diagnostics, Vaccination, Physiotherapy & Pharmacy

This benefit covers outpatient diagnostic tests including pathology and radiology, cost and administration of vaccination by a medical practitioner, physiotherapy and pharmacy expenses for treatment under Allopathy, Ayurveda, Unani, Siddha and Homeopathy. A co-pay of 20% would be applicable on the benefit limit mentioned in the schedule of benefits in non-network centres and non network pharmacies.

c) Annual Health Check-Up (Applicable to Gold Plan only)

This benefit covers a health check-up as specified in the Schedule of Benefits for the Insured Person within Network in an individual policy. 2 health check-ups would be offered in a family floater policy.

In non-network centers the insured can avail the Health Check-up benefit upto a maximum of Rs 2000 per member in an Individual policy & upto Rs 4000 per policy in a Family Floater policy.

For two year policy's the insured can avail one health checkup per year per member in case of Individual policy & two health check-up per year per policy for a family floater policy.

Section 3 Exclusions

a) Waiting Periods

There is no waiting period in the plan.

b) General Exclusions:

We will not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy.

Non Medical Exclusions	i) 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.
Medical Exclusions	ii) 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. iii) Inpatient treatment and daycare procedures will not be covered. iv) Naturopathy treatment(s) will not be covered.

Section 4 General Conditions

a) Condition precedent

The fulfilment of the terms and conditions of this Policy (including the payment of premium by the due dates mentioned in the Schedule) in so far 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 or 2 year(s) period based on Policy Period selected and mentioned on the Policy Schedule and the sum insured & benefits will be applicable on Policy Year basis. There would be no carry forward of any benefits to the next 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

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 at renewal after his application has been accepted by Us and premium has been received. Member addition is allowed only at renewal and not during the policy period

Any Insured Person in the policy has the option to migrate to similar indemnity 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 refund the premium on pro rata basis received for such person IF AND ONLY IF there are no claims in respect of that Insured Person under the Policy.

d) Discounts

We will provide a Multi-Product discount of 10% on the Day2Day Care premium if it is purchased along with Easy Health, Optima Restore or Apollo Munich Health Plan of sum insured Rs.3 Lacs and above and 5% discount if purchased along with Optima Super with Deductibles of Rs.1Lac to 3 Lacs at the time of renewal or fresh policy. To avail this discount the insured persons covered under Day2Day Care policy, must be covered in the other policy as well.

The Multi product discount will not be cumulated in case an Insured person is buying multiple policies and the highest discount as per multi product discount guidelines would apply.

An additional discount of 7.5% will be provided if insured person is paying two year premium in advance as a single premium. These discounts shall be applicable at inception and renewal of the policy.

A discount of 5% on published premium will be offered, if customer buys Day2Day Care Policy through our direct channels.

e) Supporting Documentation & Examination

In case of reimbursement claims, the Insured Person shall provide Us with any documentation and information We may request to establish the circumstances of the claim under Plan its quantum or Our liability for the claim within 15 days of Our request. 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 (consultation bill; pharmacy purchase bill, physiotherapy bill, diagnostic bill, vaccination bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.

The Insured Person additionally hereby consents to:

iii) The disclosure to Us of documentation and information that may be held by medical professionals and other insurers.
iv) Being examined by any doctor We authorise for this purpose when and so often as We may reasonably require and at Our cost.

f) 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 has requested to establish the circumstances of the claim, its quantum or Our

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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. Your receipt shall be considered as a complete discharge of Our liability against any claim under this policy. In the event of Your death, We will make payment to the Nominee (as named in the Schedule).No assignment of this Policy or the benefits thereunder shall be permitted.

iii) 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 submission of all necessary documents / 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 IRDA (Protection of Policyholders Regulation), 2002. 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 IRDA (Protection of Policyholders Regulation), 2002, we shall pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us. For the purpose of this clause, 'bank rate' shall mean the existing bank rate as notified by Reserve Bank of India, unless the extent regulation requires payment based on some other prescribed interest rate.

iv) In an event claim event falls within two Policy Period then We shall settle claim by taking into consideration the available in the two Policy Periods. Such eligible claim amount to be payable to the Insured shall be reduced to the extent of premium to be received for the renewal /due date of the premium of health insurance policy, if not received earlier.

g) 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:

i) cancelled ab initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, as per our guidelines, upon 30 day notice by sending an endorsement to Your address shown in the Schedule without refunding the Premium amount; and

ii) the claim under such Policy if any, shall be rejected/repudiated forthwith.

h) Dishonest or Fraudulent Claims

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 the Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be:

i) cancelled ab-initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, as per our guidelines, upon 30 day notice by sending an endorsement to Your address shown in the Schedule without refund of premium; and

ii) all benefits Payable, if any, under such Policy shall be forfeited with respect to such claim.

