Frequently Asked Questions

Group Activ Health

What is Group Activ Health?

Group Activ Health is a Group health insurance Policy offered by the Group master policy holder (Aditya Birla Idea Payments Bank and underwritten by Aditya Birla Health insurance

Who can enrol for this policy?

All full KYC compliant customers (having one or all of the following active account - Savings Account/ Current Account/wallet) of Aditya Birla Idea Payments Bank are eligible to enroll for this policy

Is there an eligible age limit for enrolling within this policy?

All adults aged between18-60 years are eligible to enrol for this policy

Can I include my dependents/parents/spouse/kids/ siblings to my policy?

This policy only covers self and cannot include dependents/parents/spouse/kids/ siblings

What are the benefits under my policy?

In-patient Hospitalization

Insurer will cover the Medical Expenses incurred towards one or more of the following arising out of an Insured Person's Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period.
(i) The Hospitalization is for Medically Necessary Treatment and follows written Medical Advice;
(ii) The Medical Expenses incurred are Reasonable and Customary Charges for one or more of the following:
(1) Room Rent and other boarding charges;
(2) ICU Charges;
(3) Operation theatre expenses;
(4) Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
(5) Qualified Nurses' charges;
(6) Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
(7) Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized and conducted within the same Hospital where the Insured Person is admitted;
(8) Anaesthesia, blood, oxygen and blood transfusion charges;
(9) Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.
(iii) If the Insured Person is admitted in the Hospital in a room category/Room Rent higher than the eligibility as specified in the Policy Schedule/Certificate of Insurance, then Insurer shall be liable to pay only a pro-rated proportion of the total Associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent actually incurred and the entitled room category/eligible Room Rent to the Room Rent actually incurred.

Room Rent Restriction
1% of Sum Insured for Normal & 2 % of Sum Insured for ICU, All other charges like professional fees, OT charges, investigation charges/ lab reports will be in accordance with the room rent restriction

Day Care Treatment

Insurer will cover the Medical Expenses incurred on the Insured Person's Day Care Treatment during the Policy Period following an Illness or Injury that occurs during
the Policy Period provided that:
(i) The Medical Expenses are incurred, including for any procedure which requires a period of specialized observation or care after completion of the procedure
undertaken by an Insured Person as Day Care Treatment and such list of Day Care Treatment is listed in Annexure I;
(ii) The Day Care Treatment is for Medically Necessary Treatment and follows the written Medical Advice;
(iii) Insurer will not cover any OPD Treatment under this Benefit.

Domiciliary Hospitalization

Insurer will cover Medical Expenses incurred for the Insured Person's Domiciliary Hospitalization during the Policy Period following an Illness or Injury that occurs
during the Policy Period provided that:
(i) The Domiciliary Hospitalisation continues for at least 3 consecutive days in which case Insurer will make payment under this Benefit in respect of Medical
Expenses incurred from the first day of Domiciliary Hospitalisation;
(ii) The treating Medical Practitioner confirms in writing that Domiciliary Hospitalization was medically required and the Insured Person's condition was such
that the Insured Person could not be transferred to a Hospital or the Insured Person satisfies Us that a Hospital bed was unavailable;
(iii) If a claim is accepted under this Benefit then Insurer shall not pay any Post-hospitalization Medical Expenses, but Insurer will accept a claim for Pre-hospitalization
Medical Expenses subject to the terms and conditions of Section <<1.4.>> below;
(iv) Insurer shall not be liable to pay for any claim in connection with:
(1) Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
(2) Arthritis, gout and rheumatism;
(3) Chronic nephritis and nephritic syndrome;
(4) Diarrhea and all type of dysenteries, including gastroenteritis;
(5) Diabetes mellitus and insipidus;
(6) Epilepsy;
(7) Hypertension;
(8) Psychiatric or psychosomatic disorders of all kinds;
(9) Pyrexia of unknown origin.

Pre – hospitalization Medical Expenses

Insurer will cover, on a reimbursement basis, the Insured Person's Pre-Hospitalization Medical Expenses incurred in respect of an Illness or Injury that occurs during the Policy Period upto 30 number of days as specified in the Policy Schedule or Certificate of Insurance, provided that:
(i) Insurer have accepted a claim for In-patient Hospitalization under Section in patient hospitalisation mentioned in this document;
(ii) The date of admission to the Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Illness for which Insurer have accepted an In-patient Hospitalization claim under Section on in patient hospitalisation mentioned in this document;
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Post – hospitalization Medical Expenses

Insurer will cover, on a reimbursement basis, the Insured Person's Post-Hospitalization Medical Expenses incurred following an Illness or Injury that occurs during the Policy Period upto 60 number of days, as specified in the Policy Schedule or Certificate of Insurance, provided that:
(i) Insurer have accepted a claim for In-patient Hospitalization under Section

in patient hospitalisation mentioned in this document;
;
(ii) The date of discharge from the Hospital for the purpose of this Benefit shall be the date of the Insured Person's last discharge from the Hospital in relation to the same Illness for which Insurer have accepted an In-patient Hospitalization claim under Section in patient hospitalisation mentioned in this document;

Road Ambulance Expenses

Insurer will cover Rs.1000/- max per hospitalisation on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period. Insurer will also cover the costs incurred on transportation of the Insured Person by road Ambulance in the following circumstances up to Rs.1000/-:
(i) it is medically required to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital;
(ii) it is medically required to transfer the Insured Person to another Hospital during the course of Hospitalization due to lack of super speciality treatment in the existing Hospital.

Is there any waiting period applicable in my policy?

Yes, a waiting period of 24 months from the Start Date shall apply to the treatment, whether medical or surgical and of the Illness/conditions and their complications mentioned below.

SN	Body System	Illness	Treatment/ Surgery
1	Eye	Cataract	Cataract Surgery
		Glaucoma	Glaucoma Surgery
2	Ear Nose Throat	Serous Otitis Media	
		Sinusitis	Sinus Surgery
		Rhinitis	Surgery for the nose
		Tonsillitis	Tonsillectomy
		Tympanitis	Tympanoplasty
		Deviated Nasal Septum	Surgery for Deviated Nasal Septum
		Otitis Media	Surgery or Treatment for Otitis Media
		Adenoiditis	Adenoidectomy
		Mastoiditis	Mastoidectomy
		Cholesteatoma	Resection of the Nasal Concha
3	Gynecology	All Cysts & Polyps of the female genito urinary system	Dilatation & Curettage
		Polycystic Ovarian Disease	Myomectomy
		Uterine Prolapse	Uterine prolapsed Surgery
		Fibroids (Fibromyoma)	Hysterectomy unless by necessitated malignancy
		Breast lumps	Any treatment for Menorrhagia
		Prolapse of the uterus	
		Dysfunctional Uterine Bleeding (DUB)	
		Endometriosis	

		Menorrhagia	
		Pelvic Inflammatory Disease	
4	Orthopedic / Rheumatological	Gout	Joint replacement Surgery
		Rheumatism, Rheumatoid Arthritis	Surgery for Prolapse of the intervertebral disc
		Non infective arthritis	
		Osteoarthritis	
		Osteoporosis	
		Prolapse of the intervertebral disc	
		Spondylopathies	
5	Gastroenterology and (Alimentary Canal related Organs)	Stone in Gall Bladder and Bile	Surgery for Ulcers (Gastric / Duodenal)
		[duct]Cholecystitis	
		Pancreatitis	
		Fissure, Fistula in ano, hemorrhoids (piles), Pilonidal Sinus, Ano-rectal & Perianal Abscess	
		Rectal Prolapse	
		Gastric or Duodenal Erosions or Ulcers + Gastritis & Duodenitis	
		Gastro Esophageal Reflux Disease (GERD)	
		Cirrhosis	
6	Urogenital (Urinary and Reproductive system)	Stones in Urinary system (Stone in the Kidney, Ureter,	Prostate Surgery
		Benign Hypertrophy / Enlargement of Prostate (BHP / BEP)	
		Hernia, Hydrocele,	Surgery for Hydrocele, Rectocele and Hernia
		Varicocoele / Spermatocoele	Surgery for Varicocoele / Spermatocoele
7	Skin	skin tumour (unless malignant)	Removal of such tumour unless malignant
		All skin diseases	
8	General Surgery	Any sInsurerlling, tumour, cyst, nodule, ulcer, polyp anywhere in the body (unless malignant)	Surgery for cyst, tumour, nodule, polyp unless malignant
		Varicose veins, Varicose ulcers	
		Congenital Internal Diseases or Anomalies	Surgery for Varicose veins and Varicose ulcers