i) 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 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.

j) 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.

k) Renewal

This Policy is ordinarily renewable for life unless the Insured Person or anyone acting on behalf of an Insured Person has acted in a 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 benefit or premium will be done with the approval of the Insurance Regulatory and Development Authority and will be intimated to You at least 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 similar indemnity health insurance policy available with us at the time of renewal with all the accrued continuity benefits if any provided the policy has been maintained without a break as per portability guidelines.

iii) The plan can be modified only at the time of renewal as per applicable product guidelines

iv) 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.

v) 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.

vi) We may vary the renewal premium payable with the approval of the IRDAI.

l) 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.

m) 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

il) 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.

n) 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.

o) Termination

You may terminate this Policy at any time by giving Us written notice, and the Policy shall terminate when such written notice is received. If no claim has been made under the Policy, then We will refund premium in accordance with the table below:

1 Year Policy Period		2 Year Policy Period	
Length of time Policy in force	% of premium refunded	Length of time Policy in force	% of premium refunded
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	48.00%
		Upto 15 Months	25.00%
		Upto 18 Months	12.00%
		Exceeding 18 Months	Nil

We shall terminate this Policy for the reasons as specified under aforesaid section Non-Disclosure or Misrepresentation & section Dishonest or 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, without refunding the Premium amount.

Note: If a customer has taken a 2 year policy upfront and makes a claim anytime during the 2 year tenure, then he is not eligible for any refund on cancellation as per our policy terms & conditions

p) 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.

q) **Portability:**
If you are insured continuously and without interruption in any health insurance plan with an Indian non life insurer and Health Insurer and want to shift to us on renewal, the Day2Day Care policy will allow so as per guidelines on portability issued by the insurance regulator.

Section 5 Interpretations & Definitions

The terms defined below 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. **Age** or **Aged** means completed years as at the Commencement Date.

Def.2. **Any one illness** means ontinuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

Def.3. **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.4. **Commencement Date** means the commencement date of this Policy as specified in the Schedule.

Def.5. **Clinical establishment** means a hospital, maternity home, nursing home, dispensary, clinic, sanatorium or an institution by whatever name called that offers services, facilities requiring diagnosis, treatment or care for ill ness,injury,deformity,abnormality or pregnancy in any recognised system of medicine established and administered or maintained by any person or body of persons, whether incorporated or not; or

A place established as an independent entity or part of an establishment referred to above in connection with the diagnosis or treatment of diseases where pathological,bacteriological,genetic,radiological,chemical,biological investigations or other diagnostic or investigative services with the aid of a laboratory or other medical equipment , are usually carried on, established and administered or maintained by any person or body of persons, whether incorporated or not and shall include a clinical establishment owned, controlled or managed by the Government or a department of the Government, a trust, whether public or private; a corporation (including a society) registered under a Central, Provincial or State Act, whether or owned by the Government; a local authority and a single doctor but does not include the clinical establishment owned , controlled or managed by the Armed forces.

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

Def.7. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

i. Internal Congenital Anomaly - Congenital anomaly, which is not in the visible and accessible parts of the body.

ii. External Congenital Anomaly - Congenital anomaly, which is in the visible and accessible parts of the body.

Def.8. **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.9. **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.10. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

Def.11. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –

i. has qualified nursing staff under its employment;

ii. has qualified medical practitioner/s in charge;

iii. has fully equipped operation theatre of its own where surgical procedures are carried out;

iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def.12. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and

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

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

Def.13. **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.14. **Dental treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

Def.15. **Dependent Child or Children** means Your children Aged between 91 days and 25 years at the commencement of the Policy Period if they are unmarried, still financially dependent on You and have not established their own independent households.

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

i. Your legally married

ii. Your children Aged between 91 days and 25 years if they are unmarried, still financially dependant on You and have not established their own independent households;

iii. Your natural parents or parents that have legally adopted You, provided that:

a) The parent was below 65 years at his initial participation in the Day2Day Care Policy, and

iv. Your Parent-in-law as long as Your spouse continues to be married to you and were below 65 years at their initial participation in the plan.

All Dependent parents must be financially dependent on You.

Def.17. **Disclosure to information norm:** The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, misdescription or non-disclosure of any material fact.

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

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.

Def.19. **Emergency** care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

Def.20. **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.21. **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.22. **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:

i. 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,

ii. has qualified nursing staff under its employment round the clock,

iii. has qualified Medical Practitioner(s) in charge round the clock,

iv. has a fully equipped operation theatre of its own where surgical procedures are carried out,

v. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def.23. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

Def.24. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

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

ii. Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

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

b. it needs ongoing or long-term control or relief of symptoms.

c. it requires your rehabilitation or for you to be specially trained to cope with

d. it continues indefinitely.

e. it recurs or is likely to recur.

Def.25. **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.26. **Insured Person** means You and the persons named in the Schedule.

Def.27. **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.28. **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.29. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

Def.30. **Maternity Expenses** means;

i. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

ii. expenses towards lawful medical termination of pregnancy during the policy period.

Def.31. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

Def.32. **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.33. **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.

Def.34. **Medically necessary treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

i. is required for the medical management of the illness or injury suffered by the insured;

ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii. must have been prescribed by a medical practitioner;

iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Def.35. **Network Provider or Network centre** means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured on payment by a cashless facility

Def.36. **Non Network** means any Hospital, day care centre or other provider that is not part of the Network.

Def.37. **Newborn baby** means baby born during the Policy Period and is aged upto 90 days.

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

Def.40. **Pre-Existing Disease** means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.

Def.41. **Pre - Hospitalisation Medical Expenses** means the Medical expenses incurred immediately before the Insured Person is Hospitalised, provided that:

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

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

Def.42. **Post- Hospitalisation Medical Expenses** means Medical expenses incurred immediately after the insured person is discharged from the hospital provided that:

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

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

Def.43. **Policy** means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), Appendix 1 and the Schedule (as the same may be amended from time to time).

Def.44. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def.45. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def.46. **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.47. **Pathology** means laboratory testing of blood and other bodily fluids, tissues, and microscopic evaluation of individual cells.

Def.48. **Qualified nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

Def.49. **Radiology** means the branch of medicine that deals with diagnostic images of anatomic structures through the use of electromagnetic radiation or sound waves and that treats disease through the use of radioactive compounds. Radiologic imaging techniques include x-rays, CAT scans, PET scans, MRIs, and ultrasonograms.

Def.50. **Reasonable and Customary Necessary** 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.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. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

Def.53. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

Def.54. **Unproven/Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

Def.55. **We/Our/Us** means the Apollo Munich Health Insurance Company Limited.

Def.56. **You/Your/Policyholder** means the person named in the schedule who has concluded this policy with us.

Section VIII. 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,
Road No. 2, Banjara Hills, Hyderabad-500034, Telangana.
or : Claims Department,
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.

Additional Note: Please refer to the list of empanelled network centers on our website.

Section IX. 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.

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 Governing Body of Insurance Council (Monitoring Body for Offices of Insurance Ombudsman) 3rd Floor, Jeevan Seva Annexe, Santacruz(West), Mumbai – 400054. **Tel:** 26106671/ 6889. **Email id:** inscoun@gbic.co.in **Website:** www.gbic.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 - 380 001.** **Tel:** 079 - 25501201/02/05/06 **Email:** bimalokpal.ahmedabad@gbic.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@gbic.co.in
Office of the Insurance Ombudsman, 62, Forest Park, **BHUBANESHWAR - 751 009.** **Tel:** 0674 - 2596455/2596003 **Fax:** 0674 - 2596429 **Email:** bimalokpal.bhubaneswar@gbic.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@gbic.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@gbic.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@gbic.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@gbic.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@gbic.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@gbic.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@gbic.co.in

Day2Day Care
Policy Wording

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

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@gbic.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@gbic.co.in
Office of the Insurance Ombudsman, Ground Floor, Jeevan Nidhi II, Bhawani Singh Road, **JAIPUR – 302 005.** **Tel:** 0141 - 2740363 **Email:** bimalokpal.jaipur@gbic.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@gbic.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@gbic.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@gbic.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@gbic.co.in.	

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

Schedule of Benefits

SILVER PLAN				
	Individual	**Family Floater**		
	1 member	**2 members**	**3 members**	**4 members**
Outpatient Consultation (general & specialized)	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network
Pharmacy & Diagnostics (including Pathology; radiology; vaccination; physiotherapy)	Network - Upto Rs 5000/Year Non Network- Upto Rs. 5000/ year after applying 20% co-pay	Network - Upto Rs 6000/Year Non Network- Upto Rs. 6000/ year after applying 20% co-pay	Network - Upto Rs 7000/Year Non Network- Upto Rs. 7000/ year after applying 20% co-pay	Network- Upto Rs 8000/Year Non Network- Upto Rs. 8000/ year after applying 20% co-pay
Health check	NA	NA	NA	NA