If any of the Illness/conditions listed above are Pre-Existing Diseases, then they will be covered only after the completion of the Pre-Existing Disease Waiting Period described under Pre-existing waiting period sections.

What is my Sum Insured?

You sum Insured and premium details are mentioned in your certificate of insurance

What are the options & premiums available to me for selection (inclusive of GST)?

Cover	50,000	1,00,000	2,00,000	3,00,000	5,00,000
Price to customer					
Monthly (Rs.)	150.0	198.0	258.0	288.0	402.0
Annual (Rs.)	1,644.0	2,181.0	2,832.0	3,170.0	4,428.0

Can I increase or decrease my Sum Insured now?

The Sum Insured can be changed only at your next enrolment.

What are the payment options available to me?

You have 2 payment options, Annual and Monthly. However, any change to the mode can be done only at your next enrolment and not in between the policy year. For all monthly mode policies, since premium is paid on installment basis, in case of any claim balance of remaining installment premium will be deducted from the claim amount. In the event of non-receipt of the due instalment of premium within 15 days from due date in the manner specified under Rule 58 of the Insurance Rules 1939, then the Policy shall be null and void and no Benefit shall be payable hereunder.

Can I change my payment mode?

Any changes to the policy can be made only at fresh enrolment.

Is there a Free Look period within this policy?

There is no free look period within this policy

How do I know my next premium due date?

An SMS prior to the premium due date will be shared informing you to the premium due date.

List of personal details that can be modified during midterm of the policy?

For all changes to your policy, you would need to contact the ABPB Contact Centre 1800 2092265.

The name on my Certificate is incorrect, how do I change this?

You will need to contact the ABPB Contact Centre.

What is a E-health card?

A E-health card is a card that comes along with the Policy. It is similar to an Identity card. This card would entitle you to avail cashless hospitalisation facility at any of our network hospitals. For your convenience this card has been made a part of your COI.

What are benefits of a E-health card?

A E-health card mentions the contact details and the contact numbers. In case of a medical emergency, you can call on these numbers for queries, clarifications and for seeking any kind of

assistance. Moreover, you need to display your E-health card at the time of admission into the hospital.

What is network panelled hospital?

The company ties up with hospitals for cashless claim process. When you avail of a cashless treatment in any of these network hospitals, the company would settle the claim with the hospital directly. For a complete list of network hospitals, you may call the ABPB Contact Centre.

Claim Queries:

How to intimate a claim?

A claim can be intimated by calling the ABPB contact centre toll free number (1800 209 2265). After this the Insurance company will contact the Nominee/Legal heir/Claim initiator and communicate the list of documents and formalities to be carried out. The insurance company will generate a claim number and share the same with you for future reference of the claim.

What is Pre-Authorization?

In a pre-authorization process, the insured or the service provider seeks an approval and guarantee of payment from the insurer or it's TPA for the covered services before the Hospitalization / service for planned treatment and during the course of Hospitalization / service for emergency treatment. ABHI must receive intimation from ABPB to pre-authorise Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment.

List the Coverages included in the In-Patient / Hospitalization Benefits.

Refer to in-patient hospitalisation section.

What is Cashless Hospitalization? How can I avail a cashless facility?