GOLD PLAN				
	Individual	**Family Floater**		
	1 member	**Upto 2 members**	**Upto 3 members**	**Upto 4 members**
Doctor Consultation (general & specialized)	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network	Unlimited for Network & maximum upto 5 consultation after applying 20% co-pay in Non-Network
Pharmacy & Diagnostics (including Pathology; radiology; vaccination; physiotherapy)	Network - Upto Rs 5000/Year Non Network- Upto Rs. 5000/ year after applying 20% co-pay	Network - Upto Rs 6000/Year Non Network- Upto Rs. 6000/ year after applying 20% co-payze	Network - Upto Rs 7000/Year Non Network- Upto Rs. 7000/ year after applying 20% co-pay	Network- Upto Rs 8000/Year Non Network- Upto Rs. 8000/ year after applying 20% co-pay
Health check	Annual Health Check Up at network centre Non-Network: Upto a maximum of Rs 2000 per member	2 Annual Health Check-Ups at network centre Non-Network: Upto a maximum of Rs 4000 per policy.	2 Annual Health Check-Ups at network centre Non-Network: Upto a maximum of Rs 4000 per policy.	2 Annual Health Check-Ups at network centre Non-Network: Upto a maximum of Rs 4000 per policy.

Apollo Munich Health Insurance Co. Ltd. • Central Processing Center, 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana • Corp. Off. 1st Floor, SCF-19, Sector-14, Gurgaon-122001, Haryana • Reg. Off. Apollo Hospitals Complex, Jubilee Hills, Hyderabad-500033, Telangana • For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale • IRDAI Registration Number - 131 • Corporate Identity Number: U66030AP2006PLC051760

UIN: IRDAI/HLT/AMHI/P-H/V.I/01/15-16 EC/PW/V0.01/092016

AMHI/PR/H/0012/0119/022016/P

Day2Day Care
Claim Procedure

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

Please review your Day2Day Care policy and familiarize yourself with the benefits available and the exclusions.

To help us to provide you with fast and efficient service, We kindly ask you to note the following.

1. We recommend that you keep copies of all documents submitted Apollo Munich.
2. Please quote your member ID/policy number in all your correspondences.

What do I do in case of a claim or any assistance?

Intimation & Assistance	Procedure for Reimbursement at Non Network Centers	Procedure to avail cashless Benefits at Network Centers
We can be contacted through: Apollo Munich can be contacted through: - **Website:** www.apollomunichinsurance.com - **Toll Free:** 1800 102 0333 - **Fax at:** 1800 425 4077 - **Courier:** Claims Department, Apollo Munich Health Insurance Co. Ltd., Ground Floor, Srinilaya - Cyber Spazio, Road No. 2, Banjara Hills, Hyderabad-500034, Telangana. or : Claims Department, Apollo Munich Health Insurance Co. Ltd., Central Processing Center, 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana.	**Outpatient Consultation** Upto a maximum of 5 consultations is allowed at Non Network centres on reimbursement basis. A co-pay of 20% would apply to all claims. **Diagnostics, Vaccination, Physiotherapy and Pharmacy Expenses** In case of non network centers, the claim would be settled on reimbursement basis. Diagnostic tests, vaccination and physiotherapy benefit can be availed only against a prescription from medical practitioner.A a co-pay of 20% would apply to all claims. **Health check up benefit** This benefit can be availed at Non network centers. In non-network centers the insured can avail the Health Check-up benefit upto a maximum of Rs 2000 per member in an Individual policy & upto Rs 4000 per policy in a Family Floater policy. Please send the duly signed claim form by the claimant and all the essential information / documents* once during the policy year *Documents required:- Original Invoices, Payment receipts, Original Prescription by Medical Practitioner. • If there is any deficiency in the documents/ information submitted by you, We will send the deficiency letter within 7 days of receipt of the claim documents. • On receipt of the complete set of claim documents, we will make the payment for the admissible amount, along with a settlement statement within 30 days. • The payment will be made in the name of the proposer. **Note:** **• Payment will only be made for items covered under your policy and upto the limits therein.**	**Outpatient Consultation** • The customer will approach our network center and present his Apollo Munich id card. The network clinic will check the eligible claim available on his policy from our provided system and settle the amount through a cashless transaction • Unlimited Outpatient consultation is allowed at network centers while only 5 consultations is allowed at Non Network centres on reimbursement basis. **Diagnostics, Vaccination,Physiotherapy & Pharmacy** • The customer will approach our network centre and present his Apollo Munich id card. The network centre will check the eligible claim available on his policy from our provided system and settle the amount through a cashless transaction. • Diagnostic tests, vaccination and physiotherapy benefit can be availed only against a prescription from medical practitioner. **Health check up benefit** • The customer will approach our network centre and present his Apollo Munich id card. The network centre will check the eligible claim available on his policy from our provided system and settle the amount through a cashless transaction. **Note:** **• Please refer to the list of empanelled network centers on our website.**

For any doubt or clarifications and/or information, call our **Toll Free Line** at **1800 1020 333** or log on to our website **www.apollomunichinsurance.com** or email us at **customerservice@apollomunichinsurance.com**

We would be happy to assist you. For any help contact us at: Email: customerservice@apollomunichinsurance.com Toll Free: 1800 102 0333

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