In a cashless claim the insured is required to intimate ABPB who shall intimate the TPA to avail cashless facility. After authorizing it, the TPA directly settles the claim to the network hospital and the insured is not required to pay any charges except non-medical expenses or other expenses not covered under the policy. Insured policy is entitled for cashless only in our network hospitals along with TPA's network.
For any emergency Hospitalisation, ABHI must be informed no later than 24 hours after hospitalization. For any planned hospitalization, kindly seek cashless authorization from ABHI at least 72 hours prior to the 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. Rejection of cashless in no way indicates rejection of the claim.
Or
Cashless claims facility is available on Insurer/TPA network of tied-up hospital the claims are settled directly with the hospital / nursing home without the insured having to pay the hospital. In the case of pre-planned hospitalization, if the chosen hospital is in network of cashless hospitals, the insured would need to request the hospital to send the TPA a Pre-Authorization Request form along with supporting documents from the doctor about the nature of illness and treatment.
Third Party Administrator receives the information, and if the claim is admissible, the TPA sends the insured a pre-authorization, in a matter of few hours.

What is a reimbursement claim? How can I file a reimbursement claim?

In a reimbursement claim the insured has to pay upfront for the services of the provider and seek reimbursement from the insurer for the covered services. Please check below on how to file a reimbursement claim.
a. Insured gets admitted to the hospital

b. Takes treatment and pays hospital bills. Gets back all original documents from the hospital
c. Intimates ABHI within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier. If the claim is not notified to Us within the earlier of 48 hours of the Insured Person's admission to the Hospital or before the Insured Person's discharge from the Hospital, then Insurer shall be provided the reasons for the delay in writing. Insurer will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control
e. In the unfortunate event of the Insured Person's death, Insurer will pay the nominee named in the Policy Schedule or Certificate of Insurance, or to the Insured Person's legal heirs or legal representatives holding a valid succession certificate.
f. Submits all original and necessary documents to the TPA along with duly filled claim form
e. TPA will review the documents and effect payment within 21 days of receiving the complete documents. If the claim is rejected, a letter will be sent along with the reasons of rejection

How can I claim my pre & post hospitalization expenses?

The same in-hospitalization claim process to be followed for pre and post hospitalization claim.

How do I find out which hospitals are a part of insurance network?

You may get the list on the TPA portal www.mediassistindia.com

What is the claim settlement period?

Please refer to Certificate of Insurance (CoI) or contact call centre for details.

General Queries:

1. What is a Third Party Administrator?

TPA stands for Third Party Administrator, whom insurer appoints from time to time as specified in policy schedule to administer and process all the claims registered under the policy. All the claims whether cashless or reimbursement will be processed and settled by specified Third Party Administrator (TPA) licensed by IRDA.

2. What is domiciliary hospitalization? What is cover under it?

Domiciliary hospitalization means treatment done at home in India for a period exceeding three days for disease, illness or injury, which in the normal course, would require hospitalization. This could happen if either the condition of the patient is such that he/she cannot be moved to Hospital/Nursing Home, or the patient cannot be admitted to Hospital/Nursing Home for lack of accommodation. For coverage details refer to the terms and conditions of policy.

3. Are there any territorial restrictions applicable to the policy?

Yes, the health insurance policy is meant to cover hospitalization only in India

5. How many claims are allowedin a year?

Any number of claims can be made during the policy period subject to sum insured mentioned in your policy.

6. How can I cancel my policy?

Insurer shall cancel the Policy and refund the premium (for all lives which have not registered a claim with Us) on pro rata basis

You further understand and agree that Insurer may cancel the Policy by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material fact by You without any refund of premium. Insurer may also cancel the Policy with or without refund of premium in case of non-cooperation by You or the Insured Person.

7. Is there a Grievances Redressal Procedure

In case of a grievance, ou can contact Aditya Birla Health Insurance Company with the details through:

Webite: Iecare.healthinsurance@adityabirlacapital.com

Email: PaymentBank.healthinsurance@adityabirlacapital.com

Toll Free: 1800-270-7000

Please refer to your Certificate of Insurance for further details.

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